

Blue Shield Silver 70 Off Exchange PPO

Provider Network: Exclusive

Evidence of Coverage and Health Service Agreement

Individual and Family Plans

An independent member of the Blue Shield Association

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Blue Shield of California

Blue Shield Silver 70 PPO

Evidence of Coverage and Health Service Agreement

This AGREEMENT is issued by California Physicians' Service d/b/a Blue Shield of California ("Blue Shield"), a not for profit health care service plan, to the Subscriber whose identification cards are issued with this Agreement. In consideration of statements made in the application and timely payment of Premiums, Blue Shield agrees to provide the Benefits of this Agreement.

PLEASE READ THE FOLLOWING IMPORTANT NOTICES ABOUT THIS HEALTH PLAN

Please read this Evidence of Coverage and Health Service Agreement carefully and completely to understand which services are Covered Services, and the limitations and exclusions that apply to the plan. Pay particular attention to those sections that apply to any special health care needs.

Blue Shield provides a matrix summarizing key elements of this Blue Shield health plan at the time of enrollment. This matrix allows individuals to compare the health plans available to them. The Evidence of Coverage and Health Service Agreement is available for review prior to enrollment in the plan. For questions about this plan, please contact Blue Shield Customer Service at the address or telephone number provided on the back page of this Evidence of Coverage.

Packaged Plan: This health plan is part of a package that consists of a health plan and a dental plan which is offered at a package rate. This Evidence of Coverage and Health Service Agreement describes the benefits of the health plan as part of the package

Notice About Plan Benefits: No person has the right to receive the Benefits of this plan for services or supplies furnished following termination of coverage. Benefits of this plan are available only for services and supplies furnished during the term it is in effect and while the individual claiming Benefits is actually covered by this Agreement. Benefits may be modified during the term of this plan as specifically provided under the terms of this Agreement or upon renewal. If Benefits are modified, the revised Benefits (including any reduction in Benefits or the elimination of Benefits) apply for services or supplies furnished on or after the effective date of the modification. There is no vested right to receive the Benefits of this Agreement.

Notice About Reproductive Health Services: Some hospitals and other providers do not provide one or more of the following services that may be covered under your plan contract and that you or your family member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; Infertility treatments; or abortion. You should obtain more

information before you enroll. Call your prospective doctor, medical group, independent practice association, or clinic, or call the health plan at Blue Shield's Customer Service telephone number provided on the back page of this Evidence of Coverage and Health Service Agreement to ensure that you can obtain the health care services that you need.

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

Notice About Health Information Exchange Participation: Blue Shield participates in the **California Integrated Data Exchange (Cal INDEX)** Health Information Exchange ("HIE") making its Members' health information available to Cal INDEX for access by their authorized health care providers. Cal INDEX is an independent, not-for-profit organization that maintains a statewide database of electronic patient records that includes health information contributed by doctors, health care facilities, health care service plans, and health insurance companies. Authorized health care providers (including doctors, nurses, and hospitals) may securely access their patients' health information through the Cal INDEX HIE to support the provision of safe, high-quality care.

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

Every Blue Shield Member has the right to direct Cal INDEX not to share their health information with their health care providers. Although opting out of Cal INDEX may limit your health care provider's ability to quickly access important health care information about you, a Member's health insurance or health plan benefit coverage will not be affected by an election to opt-out of Cal INDEX. No doctor or hospital participating in Cal INDEX will deny medical care to a patient who chooses not to participate in the Cal INDEX HIE.

Members who do not wish to have their healthcare information displayed in Cal INDEX, should fill out the online form at www.calindex.org/opt-out or call Cal INDEX at **(888) 510-7142**.

Blue Shield of California

Subscriber Bill of Rights

As a Blue Shield Subscriber, you have the right to:

- 1) Receive considerate and courteous care, with respect for your right to personal privacy and dignity.
 - 2) Receive information about all health services available to you, including a clear explanation of how to obtain them.
 - 3) Receive information about your rights and responsibilities.
 - 4) Receive information about your Blue Shield plan, the services we offer you, the Physicians and other practitioners available to care for you.
 - 5) Have reasonable access to appropriate medical services.
 - 6) Participate actively with your Physician in decisions regarding your medical care. To the extent permitted by law, you also have the right to refuse treatment.
 - 7) A candid discussion of appropriate or Medically Necessary treatment options for your condition, regardless of cost or benefit coverage.
 - 8) Receive from your Physician an understanding of your medical condition and any proposed appropriate or Medically Necessary treatment alternatives, including available success/outcomes information, regardless of cost or benefit coverage, so you can make an informed decision before you receive treatment.
 - 9) Receive preventive health services.
 - 10) Know and understand your medical condition, treatment plan, expected outcome, and the effects these have on your daily living.
 - 11) Have confidential health records, except when disclosure is required by law or permitted in writing by you. With adequate notice, you have the right to review your medical record with your Physician.
 - 12) Communicate with and receive information from Customer Service that is in a language you can understand.
 - 13) Know about any transfer to another Hospital, including information as to why the transfer is necessary and any alternatives available.
 - 14) Be fully informed about the Blue Shield grievance procedure and understand how to use it without fear of interruption of health care.
 - 15) Voice complaints or grievances about the Blue Shield plan or the care provided to you.
 - 16) Participate in establishing Public Policy of the Blue Shield plan, as outlined in your Evidence of Coverage.
 - 17) Make recommendations regarding Blue Shield's Member rights and responsibilities policy.
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Blue Shield of California

Subscriber Responsibilities

As a Blue Shield Subscriber, you have the responsibility to:

- 1) Carefully read all Blue Shield plan materials immediately after you are enrolled so you understand how to use your Benefits and how to minimize your out of pocket costs. Ask questions when necessary. You have the responsibility to follow the provisions of your Blue Shield plan membership as explained in the Evidence of Coverage and Health Service Agreement.
- 2) Maintain your good health and prevent illness by making positive health choices and seeking appropriate care when it is needed.
- 3) Provide, to the extent possible, information that your Physician, and/or Blue Shield need to provide appropriate care for you.
- 4) Understand your health problems and take an active role in developing treatment goals with your medical care provider, whenever possible.
- 5) Follow the treatment plans and instructions you and your Physician have agreed to and consider the potential consequences if you refuse to comply with treatment plans or recommendations.
- 6) Ask questions about your medical condition and make certain that you understand the explanations and instructions you are given.
- 7) Make and keep medical appointments and inform your Physician ahead of time when you must cancel.
- 8) Communicate openly with the Physician you choose so that you can develop a strong partnership based on trust and cooperation.
- 9) Offer suggestions to improve the Blue Shield plan.
- 10) Help Blue Shield to maintain accurate and current medical records by providing timely information regarding changes in address, family status, and other health plan coverage.
- 11) Notify Blue Shield as soon as possible if you are billed inappropriately or if you have any complaints.
- 12) Treat all Blue Shield personnel respectfully and courteously as partners in good health care.
- 13) Pay your Premiums, Copayments, Coinsurance, and charges for non-Covered Services on time.
- 14) For all Mental Health Services, follow the treatment plans and instructions agreed to by you and the Mental Health Service Administrator (MHSA) and obtain prior authorization as required.
- 15) Follow the provisions of the Blue Shield Benefits Management Program.

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Summary of Benefits

Individual and Family Plan
PPO Benefit Plan

Silver 70 Off Exchange PPO

This Summary of Benefits shows the amount you will pay for covered services under this Blue Shield of California benefit plan. It is only a summary and it is part of the contract for health care coverage, called the Evidence of Coverage (EOC).¹ Please read both documents carefully for details.

Provider Network:

Exclusive PPO Network

This benefit plan uses a specific network of health care providers, called the Exclusive PPO provider network. Providers in this network are called participating providers. You pay less for covered services when you use a participating provider than when you use a non-participating provider. You can find participating providers in this network at blueshieldca.com.

Calendar Year Deductibles (CYD)²

A calendar year deductible (CYD) is the amount a member pays each calendar year before Blue Shield pays for covered services under the benefit plan. Blue Shield pays for some covered services before the calendar year deductible is met, as noted in the Benefits chart below.

		When using a participating provider ³	When using a non-participating provider ⁴
Calendar year medical deductible	<i>Individual coverage</i>	\$2,500	\$5,000
	<i>Family coverage</i>	\$2,500: individual \$5,000: family	\$5,000: individual \$10,000: family
Calendar year pharmacy deductible	<i>Individual coverage</i>	\$130	not covered
	<i>Family coverage</i>	\$130: individual \$260: family	not covered

Calendar Year Out-of-Pocket Maximum⁵

An out-of-pocket maximum is the most a member will pay for covered services each calendar year. Any exceptions are listed in the Notes section at the end of this Summary of Benefits.

No Lifetime Benefit Maximum

Under this benefit plan there is no dollar limit on the total amount Blue Shield will pay for covered services in a member's lifetime.

	When using a participating provider ³	When using a non-participating provider ⁴
<i>Individual coverage</i>	\$7,000	\$20,000
<i>Family coverage</i>	\$7,000: individual \$14,000: family	\$20,000: individual \$40,000: family

	When using a participating provider ³	CYD ² applies	When using a non-participating provider ⁴	CYD ² applies
Preventive Health Services⁷	\$0		Not covered	
Physician services				
Primary care office visit	\$35/visit		50%	✓
Specialist care office visit	\$75/visit		50%	✓
Physician home visit	\$75/visit		50%	✓
Physician or surgeon services in an outpatient facility	20%		50%	✓
Physician or surgeon services in an inpatient facility	20%	✓	50%	✓
Other professional services				
Other practitioner office visit <i>Includes nurses, nurse practitioners, and therapists.</i>	\$35/visit		50%	✓
Acupuncture services	\$35/visit		50%	✓
Chiropractic services	Not covered		Not covered	
Teladoc consultation	\$5/consult		Not covered	
Family planning				
• Counseling, consulting, and education	\$0		Not covered	
• Injectable contraceptive; diaphragm fitting, intrauterine device (IUD), implantable contraceptive, and related procedure.	\$0		Not covered	
• Tubal ligation	\$0		Not covered	
• Vasectomy	20%		Not covered	
• Infertility services	Not covered		Not covered	
Podiatric services	\$75/visit		50%	✓
Pregnancy and maternity care⁷				
Physician office visits: prenatal and initial postnatal	\$0		50%	✓
Physician services for pregnancy termination	20%		50%	✓
Emergency services and urgent care				
Emergency room services <i>If admitted to the hospital, this payment for emergency room services does not apply. Instead, you pay the participating provider payment under Inpatient facility services/ Hospital services and stay.</i>	\$350/visit		\$350/visit	
Emergency room physician services	\$0		\$0	
Urgent care physician services	\$35/visit		50%	✓
Ambulance services	\$255/transport	✓	\$255/transport	✓

	When using a participating provider ³	CYD ² applies	When using a non-participating provider ⁴	CYD ² applies
Outpatient facility services				
Ambulatory surgery center	20%		50% up to \$300/day plus 100% of additional charges	✓
Outpatient department of a hospital: surgery	20%		50% up to \$500/day plus 100% of additional charges	✓
Outpatient department of a hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies	20%		50% up to \$500/day plus 100% of additional charges	✓
Inpatient facility services				
Hospital services and stay	20%	✓	50% up to \$500/day plus 100% of additional charges	✓
Transplant services				
<i>This payment is for all covered transplants except tissue and kidney. For tissue and kidney transplant services, the payment for Inpatient facility services/ Hospital services and stay applies.</i>				
• Special transplant facility inpatient services	20%	✓	Not covered	
• Physician inpatient services	20%	✓	Not covered	
Bariatric surgery services, designated California counties				
<i>This payment is for bariatric surgery services for residents of designated California counties. For bariatric surgery services for residents of non-designated California counties, the payments for Inpatient facility services/ Hospital services and stay and Physician inpatient and surgery services apply for inpatient services; or, if provided on an outpatient basis, the Outpatient facility services and Outpatient physician services payments apply.</i>				
Inpatient facility services	20%	✓	Not covered	
Outpatient facility services	20%		Not covered	
Physician services	20%	✓	Not covered	

	When using a participating provider ³	CYD ² applies	When using a non-participating provider ⁴	CYD ² applies
Diagnostic x-ray, imaging, pathology, and laboratory services				
<i>This payment is for covered services that are diagnostic, non-preventive health services, and diagnostic radiological procedures, such as CT scans, MRIs, MRAs, and PET scans. For the payments for covered services that are considered Preventive Health Services, see Preventive Health Services.</i>				
Laboratory services				
<i>Includes diagnostic Papanicolaou (Pap) test.</i>				
• Laboratory center	\$35/visit		50%	✓
• Outpatient department of a hospital	\$35/visit		50% up to \$500/day plus 100% of additional charges	✓
• California Prenatal Screening Program	\$0		\$0	
X-ray and imaging services				
<i>Includes diagnostic mammography.</i>				
• Outpatient radiology center	\$75/visit		50%	✓
• Outpatient department of a hospital	\$75/visit		50% up to \$500/day plus 100% of additional charges	✓
Other outpatient diagnostic testing				
<i>Testing to diagnose illness or injury such as vestibular function tests, EKG, ECG, cardiac monitoring, non-invasive vascular studies, sleep medicine testing, muscle and range of motion tests, EEG, and EMG.</i>				
• Office location	\$75/visit		50%	✓
• Outpatient department of a hospital	\$75/visit		50% up to \$500/day plus 100% of additional charges	✓
Radiological and nuclear imaging services				
• Outpatient radiology center	\$300/visit		50% up to \$300/day plus 100% of additional charges	✓

	When using a participating provider ³	CYD ² applies	When using a non-participating provider ⁴	CYD ² applies
<ul style="list-style-type: none"> Outpatient department of a hospital 	\$300/visit		50% up to \$500/day plus 100% of additional charges	✓
Rehabilitation and habilitative services <i>Includes physical therapy, occupational therapy, respiratory therapy, and speech therapy services. There is no visit limit for rehabilitation or habilitative services.</i>				
Office location	\$35/visit		50%	✓
Outpatient department of a hospital	\$35/visit		50% up to \$500/day plus 100% of additional charges	✓
Durable medical equipment (DME)				
DME	20%		50%	✓
Breast pump	\$0		Not covered	
Orthotic equipment and devices	20%		50%	✓
Prosthetic equipment and devices	20%		50%	✓
Home health services <i>Up to 100 visits per member, per calendar year, by a home health care agency. All visits count towards the limit, including visits during any applicable deductible period, except hemophilia and home infusion nursing visits.</i>				
Home health agency services <i>Includes home visits by a nurse, home health aide, medical social worker, physical therapist, speech therapist, or occupational therapist.</i>	\$45/visit		Not covered	
Home visits by an infusion nurse	\$45/visit		Not covered	
Home health medical supplies	\$45/visit		Not covered	
Home infusion agency services	\$45/visit		Not covered	
Hemophilia home infusion services <i>Includes blood factor products.</i>	\$45/visit		Not covered	

	When using a participating provider ³	CYD ² applies	When using a non-participating provider ⁴	CYD ² applies
Skilled nursing facility (SNF) services				
<i>Up to 100 days per member, per benefit period, except when provided as part of a hospice program. All days count towards the limit, including days during any applicable deductible period and days in different SNFs during the calendar year.</i>				
Freestanding SNF	20%	✓	20%	✓
Hospital-based SNF	20%	✓	50% up to \$500/day plus 100% of additional charges	✓
Hospice program services				
<i>Includes pre-hospice consultation, routine home care, 24-hour continuous home care, short-term inpatient care for pain and symptom management, and inpatient respite care.</i>				
	\$0		Not covered	
Other services and supplies				
Diabetes care services				
• Devices, equipment, and supplies	20%		50%	✓
• Self-management training	\$0		50%	✓
Dialysis services	20%		50% up to \$300/day plus 100% of additional charges	✓
PKU product formulas and special food products	20%		20%	
Allergy serum	20%		50%	✓

Mental Health and Substance Use Disorder Benefits

Your payment

<i>Mental health and substance use disorder benefits are provided through Blue Shield's mental health services administrator (MHSA).</i>	When using a MHPA participating provider³	CYD² applies	When using a MHPA non-participating provider⁴	CYD² applies
Outpatient services				
Office visit, including physician office visit	\$35/visit		50%	✓
Other outpatient services, including intensive outpatient care, behavioral health treatment for pervasive developmental disorder or autism in an office setting, home, or other non-institutional facility setting, and office-based opioid treatment	\$0		50%	✓
Partial hospitalization program	\$0		50% up to \$500/day plus 100% of additional charges	✓
Psychological testing	\$0		50% up to \$500/day plus 100% of additional charges	✓
Inpatient services				
Physician inpatient services	20%	✓	50%	✓
Hospital services	20%	✓	50% up to \$500/day plus 100% of additional charges	✓
Residential care	20%	✓	50% up to \$500/day plus 100% of additional charges	✓

Prescription Drug Benefits^{8,9}

Your payment

<i>A separate calendar year pharmacy deductible applies.</i>	When using a participating pharmacy ³	CYD ² applies	When using a non-participating pharmacy ⁴	CYD ² applies
Retail pharmacy prescription drugs				
<i>Per prescription, up to a 30-day supply.</i>				
Tier 1 drugs	\$15/prescription	✓	Not covered	
Tier 2 drugs	\$55/prescription	✓	Not covered	
Tier 3 drugs	\$80/prescription	✓	Not covered	
Tier 4 drugs (excluding specialty drugs)	20% up to \$250/prescription	✓	Not covered	
Contraceptive drugs and devices	\$0		Not covered	
Mail service pharmacy prescription drugs				
<i>Per prescription, up to a 90-day supply.</i>				
Tier 1 drugs	\$45/prescription	✓	Not covered	
Tier 2 drugs	\$165/prescription	✓	Not covered	
Tier 3 drugs	\$240/prescription	✓	Not covered	
Tier 4 drugs (excluding specialty drugs)	20% up to \$750/prescription	✓	Not covered	
Contraceptive drugs and devices	\$0		Not covered	
Specialty drugs <i>Per prescription. Specialty drugs are covered at tier 4 and only when dispensed by a network specialty pharmacy. Specialty drugs from non-participating pharmacies are not covered except in emergency situations.</i>	20% up to \$250/prescription	✓	Not covered	
Oral anticancer drugs <i>Per prescription, up to a 30-day supply.</i>	20% up to \$200/prescription		Not covered	

Pediatric Benefits

Your payment

<i>Pediatric benefits are available through the end of the month in which the member turns 19.</i>	When using a participating dentist³	CYD² applies	When using a non-participating dentist⁴	CYD² applies
Pediatric dental¹⁰				
Diagnostic and preventive services				
• Oral exam	\$0		10%	
• Preventive – cleaning	\$0		10%	
• Preventive – x-ray	\$0		10%	
• Sealants per tooth	\$0		10%	
• Topical fluoride application	\$0		10%	
• Space maintainers - fixed	\$0		10%	
Basic services				
• Restorative procedures	20%		30%	
• Periodontal maintenance	20%		30%	
Major services				
• Oral surgery	50%		50%	
• Endodontics	50%		50%	
• Periodontics (other than maintenance)	50%		50%	
• Crowns and casts	50%		50%	
• Prosthodontics	50%		50%	
Orthodontics (medically necessary)	50%		50%	

Pediatric Benefits

Your payment

<i>Pediatric benefits are available through the end of the month in which the member turns 19.</i>	When using a participating provider³	CYD² applies	When using a non-participating provider⁴	CYD² applies
Pediatric vision¹¹				
Comprehensive eye examination <i>One exam per calendar year.</i>				
• Ophthalmologic visit	\$0		\$0 up to \$30 plus 100% of additional charges	
• Optometric visit	\$0		\$0 up to \$30 plus 100% of additional charges	

Pediatric Benefits

Your payment

<i>Pediatric benefits are available through the end of the month in which the member turns 19.</i>	When using a participating provider³	CYD² applies	When using a non-participating provider⁴	CYD² applies
<p>Eyewear/materials</p> <p><i>One eyeglass frame and eyeglass lenses, or contact lenses instead of eyeglasses, up to the benefit per calendar year. Any exceptions are noted below.</i></p> <ul style="list-style-type: none"> • Contact lenses <ul style="list-style-type: none"> Non-elective (medically necessary) - hard or soft <p style="text-align: right;">\$0</p> <p><i>Up to two pairs per eye per calendar year.</i></p> Elective (cosmetic/convenience) <ul style="list-style-type: none"> Standard and non-standard, hard <p style="text-align: right;">\$0</p> <p><i>Up to a 3 month supply for each eye per calendar year based on lenses selected.</i></p> Standard and non-standard, soft <p style="text-align: right;">\$0</p> <p><i>Up to a 6 month supply for each eye per calendar year based on lenses selected.</i></p> • Eyeglass frames <ul style="list-style-type: none"> Collection frames <p style="text-align: right;">\$0</p> Non-collection frames <p style="text-align: right;">\$0 up to \$150 plus 100% of additional charges</p> • Eyeglass lenses <p><i>Lenses include choice of glass or plastic lenses, all lens powers (single vision, bifocal, trifocal, lenticular), fashion or gradient tint, scratch coating, oversized, and glass-grey #3 prescription sunglasses.</i></p> <ul style="list-style-type: none"> Single vision <p style="text-align: right;">\$0</p> 			<p>\$0 up to \$225 plus 100% of additional charges</p> <p>\$0 up to \$75 plus 100% of additional charges</p> <p>\$0 up to \$75 plus 100% of additional charges</p> <p>\$0 up to \$40 plus 100% of additional charges</p> <p>\$0 up to \$40 plus 100% of additional charges</p> <p>\$0 up to \$25 plus 100% of additional charges</p>	

Pediatric Benefits

Your payment

<i>Pediatric benefits are available through the end of the month in which the member turns 19.</i>	When using a participating provider ³	CYD ² applies	When using a non-participating provider ⁴	CYD ² applies
Lined bifocal	\$0		\$0 up to \$35 plus 100% of additional charges	
Lined trifocal	\$0		\$0 up to \$45 plus 100% of additional charges	
Lenticular	\$0		\$0 up to \$45 plus 100% of additional charges	
Optional eyeglass lenses and treatments				
• Ultraviolet protective coating (standard only)	\$0		Not covered	
• Polycarbonate lenses	\$0		Not covered	
• Standard progressive lenses	\$0		Not covered	
• Premium progressive lenses	\$95		Not covered	
• Anti-reflective lens coating (standard only)	\$35		Not covered	
• Photochromic - glass lenses	\$25		Not covered	
• Photochromic - plastic lenses	\$0		Not covered	
• High index lenses	\$30		Not covered	
• Polarized lenses	\$45		Not covered	
Low vision testing and equipment				
• Comprehensive low vision exam <i>Once every 5 calendar years.</i>	\$0		Not covered	
• Low vision devices <i>One aid per calendar year.</i>	\$0		Not covered	
Diabetes management referral	\$0		Not covered	

Prior Authorization

The following are some frequently-utilized benefits that require prior authorization:

- Radiological and nuclear imaging services
- Inpatient facility services
- Home health services from non-participating providers
- Pediatric vision non-elective contact lenses and low vision testing and equipment
- Mental health services, except outpatient office visits
- Hospice program services
- Some prescription drugs (see blueshieldca.com/pharmacy)

Please review the Evidence of Coverage for more about benefits that require prior authorization.

Notes

1 Evidence of Coverage (EOC):

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

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

2 Calendar Year Deductible (CYD):

Calendar Year Deductible explained. A deductible is the amount you pay each calendar year before Blue Shield pays for Covered Services under the benefit plan.

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

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

Essential health benefits count towards the Calendar Year Deductible.

This benefit plan has separate Deductibles for:

- medical Deductible and pharmacy Deductible
- Participating Provider Deductible and Non-Participating Provider Deductible

Family coverage has an individual Deductible within the family Deductible. This means that the Deductible will be met for an individual who meets the individual Deductible prior to the family meeting the family Deductible within a Calendar Year.

3 Using Participating Providers:

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

Your payment for services from "Other Providers." You will pay the Copayment or Coinsurance applicable to Participating Providers for Covered Services received from Other Providers. However, Other Providers do not have a contract to provide health care services to Members and so are not Participating Providers. Therefore, you will also pay all charges above the Allowable Amount. This out-of-pocket expense can be significant.

4 Using Non-Participating Providers:

Non-Participating Providers do not have a contract to provide health care services to Members. When you receive Covered Services from a Non-Participating Provider, you are responsible for both:

- the Copayment or Coinsurance (once any Calendar Year Deductible has been met), and
- any charges above the Allowable Amount (which can be significant).

"Allowable Amount" is defined in the EOC. In addition:

- Any Coinsurance is determined from the Allowable Amount.
 - Any charges above the Allowable Amount are not covered, do not count towards the Out-of-Pocket Maximum, and are your responsibility for payment to the provider. This out-of-pocket expense can be significant.
 - Some Benefits from Non-Participating Providers have the Allowable Amount listed in the Benefits chart as a specific dollar (\$) amount. You are responsible for any charges above the Allowable Amount, whether or not an amount is listed in the Benefits chart.
-

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

Your payment after you reach the calendar year OOPM. You will continue to be responsible for Copayments or Coinsurance for the following Covered Services after the Calendar Year Out-of-Pocket Maximum is met:

- bariatric surgery: additional covered travel expenses for bariatric surgery
- dialysis center benefits: dialysis services from a Non-Participating Provider
- benefit maximum: charges for services after any benefit limit is reached

Essential health benefits count towards the OOPM.

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

This benefit plan has a separate Participating Provider OOPM and Non-Participating Provider OOPM.

Family coverage has an individual OOPM within the family OOPM. This means that the OOPM will be met for an individual who meets the individual OOPM prior to the family meeting the family OOPM within a Calendar Year.

6 Separate Member Payments When Multiple Covered Services are Received:

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

7 Preventive Health Services:

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

8 Outpatient Prescription Drug Coverage: Medicare Part D-creditable coverage-

This benefit plan's prescription drug coverage is on average equivalent to or better than the standard benefit set by the federal government for Medicare Part D (also called creditable coverage). Because this benefit plan's prescription drug coverage is creditable, you do not have to enroll in Medicare Part D while you maintain this coverage; however, you should be aware that if you have a later break in this coverage of 63 days or more before enrolling in Medicare Part D you could be subject to payment of higher Medicare Part D premiums.

9 Outpatient Prescription Drug Coverage:

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

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

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

10 Pediatric Dental Coverage:

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

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

11 Pediatric Vision Coverage:

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

Covered Services from Non-Participating Providers. There is no Copayment or Coinsurance up to the listed Allowable Amount. You pay all charges above the Allowable Amount.

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

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

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

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

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

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

Introduction to the Blue Shield of California PPO Plan

This Blue Shield of California (Blue Shield) Evidence of Coverage and Health Service Agreement is the contract between Blue Shield and the Subscriber for health care coverage. A Summary of Benefits is provided with, and is incorporated as part of, the Evidence of Coverage and Health Service Agreement.

Please read both this Evidence of Coverage and Summary of Benefits carefully. Together they explain which services are covered and which are excluded. They also contain information about Member responsibilities, such as payment of applicable Copayments, Coinsurance and Deductibles and obtaining prior authorization for certain services (see the Benefits Management Program section).

Capitalized terms in this Evidence of Coverage have special meaning. Please see the Definitions section to understand these terms. Please contact Blue Shield with questions about Benefits. Contact information can be found on the last page of this Evidence of Coverage.

How to Use This Health Plan

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

Primary Care Physician

Blue Shield will designate a primary care physician for each Member at the time of enrollment, and the Member will be notified of the designation. A primary care physician can be a general practitioner, family practitioner, internist, obstetrician/gynecologist, or pediatrician. This designation will remain in effect unless the Member requests a change. The Member is not required to visit their primary care physician, or consult with their primary care physician before receiving care. However, Blue Shield urges you to

consider your primary care physician as a first point of contact when you need Covered Services.

The Member can change their designated primary care physician to a primary care physician of their choice. The Member's primary care physician must be a Participating Provider. A list of Blue Shield Participating Providers is available online at <https://www.blueshieldca.com>. Members may also call Customer Service at the number provided on the back page of this Evidence of Coverage for assistance in changing primary care physicians.

If a Member's primary care physician terminates participation in the Plan, Blue Shield will notify the Member in writing and designate a new primary care physician who is available to provide the Member's medical care. Members may then make their own selection of a new primary care physician as described above.

Choice of Providers

This Blue Shield health plan is designed for Members to obtain services from Blue Shield Participating Providers and MHSA Participating Providers. However, Members 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 the Member. Some services are not covered unless rendered by a Participating Provider or MHSA Participating Provider.

Please be aware that a provider's status as a Participating Provider or an MHSA Participating Provider may change. 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.

Call Customer Service or visit www.blueshieldca.com to determine whether a provider is a Participating Provider. Call the MHSA to determine if a provider is an MHSA Participating Provider. See the sections below and the Summary of Benefits for more details. See the

Out-of-Area Programs section for services outside of California.

Blue Shield Participating Providers

Blue Shield Participating Providers include primary care Physicians, specialists, Hospitals, and Alternate Care Services Providers that have a contractual relationship with Blue Shield to provide services to Members of this Plan. Participating Providers are listed in the Participating Provider directory.

Participating Providers agree to accept Blue Shield's payment, plus the Member's payment of any applicable Deductibles, Copayments, and Coinsurance or amounts in excess of specified Benefit maximums as payment-in-full for Covered Services, except as provided under the *Exception for Other Coverage* and the *Reductions-Third Party Liability* sections. This is not true of Non-Participating Providers.

If a Member receives services from a Non-Participating Provider, Blue Shield's payment for that service may be substantially less than the amount billed. The Subscriber is responsible for the difference between the amount Blue Shield pays and the amount billed by the Non-Participating Provider.

If a Member receives services at a facility that is a Participating Provider, Blue Shield's payment for Covered Services provided by a health professional at the Participating Provider facility will be paid at the Participating Provider level of Benefits, whether the health professional is a Participating Provider or Non-Participating Provider.

Some services are covered only if rendered by a Participating Provider. In these instances, using a Non-Participating Provider could result in a higher share of cost to the Member or no payment by Blue Shield for services received.

Payment for Emergency Services rendered by a Physician or Hospital that is not a Participating Provider will be based on Blue Shield's Allowable Amount and will be paid at the Participating level

of Benefits. The Member is responsible for notifying Blue Shield within 24 hours, or as soon as reasonably possible following medical stabilization of the emergency condition.

The Member should contact Member Services if the Member needs assistance locating a provider in the Member's Service Area. The Plan will review and consider a Member's request for services that cannot be reasonably obtained in network. If a Member's request for services from a Non-Participating Provider or MHSA Non-Participating Provider is approved at an in-network benefit level, the Plan will pay for Covered Services at a Participating Provider level.

Please call Customer Service or visit www.blueshieldca.com to determine whether a provider is a Participating Provider.

MHSA Participating Providers

For Mental Health Services, Behavioral Health Treatment, and Substance Use Disorder Services, Blue Shield has contracted with a Mental Health Service Administrator (MHSA). The MHSA is a specialized health care service plan licensed by the California Department of Managed Health Care, and will underwrite and deliver Blue Shield's Mental Health Services, Behavioral Health Treatment, and Substance Use Disorder Services through a separate network of MHSA Participating Providers.

MHSA Participating Providers are those providers who participate in the MHSA network and have contracted with the MHSA to provide Mental Health Services, Behavioral Health Treatment, and Substance Use Disorder Services to Members of this Plan. A Blue Shield Participating Provider may not be an MHSA Participating Provider. It is the Member's responsibility to ensure that the provider selected for Mental Health Services, Behavioral Health Treatment, and Substance Use Services is an MHSA Participating Provider. MHSA Participating Providers are identified in the Blue Shield Behavioral Health Provider Directory. Additionally, Members may contact the MHSA directly by calling 1-877-263-9952.

If a Member receives services at a facility that is an MHSAs Participating Provider, MHSAs payment for Mental Health and Substance Use Disorder Services provided by a health professional at the MHSAs Participating Provider facility will be paid at the MHSAs Participating Provider level of Benefits, whether the health professional is an MHSAs Participating Provider or MHSAs Non-Participating Provider.

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 from birth to 36 months of age; or who have received authorization from a now-terminated provider for surgery or another procedure as part of a documented course of treatment can request completion of care in certain situations with a provider who is leaving the Blue Shield provider network. Contact Customer Service to receive information regarding eligibility criteria and the policy and procedure for requesting continuity of care from a terminated provider.

Second Medical Opinion Policy

Members who have questions about their diagnoses, or believe that additional information concerning their condition would be helpful in determining the most appropriate plan of treatment, may make an appointment with another Physician for a second medical opinion. The Member's attending Physician may also offer a referral to another Physician for a second opinion.

The second opinion visit is subject to the applicable Copayment, Coinsurance, Calendar Year Deductible, and all plan contract Benefit limitations and exclusions.

Services for Emergency Care

The Benefits of this plan will be provided for Emergency Services received anywhere in the

world for the emergency care of an illness or injury.

For Emergency Services from either a Participating Provider or a 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.

Members who reasonably believe that they have an emergency medical condition which requires an emergency response are encouraged to use the "911" emergency response system (where available) or seek immediate care from the nearest Hospital. For the lowest out-of-pocket expenses, covered non-Emergency Services or emergency room follow-up services (e.g., suture removal, wound check, etc.) should be received in a Participating Physician's office.

NurseHelp 24/7SM

The NurseHelp 24/7SM program offers Members access to registered nurses 24 hours a day, seven days a week. Registered nurses can provide assistance in answering many health-related questions, including concerns about:

- 1) symptoms the patient is experiencing;
- 2) minor illnesses and injuries;
- 3) chronic conditions;
- 4) medical tests and medications; and
- 5) preventive care

Members may obtain this service by calling the toll-free telephone number at 1-877-304-0504 or by participating in a live online chat at www.blueshieldca.com. There is no charge for this confidential service.

In the case of a medical emergency, call 911. For personalized medical advice, Members should consult with their physicians.

Retail-Based Health Clinics

Retail-based health clinics are outpatient facilities, usually attached or adjacent to retail stores, and pharmacies that provide limited, basic medical treatment for minor health issues. They are staffed by nurse practitioners, under the direction of a physician, and offer services on a walk-in basis. Covered Services received from retail-based health clinics will be paid on the same basis and at the same Benefit levels as other Covered Services shown in the Summary of Benefits. Retail-based health clinics may be found in the Participating Provider directory or the online provider directory located at www.blueshieldca.com. See the Blue Shield Participating Providers section for information on the advantages of choosing a Participating Provider.

Blue Shield Online

Blue Shield's Internet site is located at www.blueshieldca.com. Members with Internet access may view and download healthcare information.

Health Education and Health Promotion Services

Blue Shield offers a variety of health education and health promotion services including, but not limited to, a prenatal health education program, interactive online healthy lifestyle programs, and a monthly e-newsletter.

Timely Access to Care

Blue Shield provides the following guidelines to provide Members timely access to care from Participating Providers.

Urgent Care	Access to Care
For Services that don't need prior approval	Within 48 hours
For Services that do need prior approval	Within 96 hours
Non-Urgent Care	Access to Care

Primary care appointment	Within 10 business days
Specialist appointment	Within 15 business days
Appointment with a mental health provider (who is not a physician)	Within 10 business days
Appointment for other services to diagnose or treat a health condition	Within 15 business days
Telephone Inquiries	Access to Service
Access to a health professional for telephone screenings	24 hours/day, 7 days/week

Note: For availability of interpreter services at the time of the Member's appointment, consult the Participating Provider directory available at www.blueshieldca.com or by calling Customer Service at the telephone number provided on the back page of this EOC. More information for interpreter services is located in the *Notice of the Availability of Language Assistance Services* section of this EOC.

Cost-Sharing

The Summary of Benefits provides the Member's Copayment, Coinsurance, Calendar Year Medical Deductible and Calendar Year Out-of-Pocket Maximum amounts.

Calendar Year Medical Deductible

The Calendar Year Medical Deductible is the amount an individual or a Family must pay for Covered Services each year before Blue Shield begins payment in accordance with this Evidence of Coverage and Health Service Agreement. The Calendar Year Medical Deductible does not apply to all plans. When applied, this Deductible accrues to the Calendar Year Out-of-Pocket Maximum. Information specific to the Member's plan is provided in the Summary of Benefits.

The Summary of Benefits indicates whether or not

the Calendar Year Medical Deductible applies to a particular Covered Service.

There are individual and Family Calendar Year Medical Deductible amounts for both Participating Providers and Non-Participating Providers. Deductible amounts for Covered Services provided by Participating Providers, including Covered Services provided at a Participating Provider facility by health professionals who are Non-Participating Providers, accrue only to the Participating Provider Medical Deductible. Deductible amounts paid for Covered Services provided by Non-Participating Providers accrue only to the Non-Participating Provider Medical Deductible.

The individual Medical Deductible applies when an individual is covered by the plan. The Family Medical Deductible applies when a Family is covered by the plan.

There is also an individual Medical Deductible within the Family Medical Deductible. This means Blue Shield will pay Benefits for any Family member who meets the individual Medical Deductible amount before the Family Medical Deductible is met.

Once the respective Deductible is reached, Covered Services are paid at the Allowable Amount, less any applicable Copayment or Coinsurance, for the remainder of the Calendar Year.

For Covered Services received from Non-Participating Providers, excluding Covered Services provided at a Participating Provider facility by a health professional who is a Non-Participating Provider, the Member is responsible for the applicable Copayment or Coinsurance and for amounts billed in excess of Blue Shield's Allowable Amount. Charges in excess of Blue Shield's Allowable Amount do not accrue to the Calendar Year Medical Deductible.

The Calendar Year Medical Deductible also applies to a newborn child or a child placed for adoption who is covered for the first 31 days, even if application is not made to add the child as a

Dependent on the plan. While coverage for this child is being provided, the Family Calendar Year Medical Deductible will apply.

Calendar Year Pharmacy Deductible

The Calendar Year Pharmacy Deductible is the amount a Member must pay each Calendar Year for covered Drugs before Blue Shield begins payment in accordance with the Evidence of Coverage and Health Service Agreement. The Calendar Year Pharmacy Deductible does not apply to all plans. When it does apply, this Deductible accrues to the Calendar Year Out-of-Pocket Maximum. There is an individual deductible within the Family Calendar Year Pharmacy Deductible. Information specific to the Member's plan is provided in the Summary of Benefits.

The Summary of Benefits indicates whether or not the Calendar Year Pharmacy Deductible applies to a particular Drug.

Calendar Year Out-of-Pocket Maximum

The Calendar Year Out-of-Pocket Maximum is the highest Deductible, Copayment and Coinsurance amount an individual or Family is required to pay for designated Covered Services each year. There are separate maximums for Participating Providers and Non-Participating Providers. If a benefit plan has any Calendar Year Medical Deductible it will accumulate toward the applicable Calendar Year Out-of-Pocket Maximum. The Summary of Benefits indicates whether or not Copayment and Coinsurance amounts for a particular Covered Service accrue to the Calendar Year Out-of-Pocket Maximum.

There are individual and Family Calendar Year Out-of-Pocket Maximum amounts for both Participating Providers and Non-Participating Providers. Deductible, Copayment and Coinsurance amounts paid for Covered Services provided by Participating Providers, including Covered Services provided at a Participating Provider facility by health professionals who are Non-Participating Providers, accrue only to the Participating Provider Out-of-Pocket Maximum.

Deductible, Copayment and Coinsurance amounts paid for Covered Services provided by Non-Participating Providers accrue only to the Non-Participating Provider Out-of-Pocket Maximum.

There are individual and Family Calendar Year Out-of-Pocket Maximum amounts for both Participating Providers and Non-Participating Providers. The individual Calendar Year Out-of-Pocket Maximum applies when an individual is covered by the plan. The Family Calendar Year Out-of-Pocket Maximum applies when a Family is covered by the plan.

There is also an individual Out-of-Pocket Maximum within the Family Calendar Year Out-of-Pocket Maximum. This means that any Family member who meets the individual Out-of-Pocket Maximum will receive 100% Benefits for Covered Services, before the Family Out-of-Pocket Maximum is met.

The Summary of Benefits provides the Calendar Year Out-of-Pocket Maximum amounts for Participating Providers and Non-Participating Providers at both the individual and Family levels. When the respective maximum is reached, Covered Services will be paid by Blue Shield at 100% of the Allowable Amount or contracted rate for the remainder of the Calendar Year.

Charges for services that are not covered and charges in excess of the Allowable Amount or contracted rate do not accrue to the Calendar Year Out-of-Pocket Maximum and continue to be the Member's responsibility after the Calendar Year Out-of-Pocket Maximum is reached.

Submitting a Claim Form

Participating Providers will submit claims for payment directly to Blue Shield, however, there may be times when Members and Non-Participating Providers need to submit claims.

Except in the case of Emergency Services, Blue Shield will pay Members directly for Covered Services rendered by a Non-Participating Provider. Claims for payment must be submitted to Blue Shield within one year after the month

services were provided. Blue Shield will notify the Member of its determination within 30 days after receipt of the claim.

To submit a claim for payment, send a copy of your itemized bill, along with a completed Blue Shield claim form to the Blue Shield address listed on the last page of this Evidence of Coverage.

Claim forms are available online at www.blueshieldca.com or Members may call Blue Shield Customer Service. At a minimum, each claim submission must contain the Subscriber, name, home address, contract number, Subscriber's number, a copy of the provider's billing showing the services rendered, dates of treatment and the patient's name.

Members should submit their claims for all Covered Services even if the Calendar Year Deductible has not been met. Blue Shield will keep track of the Deductible for the Member. Blue Shield also provides an Explanation of Benefits to describe how the claim was processed and to inform the Member of any financial responsibility.

Out of Area Programs

Benefits will be provided for Covered Services received by Subscribers and their Dependent(s) who are temporarily traveling outside of California within the United States, Puerto Rico and U.S. Virgin Islands. (Temporarily traveling is defined as a Subscriber or Dependent(s) who spends in the aggregate not more than 180 days each Calendar Year outside the State of California.) Blue Shield of California calculates the Subscriber's copayment as a percentage of the Allowable Amount, as defined in this booklet. When Covered Services are received in another state, the Subscriber's copayment will be based on the local Blue Cross and/or Blue Shield plan's arrangement with its providers. See the BlueCard Program section in this booklet.

If you do not see a Participating Provider through the BlueCard Program, you will have to pay for the entire bill for your medical care and submit a claim to the local Blue Cross and/or Blue Shield plan or

to Blue Shield of California for payment. Blue Shield of California will notify you of its determination within thirty (30) days after the receipt of the claim. Blue Shield of California will pay you at the Non-Participating Provider benefit level. Remember that your copayment is higher when you see a Non-Participating Provider. You will be responsible for paying the entire difference between the amount paid by Blue Shield of California and the amount billed.

Charges for services which are not covered, and charges by Non-Participating Providers in excess of the amount covered by the plan, are the Subscriber's responsibility and are not included in copayment calculations.

To receive the maximum benefits of your plan, please follow the procedure below.

When you require Covered Services while temporarily traveling outside of California:

- 1) call BlueCard Access® at 1-800-810-BLUE (2583) to locate physicians and hospitals that participate with the local Blue Cross and/or Blue Shield plan, or go on-line at www.bcbs.com and select the "Find a Doctor or Hospital" tab; and,
- 2) visit the participating physician or hospital and present your membership card.

The participating physician or hospital will verify your eligibility and coverage information by calling BlueCard Eligibility at 1-800-676-BLUE. Once verified and after services are provided, a claim is submitted electronically and the participating physician or hospital is paid directly. You may be asked to pay for your applicable copayment and plan Deductible at the time you receive the service.

You will receive an Explanation of Benefits, which will show your payment responsibility. You are responsible for the copayment and plan Deductible amounts shown in the Explanation of Benefits.

Pre-admission review is required for all inpatient hospital services and notification is required for

inpatient emergency services. Prior Authorization is required for selected inpatient and outpatient services, supplies, and durable medical equipment. To receive pre-admission review from Blue Shield of California, the out-of-area provider should call the Customer Service telephone number indicated on the back of the Member's identification card.

If you need Emergency Services, you should seek immediate care from the nearest medical facility. The Benefits of this plan will be provided for Covered Services received anywhere in the world for the emergency care of an illness or injury.

Care for Covered Urgent Care and Emergency Services Outside the United States

Benefits will also be provided for Covered Services received while temporarily traveling outside of the United States, Puerto Rico and U.S. Virgin Islands for emergency care of an illness or injury. If you need urgent care while out of the country, contact the Blue Cross Blue Shield Global™ (BCBS Global™) Service Centethrough the toll-free *BlueCard Access* number at 1-800-810-2583 or call collect at 1-804-673-1177, 24 hours a day, and seven days a week. In an emergency, go directly to the nearest hospital. If your coverage requires pre-certification or prior authorization, you should also call Blue Shield of California at the Customer Service telephone number indicated on the back of the Member's identification card. For inpatient hospital care, contact the Blue Cross Blue Shield Global™ (BCBS Global™) Service Cente to arrange cashless access. If cashless access is arranged, you are responsible for the usual out-of-pocket expenses (non-covered charges, Deductibles, and copayments). If cashless access is not arranged, you will have to pay the entire bill for your medical care and submit a claim.

When you receive services from a physician, you will have to pay the doctor and then submit a claim. Before traveling abroad, call your local Customer Service office for the most current listing of providers or you can go on-line at

www.bcbs.com and select “Find a Doctor or Hospital” and “Blue Cross Blue Shield Global™ (BCBS Global™) Service Center”

Inter-Plan Programs

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

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

BlueCard Program

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

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

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

- 1) The billed covered charges for your Covered Services; or
- 2) The negotiated price that the Host Plan makes available to Blue Shield.

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

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

Laws in a small number of states may require the Host Plan to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any covered healthcare services according to applicable law. Claims for Emergency Services are paid based on the Allowable Amount as defined in this Evidence of Coverage.

Utilization Management

State law requires that health plans disclose to Members and health plan providers the process

used to authorize or deny health care services under the plan. Blue Shield has completed documentation of this process as required under Section 1363.5 of the California Health and Safety Code. The document describing Blue Shield's Utilization Management Program is available online at www.blueshieldca.com or Members may call the Customer Service Department at the number provided on the back page of this Evidence of Coverage to request a copy.

Benefits Management Program

The Benefits Management Program applies utilization management and case management principles to assist Members and providers in identifying the most appropriate and cost-effective way to use the Benefits provided under this health plan.

The Benefits Management Program includes prior authorization requirements for various medical benefits including inpatient admissions, outpatient services, and prescription Drugs administered in the office, infusion center or provided by a home infusion agency, as well as emergency admission notification, and inpatient utilization management. The program also includes Member services such as, discharge planning, case management and, palliative care services.

The following sections outline the requirements of the Benefits Management Program.

Prior Authorization

Prior authorization allows the Member and provider to verify with Blue Shield or Blue Shield's MHSA that (1) the proposed services are a Benefit of the Member's plan, (2) the proposed services are Medically Necessary, and (3) the proposed setting is clinically appropriate. The prior authorization process also informs the Member and provider when Benefits are limited to services rendered by Participating Providers or MHSA Participating Providers (See the Summary of Benefits).

For all Prior Authorizations, except prescription Drugs covered under the medical benefit: A decision will be made on all requests for prior authorization within five business days from receipt of the request. The treating provider will be notified of the decision within 24 hours and written notice will be sent to the Member and provider within two business days of the decision. For urgent services when the routine decision making process might seriously jeopardize the life or health of a Member or when the Member is experiencing severe pain, a decision will be rendered as soon as possible to accommodate the Member's condition, not to exceed 72 hours from receipt of the request.

For Prior Authorizations of prescription Drugs covered under the medical benefit: Most prescription Drugs are covered under the *Outpatient Prescription Drug Benefits*. However, Drugs administered in the office, infusion center or provided by a home infusion agency are covered as a medical benefit. For these prescription Drugs, once all required supporting information is received, Blue Shield will provide prior authorization approval or denial, based upon Medical Necessity, within 72 hours in routine circumstances or 24 hours in exigent circumstances. Exigent circumstances exist when a Member has a health condition that may seriously jeopardize the Member's life, health, or ability to regain maximum function or when a Member is undergoing a current course of treatment using a Non-Formulary Drug.

If prior authorization was not obtained, and services provided to the Member are determined not to be a Benefit of the plan or were not medically necessary, coverage will be denied.

Prior Authorization for Radiological and Nuclear Imaging Procedures

Prior authorization is required for radiological and nuclear imaging procedures. The Member or provider should call 1-888-642-2583 for prior authorization of the following radiological and nuclear imaging procedures when performed

within California on an outpatient, non-emergency basis:

- 1) CT (Computerized Tomography) scan
- 2) MRI (Magnetic Resonance Imaging)
- 3) MRA (Magnetic Resonance Angiography)
- 4) PET (Positron Emission Tomography) scan
- 5) Diagnostic cardiac procedure utilizing Nuclear Medicine

For authorized services from a Non-Participating Provider, the Member will be responsible for applicable Deductible, Copayment and Coinsurance amounts and all charges in excess of the Allowable Amount.

If prior authorization was not obtained and the radiological or nuclear imaging services provided to the Member are determined not to be a Benefit of the plan, or were not Medically Necessary, coverage will be denied.

Prior Authorization for Medical Services and Prescription Drugs Included on the Prior Authorization List

The "Prior Authorization List" is a list of designated medical and surgical services and select prescription Drugs that require prior authorization. Members are encouraged to work with their providers to obtain prior authorization. Members and providers may call Customer Service at the telephone number provided on the back page of this Evidence of Coverage to inquire about the need for prior authorization. Members and Providers may also access the Prior Authorization List on the Blue Shield website at [www.blueshieldca.com].

Failure to obtain prior authorization for hemophilia home infusion products and services, home infusion/home injectable therapy or routine patient care delivered in a clinical trial for treatment of cancer or life-threatening condition will result in a denial of coverage. To obtain prior authorization, the Member or provider should call Customer Service at the number listed on the back

page of this Evidence of Coverage and Health Service Agreement.

For authorized services and Drugs from a Non-Participating Provider, the Member will be responsible for applicable Deductible, Copayment, and Coinsurance amounts and all charges in excess of the Allowable Amount.

For certain medical services and Drugs, Benefits are limited to services rendered by a Participating Provider. If prior authorization was not obtained and the medical services or Drugs provided to the Member are determined not to be a Benefit of the plan, were not Medically Necessary, or were not provided by a Participating Provider when required, coverage will be denied.

Prior Authorization for Medical Hospital and Skilled Nursing Facility Admissions

Prior authorization is required for all non-emergency Hospital admissions including admissions for acute medical or surgical care, inpatient rehabilitation, Skilled Nursing care, Special Transplant and bariatric surgery. The Member or provider should call Customer Service at least five business days prior to the admission. For Special Transplant and Bariatric Services for Residents of Designated Counties, failure to obtain prior authorization will result in a denial of coverage.

When inpatient Hospital admission is authorized to a Non-Participating Hospital, the Member will be responsible for applicable Deductible, Copayment and Coinsurance amounts and all charges in excess of the Allowable Amount.

If prior authorization was not obtained for an inpatient admission and the services provided to the Member are determined not to be a Benefit of the plan, or were not Medically Necessary, coverage will be denied.

Prior authorization is not required for an emergency Hospital admission; See the *Emergency Admission Notification* section for additional information.

Prior Authorization for Mental Health, Behavioral Health, or Substance Use Disorder Hospital Admissions and Other Outpatient Services

Prior authorization is required for all non-emergency mental health, behavioral health, or substance use disorder Hospital admissions including acute inpatient care and Residential Care. The provider should call Blue Shield's Mental Health Service Administrator (MHSA) at 1-877-263-9952 at least five business days prior to the admission. Other Outpatient Mental Health Services and Behavioral Health Treatment, and Outpatient Substance Use Disorder Services, including but not limited to, Behavioral Health Treatment (BHT), Partial Hospitalization Program (PHP), Intensive Outpatient Program (IOP), Electroconvulsive Therapy (ECT), Office-Based Opioid Detoxification and/or Maintenance Therapy, Psychological Testing and Transcranial Magnetic Stimulation (TMS) must also be prior authorized by the MHSA.

If prior authorization was not obtained for an inpatient mental health, behavioral health, or substance use disorder Hospital admission or for any Other Outpatient Mental Services and Behavioral Health Treatment, or Outpatient Substance Use Disorder Service, and the services provided to the Member are determined not to be a Benefit of the plan, or were not Medically Necessary, coverage will be denied.

For an authorized admission to a Non-Participating Hospital or authorized Other Outpatient Mental Health Services, and Behavioral Health Treatment, and Outpatient Substance Use Disorder Services from a Non-Participating Provider, the Member is responsible for applicable Deductible, Copayment, and Coinsurance amounts and all charges in excess of the Allowable Amount.

Prior authorization is not required for an emergency mental health, behavioral health, or substance use Hospital admission; See the Emergency Admission Notification section for additional information.

Emergency Admission Notification

When a Member is admitted to the Hospital for Emergency Services, Blue Shield or Blue Shield's MHSA should receive Emergency Admission Notification within 24 hours or as soon as it is reasonably possible following medical stabilization.

Inpatient Utilization Management

Most inpatient Hospital admissions are monitored for length of stay; exceptions are noted below. The length of an inpatient Hospital stay may be extended or reduced as warranted by the Member's condition. When a determination is made that the Member no longer requires an inpatient level of care, written notification is given to the attending Physician and to the Member. If discharge does not occur within 24 hours of notification, the Member is responsible for all inpatient charges accrued beyond the 24-hour time frame.

Maternity Admissions: the minimum length of the inpatient stay is 48 hours for a normal, vaginal delivery or 96 hours for a Cesarean section unless the attending Physician, in consultation with the mother, determines a shorter inpatient stay is adequate.

Mastectomy: The length of the inpatient stay is determined post-operatively by the attending Physician in consultation with the Member.

Discharge Planning

If further care at home or in another facility is appropriate following discharge from the Hospital, Blue Shield or Blue Shield's MHSA will work with the Member, the attending Physician and the Hospital discharge planners to determine the most appropriate and cost effective way to provide this care.

Case Management

The Benefits Management Program may also include case management, which is a service that provides the assistance of a health care professional to help the Member access necessary

services and to make the most efficient use of plan Benefits. The Member's nurse case manager may also arrange for alternative care benefits to avoid prolonged or repeated hospitalizations, when medically appropriate. Alternative care benefits are only utilized by mutual consent of the Member, the provider, and Blue Shield or Blue Shield's MHSA, and will not exceed the standard Benefits available under this plan.

The approval of alternative case benefits is specific to each Member for a specified period of time. Such approval should not be construed as a waiver of Blue Shield's right to thereafter administer this health plan in strict accordance with its express terms. Blue Shield is not obligated to provide the same or similar alternative care benefits to any other person in any other instance.

Palliative Care Services

In conjunction with Covered Services, Blue Shield provides palliative care services for Members with serious illnesses. Palliative care services include access to physicians and nurse case managers who are trained to assist Members in managing symptoms, in maximizing comfort, safety, autonomy and well-being, and in navigating a course of care. Members can obtain assistance in making informed decisions about therapy, as well as documenting their quality of life choices. Members may call the Customer Service Department at the number provided on the back page of this Agreement to request more information about these services.

Principal Benefits and Coverages (Covered Services)

Blue Shield provides the following Medically Necessary Benefits, subject to applicable Deductibles, Copayments, Coinsurance, and charges in excess of Benefit maximums, Participating Provider provisions and Benefits Management Program provisions. Coverage for these services is subject to all terms, conditions, limitations and exclusions of the Evidence of

Coverage and Health Agreement, including but not limited to, any conditions or limitations set forth in the Benefit descriptions below, and to the Principal Limitations, Exceptions, Exclusions and Reductions listed in this Evidence of Coverage. All Benefits must be Medically Necessary to be covered. If there are two or more Medically Necessary services that may be provided for the illness, injury or medical condition, Blue Shield will provide Benefits based on the most cost-effective service.

The Copayment and Coinsurance amounts for Covered Services, if applicable, are shown on the Summary of Benefits. The Summary of Benefits is provided with, and is incorporated as part of, this Evidence of Coverage and Health Service Agreement.

Except as may be specifically indicated, for services received from Non-Participating Providers, subscribers will be responsible for all charges above the Allowable Amount in addition to the indicated Copayment or Coinsurance amount.

Except as specifically provided herein, services are covered only when rendered by an individual or entity that is licensed or certified by the state to provide health care services and is operating within the scope of that license or certification.

Acupuncture Benefits

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

Allergy Testing and Treatment Benefits

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

Ambulance Benefits

Benefits are provided for (1) emergency ambulance services (surface and air) when used to transport a Member from place of illness or injury to the closest medical facility where appropriate treatment can be received; or (2) pre-authorized, non-emergency ambulance transportation from one medical facility to another.

Ambulatory Surgery Center Benefits

Benefits are provided for surgery performed in an Ambulatory Surgery Center.

Bariatric Surgery Benefits

Benefits are provided for Hospital and professional services in connection with bariatric surgery to treat morbid or clinically severe obesity as described below.

All bariatric surgery services must be prior authorized, in writing, from Blue Shield, whether the Member is a resident of a designated or non-designated county. See the *Benefits Management Program* section for more information.

Services for Residents of Designated Counties

For Members who reside in a California county designated as having facilities contracting with Blue Shield to provide bariatric services (see the list of designated counties below), Blue Shield will provide Benefits for certain Medically Necessary bariatric surgery procedures only if:

- 1) performed at a Participating Hospital or Ambulatory Surgery Center, and by a Participating Physician, that have both contracted with Blue Shield as a Bariatric Surgery Services Provider to provide the procedure;
- 2) the services are consistent with Blue Shield's medical policy; and
- 3) prior authorization is obtained, in writing, from Blue Shield's Medical Director.

Blue Shield reserves the right to review all requests for prior authorization for these bariatric Benefits and to make a decision regarding Benefits based on: (1) the medical circumstances of each patient, and (2) consistency between the treatment proposed and Blue Shield medical policy.

For Members who reside in a designated county, failure to obtain prior written authorization as described above and/or failure to have the procedure performed at a Participating Hospital or Ambulatory Surgery Center by a Bariatric Surgery Services Provider will result in denial of claims for this Benefit.

Services for follow-up bariatric surgery procedures, such as lap-band adjustments, must also be provided by a Physician participating as a Bariatric Surgery Services Provider.

The following are the designated counties in which Blue Shield has designated Bariatric Surgery Services Providers to provide bariatric services:

Imperial	San Bernardino
Kern	San Diego
Los Angeles	Santa Barbara
Orange	Ventura
Riverside	

Bariatric Travel Expense Reimbursement For Residents of Designated Counties

Members who reside in designated counties and who have obtained written authorization from Blue Shield to receive bariatric services at a Hospital or Ambulatory Surgery Center designated as a Bariatric Surgery Services Provider may be eligible to receive reimbursement for associated travel expenses.

To be eligible to receive travel expense reimbursement, the Member's home must be 50 or more miles from the nearest Hospital or Ambulatory Surgery Center designated as a

Bariatric Surgery Services Provider. All requests for travel expense reimbursement must be prior authorized by Blue Shield. Approved travel-related expenses will be reimbursed as follows:

- 1) Transportation to and from the facility up to a maximum of \$130 per round trip:
 - a) for the Member for a maximum of 3 trips:
 - i) one trip for a pre-surgical visit;
 - ii) one trip for the surgery; and
 - iii) one trip for a follow-up visit.
 - b) for one companion for a maximum of two trips:
 - i) one trip for the surgery; and
 - ii) one trip for a follow-up visit.
- 2) Hotel accommodations not to exceed \$100 per day:
 - a) for the Member and one companion for a maximum of two days per trip:
 - i) one trip for a pre-surgical visit; and
 - ii) one trip for a follow-up visit.
 - b) for one companion for a maximum of four days for the duration of the surgery admission.

Hotel accommodation is limited to one, double-occupancy room. Expenses for in-room and other hotel services are specifically excluded.

- 3) Related expenses judged reasonable by Blue Shield not to exceed \$25 per day per Member up to a maximum of four days per trip. Expenses for tobacco, alcohol, drugs, telephone, television, delivery, and recreation are specifically excluded.

Submission of adequate documentation including receipts is required before reimbursement will be made.

Services for Residents of Non-Designated Counties

Bariatric surgery services for residents of non-designated counties will be paid as any other surgery as described elsewhere in this section when:

- 1) services are consistent with Blue Shield's medical policy; and,
- 2) prior authorization is obtained, in writing, from Blue Shield's Medical Director.

For Members who reside in non-designated counties, travel expenses associated with bariatric surgery services are not covered.

Clinical Trial for Treatment of Cancer or Life-Threatening Conditions Benefits

Benefits are provided for routine patient care for Members who have been accepted into an approved clinical trial for treatment of cancer or a life-threatening condition where the clinical trial has a therapeutic intent and when prior authorized by Blue Shield, and:

- 1) the Member's Primary Care Physician or another Participating Provider determines that the Member's participation in the clinical trial would be appropriate based on either the trial protocol or medical and scientific information provided by the Member;
- 2) the Member provides medical and scientific information establishing that the Member's participation in the clinical trial would be appropriate.

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

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

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

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

- 1) federally funded and approved by one or more of the following:
 - a) one of the National Institutes of Health;
 - b) the Centers for Disease Control and Prevention;
 - c) the Agency for Health Care Research and Quality;
 - d) the Centers for Medicare & Medicaid Services;
 - e) a cooperative group or center of any of the entities in a) to d) above; or the federal Departments of Defense or Veterans Administration;

f) a qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants;

g) the federal Veterans Administration, Department of Defense, or Department of Energy where the study or investigation is reviewed and approved through a system of peer review that the Secretary of Health & Human Services has determined to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review; or

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

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

Diabetes Care Benefits

Diabetic Equipment

Benefits are provided for the following devices and equipment, including replacement after the expected life of the item, for the management and treatment of diabetes:

- 1) blood glucose monitors, including those designed to assist the visually impaired;
- 2) insulin pumps and all related necessary supplies;
- 3) podiatric devices to prevent or treat diabetes-related complications, including extra-depth orthopedic shoes; and
- 4) visual aids, excluding eyewear and/or video-

assisted devices, designed to assist the visually impaired with proper dosing of insulin.

For coverage of diabetic testing supplies including blood and urine testing strips and test tablets, lancets and lancet puncture devices and pen delivery systems for the administration of insulin, refer to the *Outpatient Prescription Drug Benefits* section.

Diabetic Outpatient Self-Management Training

Benefits are provided for diabetic outpatient self-management training, education and medical nutrition therapy to enable a Member to properly use the devices, equipment and supplies, and any additional outpatient self-management training, education and medical nutrition therapy when directed or prescribed by the Member's Physician. These Benefits shall include, but not be limited to, instruction that will enable diabetic patients and their families to gain an understanding of the diabetic disease process, and the daily management of diabetic therapy, in order to avoid frequent hospitalizations and complications. Services will be covered when provided by a Physician, registered dietician, registered nurse, or other appropriately licensed Health Care Provider who is certified as a diabetes educator.

Dialysis Benefits

Benefits are provided for dialysis services, including renal dialysis, hemodialysis, peritoneal dialysis and other related procedures.

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

Durable Medical Equipment Benefits

Benefits are provided for Durable Medical Equipment (DME) for Activities of Daily Living, supplies needed to operate Durable Medical Equipment, oxygen and its administration, and ostomy and medical supplies to support and maintain gastrointestinal, bladder or respiratory function. Other covered items include peak flow

monitors for self-management of asthma, the glucose monitor for self-management of diabetes, apnea monitors for management of newborn apnea, breast pumps and the home prothrombin monitor for specific conditions, as determined by Blue Shield. Benefits are provided at the most cost-effective level of care that is consistent with professionally recognized standards of practice. If there are two or more professionally recognized Durable Medical Equipment items equally appropriate for a condition, Benefits will be based on the most cost-effective item.

No DME Benefits are provided for the following:

- 1) rental charges in excess of the purchase cost;
- 2) replacement of Durable Medical Equipment except when it no longer meets the clinical needs of the patient or has exceeded the expected lifetime of the item. This exclusion does not apply to the Medically Necessary replacement of nebulizers, face masks and tubing, and peak flow monitors for the management and treatment of asthma. (See the *Outpatient Prescription Drug Benefit* section for benefits for asthma inhalers and inhaler spacers);
- 3) breast pump rental or purchase when obtained from a Non-Participating Provider;
- 4) repair or replacement due to loss or misuse;
- 5) environmental control equipment, generators, self-help/educational devices, air conditioners, humidifiers, dehumidifiers, air purifiers, exercise equipment, or any other equipment not primarily medical in nature; and
- 6) for backup or alternate items.

See the *Diabetes Care Benefits* section for devices, equipment, and supplies for the management and treatment of diabetes.

For Members in a Hospice program through a Participating Hospice Agency, medical equipment and supplies that are reasonable and necessary for the palliation and management of Terminal Disease or Terminal Illness and related conditions are provided by the Hospice Agency.

Emergency Room Benefits

Benefits are provided for Emergency Services provided in the emergency room of a Hospital. For the lowest out-of-pocket expenses, covered non-Emergency Services and emergency room follow-up services (e.g., suture removal, wound check, etc.) should be received in a Participating Physician's office.

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

Family Planning Benefits

Benefits are provided for the following family planning services without illness or injury being present:

- 1) family planning, counseling and consultation services, including Physician office visits for office-administered covered contraceptives; and
- 2) vasectomy

No Benefits are provided for family planning services from Non-Participating Providers.

See also the *Preventive Health Benefits* section for additional family planning services.

For plans with a Calendar Year Deductible for services by Participating Providers, the Calendar Year Deductible applies only to male sterilizations.

Home Health Care Benefits

Benefits are provided for home health care services from a Participating home health care agency when the services are ordered by the

attending Physician, and included in a written treatment plan

Services by a Non-Participating home health care agency, shift care, private duty nursing and stand-alone health aide services must be prior authorized by Blue Shield.

Covered Services are subject to any applicable Deductibles, Copayments and Coinsurance. Visits by home health care agency providers will be payable up to a combined per Member per Calendar Year visit maximum as shown on the Summary of Benefits.

Intermittent and part-time visits by a home health agency to provide Skilled Nursing and other skilled services are covered up to three visits per day, two hours per visit up to the Calendar Year visit maximum (including home health visits) by any of the following professional providers:

- 1) registered nurse;
- 2) licensed vocational nurse;
- 3) physical therapist, occupational therapist, or speech therapist; or
- 4) medical social worker.

Intermittent and part-time visits by a home health agency to provide services from a Home Health Aide are covered up to four hours per visit, and are included in the Calendar Year visit maximum.

For the purpose of this Benefit, each two hour increment of a visit from a nurse, physical therapist, occupational therapist, speech therapist, or medical social worker counts as a separate visit. Visits of two hours or less shall be considered as one visit. For visits from a Home Health Aide, each four hour increment counts as a separate visit. Visits of four hours or less shall be considered as one visit.

Medical supplies used during a covered visit by the home health agency necessary for the home health care treatment plan and related laboratory services are covered in conjunction with the professional services rendered by the home health agency.

This Benefit does not include medications or injectables covered under the Home Infusion/Home Injectable Therapy Benefit or under the Benefit for Outpatient Prescription Drugs.

See the *Hospice Program Benefits* section for information about admission into a Hospice Program and specialized Skilled Nursing services for Hospice care.

For information concerning diabetic self-management training, see the *Diabetes Care Benefits* section.

Home Infusion and Home Injectable Therapy Benefits

Benefits are provided for home infusion and injectable medication therapy. Services include home infusion agency Skilled Nursing visits, infusion therapy provided in infusion suites associated with a Participating home infusion agency, parenteral nutrition services, enteral nutritional services and associated supplements, medical supplies used during a covered visit, medications injected or administered intravenously, related laboratory services, when prescribed by a Doctor of Medicine and provided by a Participating home infusion agency. Services related to hemophilia are described separately.

This Benefit does not include medications, insulin, insulin syringes, certain Specialty Drugs covered under the Outpatient Prescription Drug Benefit, and services related to hemophilia which are described below.

Services rendered by Non-Participating home infusion agencies are not covered unless prior authorized by Blue Shield, and there is an executed letter of agreement between the Non-Participating home infusion agency and Blue Shield. Shift care and private duty nursing must be prior authorized by Blue Shield.

Hemophilia Home Infusion Products and Services

Benefits are provided for home infusion products for the treatment of hemophilia and other bleeding disorders. All services must be prior authorized by Blue Shield and must be provided by a Participating Hemophilia Infusion Provider. (Note: most Participating home health care and home infusion agencies are not Participating Hemophilia Infusion Providers.) To find a Participating Hemophilia Infusion Provider, consult the Participating Provider directory. Members may also verify this information by calling Customer Service at the telephone number shown on the last page of this Evidence of Coverage.

Hemophilia Infusion Providers offer 24-hour service and provide prompt home delivery of hemophilia infusion products.

Following Member evaluation by a Doctor of Medicine, a prescription for a blood factor product must be submitted to and approved by Blue Shield. Once prior authorized by Blue Shield, the blood factor product is covered on a regularly scheduled basis (routine prophylaxis) or when a non-emergency injury or bleeding episode occurs. (Emergencies will be covered as described in the *Emergency Room Benefits* section.)

Included in this Benefit is the blood factor product for in-home infusion by the Member, necessary supplies such as ports and syringes, and necessary nursing visits. Services for the treatment of hemophilia outside the home, except for services in infusion suites managed by a Participating Hemophilia Infusion Provider), and services to treat complications of hemophilia replacement therapy are not covered under this Benefit.

No Benefits are provided for:

- 1) physical therapy, gene therapy or medications including antifibrinolytic and hormone medications;
- 2) services from a hemophilia treatment center or

any Non-Participating Hemophilia Infusion Provider; or,

- 3) self-infusion training programs, other than nursing visits to assist in administration of the product.

Services may be covered under Outpatient Prescription Drug Benefits, or as described elsewhere in this *Principal Benefits and Coverages (Covered Services)* section.

Hospice Program Benefits

Benefits are provided for services through a Participating Hospice Agency when an eligible Member requests admission to, and is formally admitted into, an approved Hospice program. The Member must have a Terminal Disease or Terminal Illness as determined by his or her Participating Provider's certification and must receive prior approval from Blue Shield for the admission. Members with a Terminal Disease or Terminal Illness who have not yet elected to enroll in a Hospice program may receive a pre-hospice consultative visit from a Participating Hospice Agency.

A Hospice program is a specialized form of interdisciplinary care designed to provide palliative care, alleviate the physical, emotional, social and spiritual discomforts of a Member who is experiencing the last phases of life due to a Terminal Disease or Terminal Illness, and to provide supportive care to the primary caregiver and the family of the Hospice patient. Medically Necessary services are available on a 24-hour basis. Members enrolled in a Hospice program may continue to receive Covered Services that are not related to the palliation and management of their Terminal Disease or Terminal Illness from the appropriate provider. All of the services listed below must be received through the Participating Hospice Agency.

- 1) Pre-hospice consultative visit regarding pain and symptom management, Hospice and other care options including care planning.

- 2) An interdisciplinary plan of home care developed by the Participating Hospice Agency and delivered by appropriately qualified, licensed and/or certified staff, including the following:

- a) Skilled Nursing services including assessment, evaluation and treatment for pain and symptom control;
- b) Home Health Aide services to provide personal care (supervised by a registered nurse);
- c) homemaker services to assist in the maintenance of a safe and healthy home environment (supervised by a registered nurse);
- d) bereavement services for the immediate surviving family members for a period of at least one year following the death of the Member;
- e) medical social services including the utilization of appropriate community resources;
- f) counseling/spiritual services for the Member and family;
- g) dietary counseling;
- h) medical direction provided by a licensed Doctor of Medicine acting as a consultant to the interdisciplinary Hospice team and to the Member's Participating Provider with regard to pain and symptom management and as a liaison to community physicians;
- i) physical therapy, occupational therapy, and speech-language pathology services for purposes of symptom control, or to enable the Member to maintain Activities of Daily Living and basic functional skills;
- j) respiratory therapy;
- k) volunteer services.

- 3) Drugs, durable medical equipment, and supplies.

- 4) Continuous home care when medically necessary to achieve palliation or management of acute medical symptoms including the following:
 - a) 8 to 24 hours per day of continuous skilled nursing care (8-hour minimum);
 - b) homemaker or Home Health Aide Services up to 24 hours per day to supplement skilled nursing care.
- 5) Short-term inpatient care arrangements when palliation or management of acute medical symptoms cannot be achieved at home.
- 6) Short-term inpatient respite care up to five consecutive days per admission on a limited basis.
- 6) Surgical supplies, dressings and cast materials, and anesthetic supplies furnished by the Hospital.
- 7) Inpatient rehabilitation when furnished by the Hospital and approved in advance by Blue Shield under its Benefits Management Program.
- 8) Drugs and oxygen.
- 9) Administration of blood and blood plasma, including the cost of blood, blood plasma and in-Hospital blood processing.
- 10) Hospital ancillary services, including diagnostic laboratory, X-ray services, and imaging procedures including MRI, CT and PET scans.

Members are allowed to change their Participating Hospice Agency only once during each Period of Care. Members may receive care for either a 30 or 60-day period, depending on their diagnosis. The care continues through another Period of Care if the Physician recertifies that the Member is Terminally Ill.

Hospice services provided by a Non-Participating Hospice Agency are not covered except in certain circumstances in counties in California in which there are no Participating Hospice Agencies and only when prior authorized by Blue Shield.

Hospital Benefits (Facility Services)

Inpatient Services for Treatment of Illness or Injury

Benefits are provided for the following inpatient Hospital services:

- 1) Semi-private room and board unless a private room is Medically Necessary.
- 2) General nursing care, and special duty nursing.
- 3) Meals and special diets.
- 4) Intensive care services and units.
- 5) Use of operating room, specialized treatment rooms, delivery room, newborn nursery, and related facilities.
- 11) Radiation therapy, chemotherapy for cancer including catheterization, infusion devices, and associated drugs and supplies.
- 12) Surgically implanted devices and prostheses, other medical supplies, and medical appliances and equipment administered in a Hospital.
- 13) Subacute Care.
- 14) Medical social services and discharge planning.
- 15) Inpatient services including general anesthesia and associated facility charges in connection with dental procedures when hospitalization is required because of an underlying medical condition or clinical status and the Member is under the age of seven or developmentally disabled regardless of age or when the Member's health is compromised and for whom general anesthesia is Medically Necessary regardless of age. Excludes dental procedures and services of a dentist or oral surgeon.
- 16) Inpatient substance use disorder detoxification services required to treat symptoms of acute toxicity or acute withdrawal when a Member is admitted through the emergency room, or when inpatient substance use disorder

detoxification is prior authorized by Blue Shield.

Outpatient Services for Treatment of Illness or Injury or for Surgery

Benefits include the following outpatient Hospital services:

- 1) Dialysis services.
- 2) Care provided by the admitting Hospital within 24 hours before admission, when care is related to the condition for which an inpatient admission is planned.
- 3) Surgery.
- 4) Radiation therapy, chemotherapy for cancer, including catheterization, infusion devices, and associated drugs and supplies.
- 5) Routine newborn circumcision performed within 18 months of birth.

Covered Physical Therapy, Occupational Therapy, and Speech Therapy Services provided in an outpatient Hospital setting are described under the *Rehabilitation and Habilitative Services Benefits (Physical, Occupational and Respiratory Therapy) and Speech Therapy Benefits (Rehabilitation and Habilitative Services)* sections.

Medical Treatment of the Teeth, Gums, or Jaw Joints and Jaw Bones Benefits

Benefits are provided for Hospital and professional services provided for conditions of the teeth, gums or jaw joints and jaw bones, including adjacent tissues, only to the extent that they are provided for:

- 1) treatment of tumors of the gums;
- 2) treatment of damage to natural teeth caused solely by an Accidental Injury (limited to palliative services necessary for the initial medical stabilization of the Member as determined by Blue Shield).

- 3) non-surgical treatment (e.g., splint and physical therapy) of Temporomandibular Joint Syndrome (TMJ);
- 4) surgical and arthroscopic treatment of TMJ if prior history shows conservative medical treatment has failed;
- 5) treatment of maxilla and mandible (jaw joints and jaw bones);
- 6) orthognathic surgery (surgery to reposition the upper and/or lower jaw) to correct a skeletal deformity;
- 7) dental and orthodontic services that are an integral part of Reconstructive Surgery for cleft palate repair;
- 8) dental evaluation, X-rays, fluoride treatment and extractions necessary to prepare the Member's jaw for radiation therapy of cancer in the head or neck; and
- 9) general anesthesia and associated facility charges in connection with dental procedures when performed in an Ambulatory Surgery Center or Hospital due to the Member's underlying medical condition or clinical status and the Member is under the age of seven or developmentally disabled regardless of age or when the Member's health is compromised and for whom general anesthesia is Medically Necessary regardless of age. This benefit excludes dental procedures and services of a dentist or oral surgeon.

No Benefits are provided for:

- 1) orthodontia (dental services to correct irregularities or malocclusion of the teeth) for any reason other than reconstructive treatment of cleft palate, including treatment to alleviate TMJ;
- 2) dental implants (endosteal, subperiosteal or transosteal);
- 3) any procedure (e.g., vestibuloplasty) intended to prepare the mouth for dentures or for the more comfortable use of dentures;

- 4) alveolar ridge surgery of the jaws if performed primarily to treat diseases related to the teeth, gums or periodontal structures or to support natural or prosthetic teeth; and
- 5) fluoride treatments except when used with radiation therapy to the oral cavity.

Mental Health, Behavioral Health, and Substance Use Disorder Benefits

Blue Shield’s Mental Health Service Administrator (MHSA) arranges and administers Mental Health Services, Behavioral Health Treatment, and Substance Use Disorder Services for Blue Shield Members within California. See the *Out-Of- Area Program, BlueCard Program* section for an explanation of how payment is made for out of state services.

All Non-Emergency inpatient Mental Health Services, Behavioral Health Treatment, and Substance Use Disorder Services, including Residential Care, and Other Outpatient Mental Health Services, Behavioral Health Treatment, and Outpatient Substance Abuse Use Disorder Services are subject to the Benefits Management Program and must be prior authorized by the MHSA. See the Benefits Management Program section for complete information.

Mental Health and Behavioral Health-Office Visits

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

Mental Health and Behavioral Health-Other Outpatient Services

Benefits are provided for Outpatient Facility and professional services for Behavioral Health Treatment and the diagnosis and treatment of Mental Health Conditions. These services may also be provided in the office, home, or other non-institutional setting. Other Outpatient Mental Health Services and Behavioral Health Treatment include, but may not be limited to, the following:

- 1) Behavioral Health Treatment (BHT) – professional services and treatment programs, including applied behavior analysis and evidence-based intervention programs, which develop or restore, to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism.

BHT is covered when prescribed by a physician or licensed psychologist and provided under a treatment plan approved by the MHSA.

Treatment used for the purposes of providing respite, day care, or educational services, or to reimburse a parent for participation in the treatment is not covered.

- 2) Electroconvulsive Therapy - the passing of a small electric current through the brain to induce a seizure, used in the treatment of severe mental health conditions.
- 3) Intensive Outpatient Program - an outpatient mental and behavioral health treatment program utilized when a patient’s condition requires structure, monitoring, and medical/psychological intervention at least three hours per day, three days per week.
- 4) Partial Hospitalization Program – an outpatient treatment program that may be free-standing or Hospital-based and provides services at least five hours per day, four days per week. Members may be admitted directly to this level of care, or transferred from acute inpatient care following stabilization.
- 5) Psychological Testing - testing to diagnose a Mental Health Condition when referred by an MHSA Participating Provider.
- 6) Transcranial Magnetic Stimulation - a non-invasive method of delivering electrical stimulation to the brain for the treatment of severe depression.

Outpatient Substance Use Disorder Services

Benefits are provided for Outpatient Facility and professional services for the diagnosis and treatment of Substance Use Disorder Conditions. These services may also be provided in the office, home or other non-institutional setting. Outpatient Substance Use Disorder Services include, but may not be limited to, the following:

- 1) Intensive Outpatient Program - an outpatient substance use disorder treatment program utilized when a patient's condition requires structure, monitoring, and medical/psychological intervention at least three hours per day, three days per week.
- 2) Office-Based Opioid Detoxification and/or Maintenance Therapy, including Methadone maintenance treatment.
- 3) Partial Hospitalization Program – an outpatient treatment program that may be free-standing or Hospital-based and provides services at least five hours per day, four days per week. Members may be admitted directly to this level of care, or transferred from acute inpatient care following stabilization.

Inpatient Services

Benefits are provided for inpatient Hospital and professional services in connection with acute hospitalization for Behavioral Health Treatment, the treatment of Mental Health Conditions, or Substance Use Disorder Conditions.

Benefits are provided for inpatient and professional services in connection with a Residential Care admission for Behavioral Health Treatment, the treatment of Mental Health Conditions, or Substance Use Disorder Conditions.

See *Hospital Benefits (Facility Services), Inpatient Services for Treatment of Illness or Injury* for information on Medically Necessary inpatient substance use disorder detoxification.

Orthotics Benefits

Benefits are provided for orthotic appliances and devices for maintaining normal Activities of Daily Living only. Benefits include:

- 1) shoes only when permanently attached to such appliances;
- 2) special footwear required for foot disfigurement which includes, but is not limited to, foot disfigurement from cerebral palsy, arthritis, polio, spina bifida, and foot disfigurement caused by accident or developmental disability;
- 3) knee braces for post-operative rehabilitation following ligament surgery, instability due to injury, and to reduce pain and instability for patients with osteoarthritis;
- 4) functional foot orthoses that are custom made rigid inserts for shoes, ordered by a physician or podiatrist, and used to treat mechanical problems of the foot, ankle or leg by preventing abnormal motion and positioning when improvement has not occurred with a trial of strapping or an over-the-counter stabilizing device;
- 5) initial fitting and adjustment of these devices, their repair or replacement after the expected life of the orthosis is covered.

No Benefits are provided for orthotic devices such as knee braces intended to provide additional support for recreational or sports activities or for orthopedic shoes and other supportive devices for the feet not listed above. No Benefits are provided for backup or alternate items, or replacement due to loss or misuse.

See the *Diabetes Care Benefits* section for devices, equipment, and supplies for the management and treatment of diabetes.

Outpatient Prescription Drug Benefits

This Plan provides benefits for outpatient prescription Drugs as specified in this section.

A Physician or Health Care Provider must prescribe all Drugs covered under this Benefit, including over-the-counter items. Members must obtain all Drugs from a Participating Pharmacy, except as noted below.

Some drugs, most Specialty Drugs, and prescriptions for Drugs exceeding specific quantity limits require prior authorization by Blue Shield for Medical Necessity, as described in the *Prior Authorization/Exception Request Process /Step Therapy* section. The Member or his/her Physician or Health Care Provider may request prior authorization from Blue Shield.

Outpatient Drug Formulary

Blue Shield’s Drug Formulary is a list of Food and Drug Administration (FDA)-approved preferred Generic and Brand Drugs that assists Physicians and Health Care Providers to prescribe Medically Necessary and cost-effective Drugs. Coverage is limited to Drugs listed on the Formulary; however, Drugs not listed on the Formulary may be covered when prior authorized by Blue Shield.

Blue Shield’s Formulary is established by Blue Shield’s Pharmacy and Therapeutics (P&T) Committee. This committee consists of physicians and pharmacists responsible for evaluating drugs for relative safety, effectiveness, health benefit based on the medical evidence, and comparative cost. They also review new drugs, dosage forms, usage and clinical data to update the Formulary four times a year. Note: The Member’s Physician or Health Care Provider might prescribe a drug even though the drug is not included on the Formulary.

The Formulary is categorized into drug tiers as described in the chart below. The Member’s Copayment or Coinsurance will vary based on the drug tier. Drug tiering is based on recommendations made by the P&T Committee.

Drug Tier	Description
Tier 1	Most Generic Drugs and low cost Preferred Brands
Tier 2	<ol style="list-style-type: none"> 1. Non-preferred Generic Drugs; 2. Preferred Brand Name Drugs; and 3. Any other Drugs recommended by the plan’s Pharmacy and Therapeutics (P&T) Committee based on drug safety, efficacy and cost.
Tier 3	<ol style="list-style-type: none"> 1. Non-preferred Brand Name Drugs; 2. Drugs that are recommended by the P&T Committee based on drug safety, efficacy and cost; or 3. Generally, have a preferred and often less costly therapeutic alternative at a lower tier
Tier 4	<ol style="list-style-type: none"> 1) Drugs that are biologics, and Drugs that the Food and Drug Administration (FDA) or drug manufacturer requires to be distributed through specialty pharmacies; 2) Drugs that require the Member to have special training or clinical monitoring; or 3) Drugs that cost the health plan (net of rebates) more than \$600 for a one-month supply.

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

Obtaining Outpatient Prescription Drugs at a Participating Pharmacy

The Member must present a Blue Shield Identification Card at a Participating Pharmacy to obtain Drugs. The Member can obtain prescription Drugs at any retail Participating Pharmacy unless the Drug is a Specialty Drug. Refer to the section *Obtaining Specialty Drugs through the Specialty Drug Program* for additional information. The Member can locate a retail Participating Pharmacy by visiting <https://www.blueshieldca.com/bsca/pharmacy/home.sp> or by calling Customer Service at the number listed on the Identification Card. If the Member obtains Drugs at a Non-Participating Pharmacy or without a Blue Shield Identification Card, Blue Shield will deny the claim, unless it is for an Emergency Service.

Blue Shield negotiates contracted rates with Participating Pharmacies for Drug. If the Member's Plan has a Calendar Year Pharmacy Deductible, the Member is responsible for paying the contracted rate for Drugs until the Calendar Year Pharmacy Deductible is met.

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

Coverage is limited to Drugs listed on the Formulary; however, Drugs not listed on the Formulary may be covered when Medically Necessary and when prior authorized by Blue

Shield. If prior authorized, Drugs that are categorized as Tier 4 will be covered at the Tier 4 Copayment or Coinsurance (refer to the Drug Tier table in the *Outpatient Drug Formulary* section of this Evidence of Coverage.). For all other Drugs, the Tier 3 Copayment or Coinsurance applies when prior authorization is obtained. If prior authorization is not obtained, the Member is responsible for paying 100% of the cost of the Drug(s).

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

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

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

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

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

- The Member must first pay all charges for the prescription,
- Submit a completed Prescription Drug Claim Form to
Blue Shield of California
Argus Health Systems, Inc.
P.O. Box 419019,
Dept 191
Kansas City, MO 64141
- Blue Shield will reimburse the Member based on the price the Member paid for the Drugs, minus any applicable Deductible and Copayment or Coinsurance.

Claim forms may be obtained by calling Customer Service or visiting www.blueshieldca.com. Claims must be received within one year from the date of service to be considered for payment. Claim submission is not a guarantee of payment.

Obtaining Outpatient Prescription Drugs Through the Mail Service Prescription Drug Program

The Member has an option to use Blue Shield's Mail Service Prescription Drug Program when he or she takes maintenance Drugs for an ongoing condition. This allows the Member to receive up to a 90-day supply of his/her Drug and may help the Member to save money. The Member may enroll online, by phone, or by mail. Please allow up to 14 days to receive the Drug. The Member's Physician or Health Care Provider must indicate a prescription quantity equal to the amount to be dispensed. Specialty Drugs are not available through the Mail Service Prescription Drug Program.

The Member must pay the applicable Mail Service Prescription Drug Copayment or Coinsurance for each prescription Drug.

Visit www.blueshieldca.com or call Customer Service to get additional information about the Mail Service Prescription Drug Program.

Obtaining Specialty Drugs through the Specialty Drug Program

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

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

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

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

Prior Authorization/Exception Request Process/Step Therapy

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

The following Drugs require prior authorization:

- 1) Some Formulary, preferred, non-preferred, compound Drugs, and most Specialty Drugs; Drugs to a maximum allowable quantity based on Medical Necessity and appropriateness of therapy.
- 2) Drugs exceeding the maximum allowable quantity based on Medical Necessity and appropriateness of therapy;
- 3) Brand contraceptives may require prior authorization to be covered without a Copayment or Coinsurance;
- 4) When a Brand Drug is Medically Necessary, prior authorization is required if the Member, Physician or Health Care Provider is requesting an exception to the difference in cost between the Brand Drug and the Generic Drug equivalent;

Blue Shield covers compounded medication(s) when:

- The compounded medication(s) include at least one Drug
- There are no FDA-approved, commercially available, medically appropriate alternative(s),
- The compounded medication is self administered, and
- Medical literature supports its use for the requested diagnosis.

The Member pays the Tier 3 Copayment or Coinsurance for covered compound Drugs.

The Member, his/her Physician or Health Care Provider may request prior authorization for the Drugs listed above by submitting supporting information to Blue Shield. Once all required supporting information is received, Blue Shield

will provide prior authorization approval or denial, based upon Medical Necessity, within 72 hours in routine circumstances or 24 hours in exigent circumstances. Exigent circumstances exist when a Member has a health condition that may seriously jeopardize the Member's life, health, or ability to regain maximum function or when a Member is undergoing a current course of treatment using a Non-Formulary Drug.

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

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

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

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

- 1) Except as otherwise stated below, the Member may receive up to a 30-day supply of Outpatient Prescription Drugs. If a Drug is available only in supplies greater than 30 days,

the Member must pay the applicable retail Copayment or Coinsurance for each additional 30-day supply.

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

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

- 3) You may receive up to a 90-day supply of Drugs in the Mail Service Prescription Drug Program. Note: if your Physician or Health Care Provider writes a prescription for less than a 90-day supply, the mail service pharmacy will dispense that amount and you are responsible for the applicable Mail Service Copayment or Coinsurance. Refill authorizations cannot be combined to reach a 90-day supply.
- 4) Select over-the-counter (OTC) drugs with a United States Preventive Services Task Force (USPSTF) rating of A or B may be covered at a quantity greater than a 30-day supply.
- 5) You may receive up to a 12-month supply of contraceptive Drugs.

- 6) The Member may refill covered prescriptions at a Medically Necessary frequency.

Outpatient Prescription Drug Exclusions and Limitations

Blue Shield does not provide coverage in the Outpatient Prescription Drug Benefit for the following. The Member may receive coverage for certain services excluded below under other Benefits. Refer to the applicable section(s) of your Evidence of Coverage to determine if the Plan covers Drugs under that Benefit.

- 1) Any Drug the Member receives while an inpatient, in a Physician's office, Skilled Nursing Facility or Outpatient Facility. See the *Professional Benefits and Hospital Benefits (Facility Services)* sections of this Evidence of Coverage.
- 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 this Evidence of Coverage.
- 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/Step Therapy* 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. This exclusion also applies to prescription preparations applied to the skin

that are approved by the FDA as medical devices. See the *Prosthetic Appliances Benefits*, *Durable Medical Equipment Benefits*, and the *Orthotics Benefits* sections of this Evidence of Coverage

- 8) Blood or blood products (see the *Hospital Benefits (Facility Services)* section of this Evidence of Coverage).
- 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 Benefits*, *Home Infusion and Home Injectable Therapy Benefits*, *PKU-Related Formulas and Special Food Product Benefits* sections of this Evidence of Coverage.
- 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 and Home Injectable Therapy Benefits*, *Hospice Program Benefits*, or *Family Planning Benefits* sections of this Evidence of Coverage.
- 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:
 - Are FDA-approved.
 - Are ordered by a Physician or Health Care Provider
 - Are generally purchased at an outpatient pharmacy, and
 - Are self-administered.

Other contraceptive methods may be covered under the *Family Planning Benefits* section of this Evidence of Coverage.

- 15) Compounded medication(s) which do not meet all of the following requirements:
 - The compounded medication(s) include at least one Drug
 - There are no FDA-approved, commercially available, medically appropriate alternatives
 - The compounded medications is self-administered, and
 - 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 this Evidence of Coverage.
- 18) Drugs prescribed for treatment of dental conditions. This exclusion does not apply to
 - antibiotics prescribed to treat infection,
 - Drugs prescribed to treat pain, or
 - Drug treatment related to surgical procedures for conditions affecting the upper/lower jawbone or associated bone joints.
- 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.
- 22) Repackaged prescription drugs (drugs that are repackaged by an entity other than the original manufacturer).

Outpatient X-ray, Imaging, Pathology and Laboratory Benefits

Benefits are provided to diagnose or treat illness or injury, including:

- 1) diagnostic and therapeutic imaging services, such as X-ray and ultrasounds (certain imaging services require prior authorization;
- 2) clinical pathology
- 3) laboratory services

Benefits are provided for genetic testing for certain conditions when the Member has risk factors such as family history or specific symptoms. The testing must be expected to lead to increased or altered monitoring for early detection of disease, a treatment plan or other therapeutic intervention.

Routine laboratory services performed as part of a preventive health screening are covered under the Preventive Health Benefits section.

Radiological and Nuclear Imaging

The following radiological procedures, when performed on an outpatient, non-emergency basis, require prior authorization under the Benefits Management Program. See the *Benefits Management Program* section for complete information.

- 1) CT (Computerized Tomography) scans;
- 2) MRIs (Magnetic Resonance Imaging);

- 3) MRAs (Magnetic Resonance Angiography);
- 4) PET (Positron Emission Tomography) scans; and
- 5) cardiac diagnostic procedures utilizing Nuclear Medicine.

See the *Pregnancy and Maternity Care Benefits* section for genetic testing for prenatal diagnosis of genetic disorders of the fetus.

PKU-Related Formulas and Special Food Products Benefits

Benefits are provided for enteral formulas, related medical supplies, and Special Food Products for the dietary treatment of phenylketonuria (PKU). All formulas and Special Food Products must be prescribed and ordered through the appropriate health care professional.

Podiatric Benefits

Podiatric services include office visits and other Covered Services for the diagnosis and treatment of the foot, ankle and related structures. These services are customarily provided by a licensed doctor of podiatric medicine. Covered lab and X-ray services provided in conjunction with this Benefit are described under the *Outpatient X-ray, Imaging, Pathology and Laboratory Benefits* section.

Pregnancy and Maternity Care Benefits

Benefits are provided for maternity services, including the following:

- 1) prenatal care;
- 2) prenatal diagnosis of genetic disorders of the fetus by means of diagnostic procedures in case of high-risk pregnancy;
- 3) outpatient maternity services;
- 4) involuntary complications of pregnancy (including puerperal infection, eclampsia, cesarean section delivery, ectopic pregnancy, and toxemia);

- 5) inpatient hospital maternity care including labor, delivery and post-delivery care;
- 6) Abortion services; and
- 7) outpatient routine newborn circumcision within 18 months of birth.

See the *Outpatient X-ray, Imaging, Pathology and Laboratory Benefits* section for information on coverage of other genetic testing and diagnostic procedures.

The Newborns' and Mothers' Health Protection Act requires health plans to provide a minimum Hospital stay for the mother and newborn child of 48 hours after a normal, vaginal delivery and 96 hours after a C-section unless the attending Physician, in consultation with the mother, determines a shorter Hospital length of stay is adequate.

If the Hospital stay is less than 48 hours after a normal, vaginal delivery or less than 96 hours after a C-section, a follow-up visit for the mother and newborn within 48 hours of discharge is covered when prescribed by the treating Physician. This visit shall be provided by a licensed Health Care Provider whose scope of practice includes postpartum and newborn care. The treating Physician, in consultation with the mother, shall determine whether this visit shall occur at home, the contracted facility, or the Physician's office.

Preventive Health Benefits

Preventive Health Services are only covered when rendered by a Participating Provider. These services include primary preventive medical screening and laboratory testing for early detection of disease as specifically listed below:

- 1) evidence-based items, drugs or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
- 2) immunizations that have in effect a recommendation from either the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or

the most current version of the Recommended Childhood Immunization Schedule/United States, jointly adopted by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices, and the American Academy of Family Physicians;

- 3) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;
- 4) with respect to women, such additional preventive care and screenings not described in paragraph 1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

Preventive Health Services include, but are not limited to, cancer screening (including, but not limited to, colorectal cancer screening, cervical cancer and HPV screening, breast cancer screening and prostate cancer screening), osteoporosis screening, screening for blood lead levels in children at risk for lead poisoning, and health education. More information regarding covered Preventive Health Services is available at www.blueshieldca.com/preventive or by calling Customer Service.

In the event there is a new recommendation or guideline in any of the resources described in paragraphs 1) through 4) above, the new recommendation will be covered as a Preventive Health Service no later than 12 months following the issuance of the recommendation.

Diagnostic audiometry examinations are covered under the Professional Benefits.

Professional Benefits

Benefits are provided for services of Physicians for treatment of illness or injury, as indicated below.

- 1) Office visits.
- 2) Services of consultants, including those for second medical opinion consultations.

- 3) Mammography and Papanicolaou tests or other FDA (Food and Drug Administration) approved cervical cancer screening tests.
- 4) Asthma self-management training and education to enable a Member to properly use asthma-related medication and equipment such as inhalers, spacers, nebulizers and peak flow monitors.
- 5) Visits to the home, Hospital, Skilled Nursing Facility and Emergency Room.
- 6) Routine newborn care in the Hospital including physical examination of the baby and counseling with the mother concerning the baby during the Hospital stay.
- 7) Surgical procedures.
- 8) Chemotherapy for cancer, including catheterization, and associated drugs and supplies.
- 9) Extra time spent when a Physician is detained to treat a Member in critical condition.
- 10) Necessary preoperative treatment.
- 11) Treatment of burns.
- 12) Outpatient routine newborn circumcision performed within 18 months of birth.
- 13) Diagnostic audiometry examination.
- 14) Teladoc consultations. Teladoc consultations for primary care services provide confidential consultations using a network of U.S. board certified Physicians who are available 24 hours a day by telephone and from 7 a.m. and 9 p.m. by secure online video, 7 days a week. If your Physician's office is closed or you need quick access to a Physician, you can call Teladoc toll free at 1-800-Teladoc (800-835-2362) or visit <http://www.teladoc.com/bsc>. The Teladoc Physician can provide diagnosis and treatment for routine medical conditions and can also prescribe certain medications.

Before this service can be accessed, you must complete a Medical History Disclosure form (MHD). The MHD form can be completed online

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

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

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

A Participating Physician may offer extended hour and urgent care services on a walk-in basis in a non-hospital setting such as the Physician's office or an urgent care center. Services received from a Participating Physician at an extended hours facility will be reimbursed as Physician office visits. A list of urgent care providers may be found online at www.blueshieldca.com.

Professional services by providers other than Physicians are described elsewhere under Covered Services.

Covered lab and X-ray services provided in conjunction with these professional services listed above are described under the *Outpatient X-ray, Imaging, Pathology and Laboratory Benefits* section.

Prosthetic Appliances Benefits

Benefits are provided for Prostheses for Activities of Daily Living at the most cost-effective level of care that is consistent with professionally recognized standards of practice. If there are two or more professionally recognized Prosthetic appliances equally appropriate for a condition,

Benefits will be based on the most cost-effective Prosthetic appliance. Benefits include:

- 1) blom-Singer and artificial larynx prostheses for speech following a laryngectomy (covered as a surgical professional benefit);
- 2) artificial limbs and eyes;
- 3) internally implanted devices such as pacemakers, intraocular lenses, cochlear implants, osseointegrated hearing devices and hip joints if surgery to implant the device is covered;
- 4) contact lenses to treat eye conditions such as keratoconus or keratitis sicca, aniridia, or aphakia following cataract surgery when no intraocular lens has been implanted. ;
- 5) supplies necessary for the operation of prostheses;
- 6) initial fitting and replacement after the expected life of the item; and
- 7) repairs, except for loss or misuse.

No Benefits are provided for wigs for any reason or any type of speech or language assistance devices (except as specifically provided above). No Benefits are provided for backup or alternate items.

For surgically implanted and other prosthetic devices (including prosthetic bras) provided to restore and achieve symmetry incident to a mastectomy, see the Reconstructive Surgery Benefits section.

Reconstructive Surgery Benefits

Benefits are provided to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following: (1) to improve function, or (2) to create a normal appearance to the extent possible. Benefits include dental and orthodontic services that are an integral part of this surgery for cleft palate procedures. Reconstructive Surgery is covered to create a normal appearance only when

it offers more than a minimal improvement in appearance.

In accordance with the Women's Health & Cancer Rights Act, Reconstructive Surgery, and surgically implanted and non-surgically implanted prosthetic devices (including prosthetic bras), are covered on either breast to restore and achieve symmetry incident to a mastectomy, and treatment of physical complications of a mastectomy, including lymphedemas.

Benefits will be provided in accordance with guidelines established by Blue Shield and developed in conjunction with plastic and reconstructive surgeons.

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

Benefits are provided for outpatient Physical, Occupational, and Respiratory Therapy for the treatment of functional disability in the performance of activities of daily living. Continued outpatient Benefits will be provided as long as treatment is Medically Necessary pursuant to the treatment plan, to help the Member regain his or her previous level of functioning or to keep, learn, or improve skills and functioning.

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

Benefits for Speech Therapy are described in the *Speech Therapy Benefits (Rehabilitation and Habilitative Services)* section.

See the *Home Health Care Benefits and Hospice Program Benefits* sections for information on coverage for Rehabilitation/Habilitative services rendered in the home.

Skilled Nursing Facility Benefits

Benefits are provided for Skilled Nursing services in a Skilled Nursing unit of a Hospital or a free-standing Skilled Nursing Facility, up to the Benefit maximum as shown on the Summary of Benefits. The Benefit maximum is per Member per Benefit

Period, except that room and board charges in excess of the facility's established semi-private room rate are excluded. A "Benefit Period" begins on the date the Member is admitted into the facility for Skilled Nursing services, and ends 60 days after being discharged and Skilled Nursing services are no longer being received. A new Benefit Period can begin only after an existing Benefit Period ends.

Speech Therapy Benefits (Rehabilitation and Habilitative Services)

Benefits are provided for outpatient Speech Therapy for the treatment of (1) a communication impairment; (2) a swallowing disorder; (3) an expressive or receptive language disorder; or (4) an abnormal delay in speech development. Continued outpatient Benefits will be provided as long as treatment is Medically Necessary pursuant to the treatment plan, to help the Member regain his or her previous performance level or to keep, learn, or improve skills and functioning. Blue Shield may periodically review the provider's treatment plan and records for Medical Necessity.

See the *Hospital Benefits (Facility Services)* section for information on inpatient Benefits.

Transplant Benefits

Tissue and Kidney Transplants

Benefits are provided for Hospital and professional services provided in connection with human tissue and kidney transplants when the Member is the transplant recipient. Benefits include services incident to obtaining the human transplant material from a living donor or a tissue/organ transplant "bank."

Special Transplants

Benefits are provided for certain procedures, listed below, only if (1) performed at a Special Transplant Facility contracting with Blue Shield to provide the procedure, or in the case of Members accessing this Benefit outside of California, the procedure is performed at a transplant facility

designated by Blue Shield, (2) prior authorization is obtained, in writing through the Benefits Management Program and (3) the recipient of the transplant is a Subscriber or Dependent.

Failure to obtain prior written authorization and/or failure to have the procedure performed at a contracting Special Transplant Facility will result in denial of claims for this Benefit.

The following procedures are eligible for coverage under this provision:

- 1) Human heart transplants;
- 2) Human lung transplants;
- 3) Human heart and lung transplants in combination;
- 4) Human liver transplants;
- 5) Human kidney and pancreas transplants in combination;
- 6) Human bone marrow transplants, including autologous bone marrow transplantation (ABMT) or autologous peripheral stem cell transplantation used to support high-dose chemotherapy when such treatment is Medically Necessary and is not Experimental or Investigational;
- 7) Pediatric human small bowel transplants;
- 8) Pediatric and adult human small bowel and liver transplants in combination.
- 9) Transplant benefits include coverage for donation-related services for a living donor (including a potential donor), or a transplant organ bank. Donor services must be directly related to a covered transplant and must be prior authorized by Blue Shield. Donation-related services include harvesting of the organ, tissue, or bone marrow and treatment of medical complications for a period of 90 days following the evaluation or harvest service.

Pediatric Dental Benefits

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 Care 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.

If the Member purchased a Family dental plan that includes a supplemental pediatric dental plan on the Health Benefits Exchange, embedded pediatric dental Benefits covered under this plan will be paid first. 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 the Member has any questions regarding the information in this booklet, need assistance, or have any problems, he/she may contact the dental Member Services Department at: 1-888-679-8928.

Before Obtaining Dental Services

The Member is responsible for assuring that the Dentist he/she chooses is a Participating Dentist. Note: A Participating Dentist's status may change. It is the Member's obligation to verify whether the Dentist the Member chooses 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 the Member's area, can be obtained by contacting the DPA at 1-888-679-8928. The Member may also access a list of Participating Dentists through Blue Shield of California's internet site located at <http://www.blueshieldca.com>. The Member is 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 5 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 the Member and the Dentist will know in advance which services are covered and the Benefits that are payable.

Participating Dentists

The Blue Shield of California Dental PPO Plan is specifically designed for Members to use Participating Dentists. Participating Dentists agree to accept the DPA's payment, plus the Member's payment of any applicable deductible and coinsurance amount, as payment in full for Covered Services. This is not true of Non-Participating Dentists.

If the Member goes to a Non-Participating Dentist, the Member will be reimbursed up to a pre-determined maximum amount, for Covered Services. The Member's reimbursement may be substantially less than the billed amount. The Member is responsible for all differences between the amount the Member is reimbursed and the amount billed by Non-Participating Dentists. It is therefore to the Member's advantage to obtain Dental Care Services from Participating Dentists.

Participating Providers submit claims for payment after their services have been rendered. These payments go directly to the Participating Provider. The Member or his/her Non-Participating Providers submits claims for reimbursement after services have been rendered. If the Member receives services from Non-Participating Providers, the Member has the option of having payments sent directly to the Non-Participating Provider or sent directly to the Member. The DPA will notify the Member of its determination within 30 days after receipt of the claim.

Providers do not receive financial incentives or bonuses from Blue Shield of California.

The Member may access a Directory of Participating Dentists through Blue Shield of

California's Internet site located at <http://www.blueshieldca.com>. The names of Participating Dentists in the Member's area may also be obtained by the DPA at 1-888-679-8928.

Continuity of Care by a Terminated Provider

Persons who are being treated for acute dental conditions, serious chronic dental conditions, or who are children from birth to 36 months of age, or who have received authorization from a now-terminated provider for dental surgery or another dental procedure as part of a documented course of treatment can request completion of care in certain situations with a provider who is leaving a the DPA's network of Participating Dentists. Contact Customer Service to receive information regarding eligibility criteria and the policy and procedure for requesting continuity of care from a terminated provider.

Timely Access to Dental Care Services

Blue Shield provides the following guidelines for timely access to care from Dental Providers:

Service	Access to Care
Urgent Care	Within 72 hours
Non-urgent care	Within 30 business days
Preventive dental care	Within 40 business days
<u>Telephone Inquiries</u>	<u>Access to Care</u>
<u>Access to a dental professional to evaluate the Member's dental concerns and symptoms</u>	<u>Within 30 minutes, 24 hours/day 7 days/week</u>

Note: For availability of interpreter services at the time of the Member's appointment, contact Customer Service at the number shown in the "Customer Service" section of this booklet. More information for interpreter services is located in the Notice of the Availability of Language Assistance Services section of this EOC.

Financial Responsibility for Continuity of Care Services

If a Member is entitled to receive services from a terminated provider under the preceding Continuity of Care provision, the responsibility of the Member to that provider for services rendered under the Continuity of Care provision shall be no greater than for the same services rendered by a Participating Dentist in the same geographic area.

Pre-certification of Dental Benefits

Before any course of treatment expected to cost more than \$250 is started, the Member should obtain Pre-certification of Benefits. The Member's Dentist should submit the recommended treatment plan and fees together with appropriate diagnostic X-rays to the DPA. The DPA will review the dental treatment plan to determine the Benefits payable under the plan. The Benefit determination for the proposed treatment plan will then be promptly returned to the Dentist. When the treatment is completed, the Member's claim form should be submitted to the DPA for payment determination. The DPA will notify the Member of its determination within 30 days after receipt of the claim.

The dental plan provides Benefits for Covered Services at the most cost-effective level of care that is consistent with professionally recognized standards of care. If there are two or more professionally recognized procedures for treatment of a dental condition, this plan will in most cases provide Benefits based on the most cost-effective procedure. The Benefits provided under this plan are based on these considerations but the Member and his/her Dentist make the final decision regarding treatment.

Failure to obtain Pre-certification of Benefits may result in a denial of Benefits. If the Pre-certification process is not followed, the DPA will still determine payment by taking into account alternative procedures; services or materials for the dental condition based on professionally recognized standards of dental practice. However, by following the Pre-certification process both the

Member and his/her Dentist will know in advance which services are covered and the Benefits that are payable.

The covered dental expense will be limited to the Allowable Amount for the procedure, service or material which meets professionally recognized standards of quality dental care and is the most cost effective as determined by the DPA. If the Member and his/her Dentist decide on a more costly procedure, service or material than the DPA determined is payable under the plan, then Benefits will be applied to the selected treatment plan up to the Benefit maximum for the most cost effective alternative. The Member will be responsible for any charges in excess of the Benefit amount. The DPA reserves the right to use the services of dental consultants in the Pre-certification review.

Example:

- 1) If a crown is placed on a tooth which can be restored by a filling, Benefits will be based on the filling;
- 2) If a semi-precision or precision partial denture is inserted, Benefits may be based on a conventional clasp partial denture
- 3) If a bridge is placed and the Member has multiple unrestored missing teeth, Benefits will be based on a partial denture.

Participating Dentists

When the Member receives covered dental services from a Participating Dentist, the Member will be responsible for a coinsurance amount as outlined in the section entitled Summary of Benefits. Participating Dentists will file claims on the Member's behalf.

Participating Dentists will be paid directly by the plan, and have agreed to accept the DPA's payment, plus the Member's payment of any applicable deductible or coinsurance amount, as payment in full for Covered Services.

If the covered Member recovers from a third party the reasonable value of Covered Services rendered by a Participating Dentist, the

Participating Dentist who rendered these services is not required to accept the fees paid by the DPA as payment in full, but may collect from the covered Member the difference, if any, between the fees paid by the DPA and the amount collected by the covered Member for these services.

Non-Participating Dentists

When the Member receives Covered Services from a Non-Participating Dentist, the Member will be reimbursed up to a specified maximum amount as outlined in the section entitled Summary of Benefits and Member Coinsurance. The Member will be responsible for the remainder of the Dentist's billed charges. The Member should discuss this beforehand with his/her Dentist if he is not a Participating Dentist. Any difference between a contracted Dental Plan Administrator's or Blue Shield of California's payment and the Non-Participating Dentist's charges are the Member's responsibility. Members are expected to follow the billing procedures of the dental office.

If the Member receives Covered Services from a Non-Participating Dentist, either the Member or his/her provider may file a claim using the dental claim form which may be obtained by calling Dental Member Services at:

1-888-679-8928

Claims for all Covered California services should be sent to:

Blue Shield of California
Dental Plan Administrator
P O Box 400
Chico, CA 95927

Procedure for Filing a Claim

Claims for covered dental services should be submitted on a dental claim form which may be obtained from the DPA or at blueshieldca.com. Have the Dentist complete the form and mail it to the DPA Service Center as shown in the Pediatric Dental Benefits Customer Services section.

The DPA will provide payment in accordance with the provisions of this Agreement. The Member will receive an explanation of Benefits after the claim has been processed.

All claims for reimbursement must be submitted to the DPA within one (1) year after the month in which the service is rendered. The DPA will notify the Member of its determination within 30 days after receipt of the claim.

Coordination of Dental Benefits

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.

Emergency Dental Care Services

A dental emergency means, “an unexpected dental condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate dental attention could reasonably be expected to result in any of the following: (1) placing the Member’s health in serious jeopardy; (2) serious impairment to bodily functions; (3) subjecting the member to undue suffering.”

If the Member is in need of emergency treatment, the Member should contact a Dentist of their choice. Emergency treatment refers only to those dental services required to alleviate pain and suffering. The Member will be directly reimbursed for this treatment up to the maximum allowed under their Plan Benefits.

General Exclusions and Limitations

Unless exceptions to the following general exclusions are specifically made elsewhere under this plan, this plan does not provide Benefits for:

1) Dental services not appearing on the Summary of Benefits or on the Dental Schedule and Limitations Table below;

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

on the Summary of Benefits or on the Dental Schedule and Limitations Table or is given by a Dentist for a covered oral surgery;

- 11) Hospital charges of any kind;
- 12) Loss or theft of dentures or bridgework;
- 13) Malignancies;
- 14) Dispensing of drugs not normally supplied in a dental office;
- 15) Additional treatment costs incurred because a dental procedure is unable to be performed in the Dentist's office due to the general health and physical limitations of the Member;
- 16) The cost of precious metals used in any form of dental Benefits;
- 17) Services of a pedodontist/pediatric Dentist for Member except when a Member child is unable to be treated by his or her Dental Provider or for Medically Necessary Dental Services or his or her Dental Provider is a pedodontist/pediatric Dentist.
- 18) Charges for services performed by a close relative or by a person who ordinarily resides in the Member's home;
- 19) Treatment for any condition for which Benefits could be recovered under any worker's compensation or occupational disease law, when no claim is made for such Benefits;
- 20) Treatment for which payment is made by any governmental agency, including any foreign government;
- 21) Charges for second opinions, unless previously authorized by the DPA; and
- 22) Services provided by an individual or entity that is not licensed or certified by the state to provide health care services, or is not operating within the scope of such license or certification, except as specifically stated herein.

Preventive Exclusions and Limitations (D1000-D1999)

- 1) Fluoride treatment (D1206 and D1208) is a Benefit only for prescription strength fluoride products;
- 2) Fluoride treatments do not include treatments that incorporate fluoride with prophylaxis paste, topical application of fluoride to the prepared portion of a tooth prior to restoration and applications of aqueous sodium fluoride; and
- 3) The application of fluoride is only a Benefit for caries control and is payable as a full mouth treatment regardless of the number of teeth treated.

Restorative Exclusions and Limitations (D2000-D2999)

- 1) Restorative services provided solely to replace tooth structure lost due to attrition, abrasion, erosion or for cosmetic purposes;
- 2) Restorative services when the prognosis of the tooth is questionable due to non-restorability or periodontal involvement;
- 3) Restorations for primary teeth near exfoliation;
- 4) Replacement of otherwise satisfactory amalgam restorations with resin-based composite restorations unless a specific allergy has been documented by a medical specialist (allergist) on their professional letterhead or prescription;
- 5) Prefabricated crowns for primary teeth near exfoliation;
- 6) Prefabricated crowns are not a Benefit for abutment teeth for cast metal framework partial dentures (D5213 and D5214);
- 7) Prefabricated crowns provided solely to replace tooth structure lost due to attrition,

abrasion, erosion or for cosmetic purposes;

- 8) Prefabricated crowns are not a Benefit when the prognosis of the tooth is questionable due to non-restorability or periodontal involvement;
- 9) Prefabricated crowns are not a Benefit when a tooth can be restored with an amalgam or resin-based composite restoration;
- 10) Restorative services provided solely to replace tooth structure lost due to attrition, abrasion, erosion or for cosmetic purposes;
- 11) Laboratory crowns are not a Benefit when the prognosis of the tooth is questionable due to non-restorability or periodontal involvement; and
- 12) Laboratory processed crowns are not a Benefit when the tooth can be restored with an amalgam or resin-based composite.

Endodontic Exclusions and Limitations (D3000-D3999)

- 1) Endodontic procedures when the prognosis of the tooth is questionable due to non-restorability or periodontal involvement;
- 2) Endodontic procedures when extraction is appropriate for a tooth due to non-restorability, periodontal involvement or for a tooth that is easily replaced by an addition to an existing or proposed prosthesis in the same arch; and
- 3) Endodontic procedures for third molars, unless the third molar occupies the first or second molar positions or is an abutment for an existing fixed or removable partial denture with cast clasps or rests.

Periodontal Exclusions and Limitations (D4000-D4999)

- 1) Tooth bounded spaces shall only be counted in conjunction with osseous surgeries (D4260

and D4261) that require a surgical flap. Each tooth bounded space shall only count as one tooth space regardless of the number of missing natural teeth in the space.

Prosthodontic (Removable) Exclusions and Limitations (D5000-D5899)

- 1) Prosthodontic services provided solely for cosmetic purposes;
- 2) Temporary or interim dentures to be used while a permanent denture is being constructed;
- 3) Spare or backup dentures;
- 4) Evaluation of a denture on a maintenance basis;
- 5) Preventative, endodontic or restorative procedures are not a Benefit for teeth to be retained for overdentures. Only extractions for the retained teeth will be a Benefit;
- 6) Partial dentures are not a Benefit to replace missing 3rd molars;
- 7) Laboratory relines (D5760 and D5761) are not a Benefit for resin based partial dentures (D5211 and D5212);
- 8) Laboratory relines (D5750, D5751, D5760 and D5761) are not a Benefit within 12 months of chairside relines (D5730, D5731, D5740 and D5741);
- 9) Chairside relines (D5730, D5731, D5740 and D5741) are not a Benefit within 12 months of laboratory relines (D5750, D5751, D5760 and D5761);
- 10) Tissue conditioning (D5850 and D5851) is only a Benefit to heal unhealthy ridges prior to a definitive prosthodontic treatment; and
- 11) Tissue conditioning (D5850 and D5851) is a Benefit the same date of service as an immediate prosthesis that required extractions.

Implant Exclusions and Limitations (D6000-D6199)

- 1) Implant services are a Benefit only when exceptional medical conditions are documented and the services are considered Medically Necessary; and
- 2) Single tooth implants are not a Benefit.

Prosthodontic (Fixed) Exclusions and Limitations (D6200-D6999)

- 1) Fixed partial dentures (bridgework) are not a Benefit; however, the fabrication of a fixed partial denture shall be considered when medical conditions or employment preclude the use of a removable partial denture;
- 2) Fixed partial dentures are not a Benefit when the prognosis of the retainer (abutment) teeth is questionable due to non-restorability or periodontal involvement;
- 3) Posterior fixed partial dentures are not a Benefit when the number of missing teeth requested to be replaced in the quadrant does not significantly impact the Member's masticatory ability;
- 4) Fixed partial denture inlay/onlay retainers (abutments) (D6545-D6634); and
- 5) Cast resin bonded fixed partial dentures (Maryland Bridges).

Oral and Maxillofacial Surgery Exclusions and Limitations (D7000-D7999)

- 1) The prophylactic extraction of 3rd molars is not a Benefit;
- 2) TMJ dysfunction procedures are limited to differential diagnosis and symptomatic care. Not included as a Benefit are those TMJ treatment modalities that involve prosthodontia, orthodontia and full or partial occlusal rehabilitation;
- 3) TMJ dysfunction procedures solely for the treatment of bruxism is not a Benefit; and

- 4) Suture procedures (D7910, D7911 and D7912) are not a Benefit for the closure of surgical incisions.

Orthodontic Exclusions and Limitations

Orthodontic procedures are Benefits for Medically Necessary handicapping malocclusion, cleft palate and facial growth management cases for Members under the age of 19 and shall be prior authorized.

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

Orthodontic procedures are a Benefit only when the diagnostic casts verify a minimum score of 26 points on the Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheet Form, DC016 (06/09) or one of the six automatic qualifying conditions below exist or when there is written documentation of a craniofacial anomaly from a credentialed specialist on their professional letterhead.

Those immediate qualifying conditions are:

- 1) Cleft lip and or palate deformities
- 2) Craniofacial Anomalies including the following:
 - Crouzon's syndrome,
 - Treacher-Collins syndrome,
 - Pierre-Robin syndrome,
 - Hemi-facial atrophy, Hemifacial hypertrophy and other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by our dental consultants.

- 3) Deep impinging overbite, where the lower incisors are destroying the soft tissue of the palate and tissue laceration and/or clinical attachment loss are present. (Contact only does not constitute deep impinging overbite).
- 4) Crossbite of individual anterior teeth when clinical attachment loss and recession of the gingival margin are present (e.g., stripping of the labial gingival tissue on the lower incisors). Treatment of bi-lateral posterior crossbite is not a Benefit of the program.
- 5) Severe traumatic deviation must be justified by attaching a description of the condition.
- 6) Overjet greater than 9mm or mandibular protrusion (reverse overjet) greater than 3.5mm.

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

Medical Necessity Exclusion

All dental services received must be Medically Necessary Dental Services. The fact that a Dentist or other Plan Provider may prescribe, order, recommend, or approve a service or supply does not, in itself, determine Medical Necessity.

Alternate Benefits Provision

If dental standards indicate that a condition can be treated by a less costly alternative to the service proposed by the attending Dentist, the DPA will pay for Benefits based upon the less costly service.

Pediatric Dental Benefits Customer Services

Questions about Services, providers, Benefits, how to use this Plan, or concerns regarding the quality of care or access to care that the Member has experienced should be directed to your Dental Customer Service at the phone number or address which appear below:

1-888-679-8928

Blue Shield of California

Dental Plan Administrator

425 Market Street, 15th Floor

San Francisco, CA 94105

Dental Customer Service can answer many questions over the telephone.

Note: Dental Benefit Providers has established a procedure for our Subscribers to request an expedited decision. A Subscriber, Physician, or representative of a Subscriber may request an expedited decision when the routine decision making process might seriously jeopardize the life or health of a Subscriber, or when the Subscriber is experiencing severe pain. Dental Benefit Providers shall make a decision and notify the Subscriber and Physician within 72 hours following the receipt of the request. If you would

like additional information regarding the expedited decision process, or if you believe your particular situation qualifies for an expedited decision, please contact the Dental Customer Service Department at the number listed above.

Pediatric Dental Benefits Grievance Process

Members, a designated representative, or a provider on behalf of the Member, may contact the Dental Member Service Department by telephone, letter or online to request a review of an initial determination concerning a claim or service. Members may contact the Dental Member Service Department at the telephone number as noted below. If the telephone inquiry to the Dental Member Service Department does not resolve the question or issue to the Member's satisfaction, the Member may request a grievance at that time, which the Dental Member Service Representative will initiate on the Member's behalf.

The Member, a designated representative, or a provider on behalf of the Member, may also initiate a grievance by submitting a letter or a completed "Grievance Form". The Member may request this Form from the Dental Member Service Department. If the Member wishes, the Dental Member Service staff will assist in completing the grievance form. Completed grievance forms must be mailed to the DPA at the address provided below. The Member may also submit the grievance to the Dental Member Service Department online by visiting <http://www.blueshieldca.com>.

1-888-679-8928

Blue Shield of California

Dental Plan Administrator

PO Box 30569

Salt Lake City, UT 84130-0569

The DPA will acknowledge receipt of a written grievance within 5 calendar days. Grievances are resolved within 30 days.

The grievance system allows Members to file grievances for at least 180 days following any

incident or action that is the subject of the Member's dissatisfaction. See the previous Member Service section for information on the expedited decision process.

Pediatric Dental Benefits Definitions –

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

Alternate Benefit Provision (ABP) — A provision that allows Benefit paid to be based on an alternate procedure, which is professionally acceptable and more cost effective.

Billed Charges — the prevailing rates of the Dental office.

Dental Allowable Amount — the Allowance is:

- 1) The amount a contracted Dental Plan Administrator has determined is an appropriate payment for the service(s) rendered in the provider's geographic area, based upon such factors as evaluation of the value of the service(s) relative to the value of other services, market considerations, and provider charge patterns; or
- 2) Such other amount as the Participating Dentist and a contracted Dental Plan Administrator have agreed will be accepted as payment for the service(s) rendered; or
- 3) If an amount is not determined as described in either 1. or 2. above, the amount a contracted Dental Plan Administrator determines is appropriate considering the particular circumstances and the services rendered.

Dental Care Services — Necessary treatment on or to the teeth or gums, including any appliance or device applied to the teeth or gums, and necessary dental supplies furnished incidental to Dental Care Services.

Dental Center – means a Dentist or a dental practice (with one or more Dentists) which has contracted with the DPA to provide dental care Benefits to Members and to diagnose, provide, refer, supervise, and coordinate the provision of all

Benefits to Members in accordance with this Contract.

Medically Necessary Dental Services — Benefits are provided only for Dental Care Services that are Medically Necessary as defined in this Section.

- 1) Dental Care Services which are Medically Necessary include only those which have been established as safe and effective and are furnished in accordance with generally accepted national and California dental standards, including services in circumstances of Medical Necessity as defined in the Early Periodic Screening, Diagnosis and Treatment (EPSDT) program which, as determined by a contracted Dental Plan Administrator, are:
 - a) Consistent with the symptoms or diagnosis of the condition; and
 - b) Not furnished primarily for the convenience of the Member, the attending Dentist or other provider; and
 - c) Furnished in a setting appropriate for delivery of the service (e.g., a dentist's office).
- 2) If there are two (2) or more Medically Necessary Dental Services that can be provided for the condition, Blue Shield will provide Benefits based on the most cost-effective service.

Dental Plan Administrator (DPA) — Blue Shield has contracted with a Dental Plan Administrator (DPA). A DPA is a dental care service plan licensed by the California Department of Managed Health Care, which contracts with Blue Shield to administer delivery of Dental Care Services through a network of Participating Dentists. A DPA also contracts with Blue Shield to serve as a claims administrator for the processing of claims received from Non-Participating Dentists.

Dental Provider (Plan Provider) – means a Dentist or other provider appropriately licensed to provide Dental Care Services who contracts with a Dental Center to provide Benefits to Plan

Members in accordance with their Dental Services Contract.

Dentist — a duly licensed Doctor of Dental Surgery (DDS) or Doctor of Dental Medicine (DMD).

Elective Dental Procedure — any dental procedures which are unnecessary to the dental health of the Member, as determined by a contracted Dental Plan Administrator.

Emergency Dental Care Services — Services provided for an unexpected dental condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- 1) placing the Member's health in serious jeopardy;
- 2) serious impairment to bodily functions;
- 3) serious dysfunction of any bodily organ or part.

Experimental or Investigational in Nature Dental Care Services — any treatment, therapy, procedure, drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supplies which are not recognized in accordance with generally accepted professional medical/dental standards as being safe and effective for use in the treatment of the illness, injury, or condition at issue. Services which require approval by the Federal government or any agency thereof, or by any State government agency, prior to use and where such approval has not been granted at the time the services or supplies were rendered, shall be considered Experimental or Investigational in Nature. Services or supplies which themselves are not approved or recognized in accordance with accepted professional medical/dental standards, but nevertheless are authorized by law or by a government agency for use in testing, trials, or other studies on human patients, shall be considered Experimental or Investigational in Nature.

Maximum Plan Payment — the maximum amount that the Member will be reimbursed for services obtained from a Non-Participating Dentist.

Participating Dentist — a Doctor of Dental Surgery or Doctor of Dental Medicine who has signed a service contract with a contracted Dental Plan Administrator to provide dental services to Members.

Pedodontics — Dental Care Services related to the diagnosis and treatment of conditions of the teeth and mouth in children.

Prosthesis — an artificial part, appliance, or device used to replace a missing part of the body.

Prosthodontics — Dental Care Services specifically related to necessary procedures for providing artificial replacements for missing natural teeth.

Treatment in Progress — Partially completed dental procedures including prepped teeth, root canals in process of treatment, and full and partial denture cases after final impressions have been taken.

Dental Schedule and Limitations Table

The below schedule outlines the pediatric dental Benefits covered by this Plan along with limitations related to the listed dental procedure codes:

Code	Description	Limitation
Diagnostic Procedures (D0100-D0999)		
D0120	Periodic oral evaluation - established patient	once every 6 months, per provider or after 6 months have elapsed following comprehensive oral evaluation (D0150), same provider.
D0140	Limited oral evaluation – problem focused	once per Member per provider.
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	
D0150	Comprehensive oral evaluation – new or established patient	once per Member per provider for the initial evaluation.
D0160	Detailed and extensive oral evaluation – problem focused, by report	once per Member per provider.
D0170	Re-evaluation – limited, problem focused (established patient; not post- operative visit)	a Benefit for the ongoing symptomatic care of temporomandibular joint dysfunction: a. up to 6 times in a 3 month period; and b. up to a maximum of 12 in a 12 month period.
D0171	Re-evaluation – post-operative office visit	
D0180	Comprehensive periodontal evaluation – new or established patient	
D0190	Screening of a patient	not a Benefit.
D0191	Assessment of a patient	not a Benefit.
D0210	Intraoral - complete series of radiographic images	once per provider every 36 months.
D0220	Intraoral - periapical first radiographic image	up to a maximum of 20 periapicals in a 12-month period by the same provider, in any combination of the following: intraoral- periapical first radiographic image (D0220) and intraoral- periapical each additional radiographic image (D0230). Periapicals

Code	Description	Limitation
		taken as part of an intraoral-complete series of radiographic images (D0210) are not considered against the maximum of 20 periapicals in a 12 month period.
D0230	Intraoral - periapical each additional radiographic image	up to a maximum of 20 periapicals in a 12 month period to the same provider, in any combination of the following: intraoral- periapical first radiographic image (D0220) and intraoral- periapical each additional radiographic image (D0230). Periapicals taken as part of an intraoral complete series of radiographic images (D0210) are not considered against the maximum of 20 periapical films in a 12 month period.
D0240	Intraoral - occlusal radiographic image	up to a maximum of two in a 6 month period per provider.
D0250	Extra-oral - 2D projection radiographic image created using a stationary radiation source, and detector	once per date of service.
D0251	Extra-oral posterior dental radiographic image	up to a maximum of 4 on the same date of service.
D0270	Bitewing - single radiographic image	once per date of service. Not a Benefit for a totally edentulous area.
D0272	Bitewings - 2 radiographic images	once every 6 months per provider. Not a Benefit: a. within 6 months of intraoral complete series of radiographic images (D0210), same provider; and b. for a totally edentulous area.
D0273	Bitewings - 3 radiographic images	
D0274	Bitewings - 4 radiographic images	once every 6 months per provider. Not a Benefit: a. within 6 months of intraoral-complete series of radiographic images (D0210), same provider; b. for Members under the age of 10; and c. for a totally edentulous area.

Code	Description	Limitation
D0277	Vertical bitewings - 7 to 8 radiographic images	
D0310	Sialography	
D0320	Temporomandibular joint arthrogram, including injection	limited to the survey of trauma or pathology, up to a maximum of 3 per date of service.
D0322	Tomographic survey	up to twice in a 12 month period per provider.
D0330	Panoramic radiographic image	once in a 36 month period per provider, except when documented as essential for a follow-up/ post-operative exam (such as after oral surgery).
D0340	2D cephalometric radiographic image – acquisition, measurement and analysis	twice in a 12 month period per provider.
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	up to a maximum of 4 per date of service.
D0351	3D photographic image	
D0431	Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	not a Benefit.
D0460	Pulp vitality tests	
D0470	Diagnostic casts	once per provider unless special circumstances are documented (such as trauma or pathology which has affected the course of orthodontic treatment); for permanent dentition (unless over the age of 13 with primary teeth still present or has a cleft palate or craniofacial anomaly); and when provided by a certified orthodontist.
D0502	Other oral pathology procedures, by report	must be provided by a certified oral pathologist.
D0601	Caries risk assessment and documentation, with a finding of low risk	
D0602	Caries risk assessment and documentation, with a finding of moderate risk	
D0603	Caries risk assessment and documentation, with a finding of high risk	

Code	Description	Limitation
D0999	Unspecified diagnostic procedure, by report	
Preventive Procedures (D1000-D1999)		
D1110	Prophylaxis - adult	
D1120	Prophylaxis – child	once in a 6 month period.
D1206	Topical application of fluoride varnish	once in a 6 month period.
D1208	Topical application of fluoride – excluding varnish	once in a 6 month period.
D1310	Nutritional counseling for control of dental disease	
D1320	Tobacco counseling for the control and prevention of oral disease	
D1330	Oral hygiene instructions	
D1351	Sealant – per tooth	limited to the first, second and third permanent molars that occupy the second molar position; only on the occlusal surfaces that are free of decay and/or restorations; and once per tooth every 36 months per provider regardless of surfaces sealed.
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth	limited to the for first, second and third permanent molars that occupy the second molar position; for an active cavitated lesion in a pit or fissure that does not cross the dentinoenamel junction (DEJ); and once per tooth every 36 months per provider regardless of surfaces sealed.
D1353	Sealant repair – per tooth	
D1510	Space maintainer-fixed – unilateral	once per quadrant per Member, for Members under the age of 18 and only to maintain the space for a single tooth.
D1515	Space maintainer-fixed – bilateral	once per arch when there is a missing primary molar in both quadrants or when there are 2 missing primary molars in the same quadrant and for Members under the age of 18. Not a Benefit: a. when the permanent tooth is near eruption or is missing;

Code	Description	Limitation
		<p>b. for upper and lower anterior teeth; and</p> <p>c. for orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires.</p>
D1520	Space maintainer-removable – unilateral	<p>once per quadrant per Member, for Members under the age of 18 and only to maintain the space for a single tooth.</p> <p>Not a Benefit:</p> <p>a. when the permanent tooth is near eruption or is missing;</p> <p>b. for upper and lower anterior teeth; and</p> <p>c. for orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires.</p>
D1525	Space maintainer-removable – bilateral	<p>once per arch when there is a missing primary molar in both quadrants or when there are 2 missing primary molars in the same quadrant or for Members under the age of 18.</p> <p>Not a Benefit:</p> <p>a. when the permanent tooth is near eruption or is missing;</p> <p>b. for upper and lower anterior teeth; and</p> <p>c. for orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires.</p>
D1550	Re-cement or re-bond space maintainer	once per provider, per applicable quadrant or arch for Members under the age of 18.
D1555	Removal of fixed space maintainer	not a Benefit to the original provider who placed the space maintainer.
D1575	Distal shoe space maintainer – fixed – unilateral	
Restorative Procedures (D2000-D2999)		
D2140	Amalgam – 1 surface, primary or permanent	once in a 12 month period for primary teeth and once in a 36 month period for permanent teeth.

Code	Description	Limitation
D2150	Amalgam – 2 surfaces, primary or permanent	once in a 12 month period for primary teeth and once in a 36 month period for permanent teeth.
D2160	Amalgam – 3 surfaces, primary or permanent	once in a 12 month period for primary teeth and once in a 36 month period for permanent teeth.
D2161	Amalgam – 4 or more surfaces, primary or permanent	once in a 12 month period for primary teeth and once in a 36 month period for permanent teeth.
D2330	Resin-based composite – 1 surface, anterior	once in a 12 month period for primary teeth and once in a 36 month period for permanent teeth.
D2331	Resin-based composite – 2 surfaces, anterior	once in a 12 month period for primary teeth and once in a 36 month period for permanent teeth.
D2332	Resin-based composite – 3 surfaces, anterior	once in a 12 month period for primary teeth and once in a 36 month period for permanent teeth.
D2335	Resin-based composite – 4 or more surfaces or involving incisal angle (anterior)	once in a 12 month period for primary teeth and once in a 36 month period for permanent teeth.
D2390	Resin-based composite crown, anterior	once in a 12 month period for primary teeth and once in a 36 month period for permanent teeth.
D2391	Resin-based composite – 1 surface, posterior	once in a 12 month period for primary teeth and once in a 36 month period for permanent teeth.
D2392	Resin-based composite – 2 surfaces, posterior	once in a 12 month period for primary teeth and once in a 36 month period for permanent teeth.
D2393	Resin-based composite – 3 surfaces, posterior	once in a 12 month period for primary teeth and once in a 36 month period for permanent teeth.
D2394	Resin-based composite – 4 or more surfaces, posterior	once in a 12 month period for primary teeth and once in a 36 month period for permanent teeth.
D2542	Onlay - metallic – 2 surfaces	not a Benefit.

Code	Description	Limitation
D2543	Onlay - metallic – 3 surfaces	not a Benefit.
D2544	Onlay - metallic – 4 or more surfaces	not a Benefit.
D2642	Onlay - porcelain/ceramic – 2 surfaces	not a Benefit.
D2643	Onlay - porcelain/ceramic – 3 surfaces	not a Benefit.
D2644	Onlay - porcelain/ceramic – 4 or more surfaces	not a Benefit.
D2662	Onlay - resin-based composite – 2 surfaces	not a Benefit.
D2663	Onlay - resin-based composite – 3 surfaces	not a Benefit.
D2664	Onlay - resin-based composite – 4 or more surfaces	not a Benefit.
D2710	Crown – resin-based composite (indirect)	<p>permanent anterior teeth and permanent posterior teeth (ages 13 or older):</p> <p>once in a 5 year period and for any resin based composite crown that is indirectly fabricated.</p> <p>Not a Benefit:</p> <p>a. for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests; and</p> <p>b. for use as a temporary crown.</p>
D2712	Crown - 3/4 resin-based composite (indirect)	<p>permanent anterior teeth and permanent posterior teeth (ages 13 or older):</p> <p>once in a 5 year period and for any resin based composite crown that is indirectly fabricated.</p> <p>Not a Benefit:</p> <p>a. for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests; and</p> <p>b. for use as a temporary crown.</p>
D2720	Crown - resin with high noble metal	not a Benefit.

Code	Description	Limitation
D2721	Crown – resin with predominantly base metal	permanent anterior teeth and permanent posterior teeth (ages 13 or older): once in a 5 year period. Not a Benefit: for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests.
D2722	Crown - resin with noble metal	not a Benefit.
D2740	Crown – porcelain/ceramic substrate	permanent anterior teeth and permanent posterior teeth (ages 13 or older): once in a 5 year period. Not a Benefit: for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests.
D2750	Crown - porcelain fused to high noble metal	not a Benefit.
D2751	Crown – porcelain fused to predominantly base metal	permanent anterior teeth and permanent posterior teeth (ages 13 or older): once in a 5 year period. Not a Benefit: for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests.
D2752	Crown - porcelain fused to noble metal	not a Benefit.
D2780	Crown - 3/4 cast high noble metal	not a Benefit.
D2781	Crown – 3/4 cast predominantly base metal	permanent anterior teeth and permanent posterior teeth (ages 13 or older): once in a 5 year period. Not a Benefit: for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an

Code	Description	Limitation
		abutment for an existing removable partial denture with cast clasps or rests.
D2782	Crown - 3/4 cast noble metal	not a Benefit.
D2783	Crown – 3/4 porcelain/ceramic	permanent anterior teeth and permanent posterior teeth (ages 13 or older): once in a 5 year period. Not a Benefit: for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests.
D2790	Crown - full cast high noble metal	not a Benefit.
D2791	Crown – full cast predominantly base metal	permanent anterior teeth and permanent posterior teeth (ages 13 or older): once in a 5 year period; for permanent anterior teeth only; for Members 13 or older only. Not a Benefit: for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests.
D2792	Crown - full cast noble metal	not a Benefit.
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	once in a 12 month period, per provider.
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	
D2920	Re-cement or re-bond crown	the original provider is responsible for all re-cementations within the first 12 months following the initial placement of prefabricated or laboratory processed crowns. Not a Benefit within 12 months of a previous re-cementation by the same provider.

Code	Description	Limitation
D2921	Reattachment of tooth fragment, incisal edge or cusp	
D2929	Prefabricated porcelain/ceramic crown - primary tooth	once in a 12 month period.
D2930	Prefabricated stainless steel crown – primary tooth	once in a 12 month period.
D2931	Prefabricated stainless steel crown – permanent tooth	once in a 36 month period. Not a Benefit for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position.
D2932	Prefabricated resin crown	once in a 12 month period for primary teeth and once in a 36 month period for permanent teeth. Not a Benefit for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position.
D2933	Prefabricated stainless steel crown with resin window	once in a 12 month period for primary teeth and once in a 36 month period for permanent teeth. Not a Benefit for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position.
D2940	Protective restoration	once per tooth in a 6 month period, per provider. Not a Benefit: a. when performed on the same date of service with a permanent restoration or crown, for same tooth; and b. on root canal treated teeth.
D2941	Interim therapeutic restoration – primary dentition	
D2949	Restorative foundation for an indirect restoration	
D2950	Core buildup, including any pins when required	
D2951	Pin retention – per tooth, in addition to restoration	for permanent teeth only; when performed on the same date of service with an amalgam or composite; once per tooth regardless of the number of pins placed; for a posterior restoration when the destruction involves 3 or more connected surfaces and at least 1

Code	Description	Limitation
		cuspid; or, for an anterior restoration when extensive coronal destruction involves the incisal angle.
D2952	Post and core in addition to crown, indirectly fabricated	once per tooth regardless of number of posts placed and only in conjunction with allowable crowns (prefabricated or laboratory processed) on root canal treated permanent teeth.
D2953	Each additional indirectly fabricated post – same tooth	
D2954	Prefabricated post and core in addition to crown	once per tooth regardless of number of posts placed and only in conjunction with allowable crowns (prefabricated or laboratory processed) on root canal treated permanent teeth.
D2955	Post removal	
D2957	Each additional prefabricated post - same tooth	
D2971	Additional procedures to construct new crown under existing partial denture framework	
D2980	Crown repair, necessitated by restorative material failure	limited to laboratory processed crowns on permanent teeth. Not a Benefit within 12 months of initial crown placement or previous repair for the same provider.
D2999	Unspecified restorative procedure, by report	
Endodontic Procedures (D3000-D3999)		
D3110	Pulp cap – direct (excluding final restoration)	
D3120	Pulp cap – indirect (excluding final restoration)	
D3220	Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament	once per primary tooth. Not a Benefit: a. for a primary tooth near exfoliation; b. for a primary tooth with a necrotic pulp or a periapical lesion; c. for a primary tooth that is non-restorable;

Code	Description	Limitation
		and d. for a permanent tooth.
D3221	Pulpal debridement, primary and permanent teeth	once per permanent tooth; over-retained primary teeth with no permanent successor. Not a Benefit on the same date of service with any additional services, same tooth.
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	once per permanent tooth. Not a Benefit: a. for primary teeth; b. for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests; and c. on the same date of service as any other endodontic procedures for the same tooth.
D3230	Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration)	once per primary tooth. Not a Benefit: a. for a primary tooth near exfoliation; b. with a therapeutic pulpotomy (excluding final restoration) (D3220), same date of service, same tooth; and c. with pulpal debridement, primary and permanent teeth (D3221), same date of service, same tooth.
D3240	Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration)	once per primary tooth. Not a Benefit: a. for a primary tooth near exfoliation; b. with a therapeutic pulpotomy (excluding final restoration) (D3220), same date of service, same tooth; and c. with pulpal debridement, primary and permanent teeth (D3221), same date of service, same tooth.
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	once per tooth for initial root canal therapy treatment.

Code	Description	Limitation
D3320	Endodontic therapy, bicuspid tooth (excluding final restoration)	once per tooth for initial root canal therapy treatment.
D3330	Endodontic therapy, molar tooth (excluding final restoration)	once per tooth for initial root canal therapy treatment. Not a Benefit for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests.
D3331	Treatment of root canal obstruction; non-surgical access	
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	not a Benefit.
D3333	Internal root repair of perforation defects	
D3346	Retreatment of previous root canal therapy – anterior	once per tooth after more than 12 months has elapsed from initial treatment.
D3347	Retreatment of previous root canal therapy – bicuspid	once per tooth after more than 12 months has elapsed from initial treatment.
D3348	Retreatment of previous root canal therapy – molar	once per tooth after more than 12 months has elapsed from initial treatment. Not a Benefit for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests.
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	once per permanent tooth. Not a Benefit: a. for primary teeth; b. for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests; and c. on the same date of service as any other endodontic procedures for the same tooth.
D3352	Apexification/recalcification - interim medication replacement	once per permanent tooth and only following apexification/ recalcification initial visit (apical closure/ calcific repair of perforations, root resorption, etc.) (D3351).

Code	Description	Limitation
		<p>Not a Benefit:</p> <ul style="list-style-type: none"> a. for primary teeth; b. for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests; and c. on the same date of service as any other endodontic procedures for the same tooth.
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	not a Benefit.
D3410	Apicoectomy – anterior	for permanent anterior teeth only; must be performed after more than 90 days from a root canal therapy has elapsed except when medical necessity is documented or after more than 24 months of a prior apicoectomy/periradicular surgery has elapsed.
D3421	Apicoectomy – bicuspid (first root)	for permanent bicuspid teeth only; must be performed after more than 90 days from a root canal therapy has elapsed except when medical necessity is documented, after more than 24 months of a prior apicoectomy/periradicular surgery has elapsed. Not a Benefit for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests.
D3425	Apicoectomy – molar (first root)	for permanent 1st and 2nd molar teeth only; must be performed after more than 90 days from a root canal therapy has elapsed except when medical necessity is documented or after more than 24 months of a prior apicoectomy/periradicular surgery has elapsed. Not a Benefit for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial

Code	Description	Limitation
		denture with cast clasps or rests.
D3426	Apicoectomy – (each additional root)	for permanent teeth only; must be performed after more than 90 days from a root canal therapy has elapsed except when medical necessity is documented or after more than 24 months of a prior apicoectomy/periradicular surgery has elapsed.
D3427	Periradicular surgery without apicoectomy	
D3430	Retrograde filling – per root	
D3450	Root amputation - per root	not a Benefit.
D3910	Surgical procedure for isolation of tooth with rubber dam	
D3920	Hemisection (including any root removal), not including root canal therapy	not a Benefit.
D3950	Canal preparation and fitting of preformed dowel or post	not a Benefit.
D3999	Unspecified endodontic procedure, by report	
Periodontal Procedures (D4000-D4999)		
D4210	Gingivectomy or gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant	once per quadrant every 36 months and limited to Members age 13 or older.
D4211	Gingivectomy or gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quadrant	once per quadrant every 36 months and limited to Members age 13 or older.
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	not a Benefit.
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	not a Benefit.
D4249	Clinical crown lengthening – hard tissue	for Members age 13 or older.

Code	Description	Limitation
D4260	Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant	once per quadrant every 36 months and limited to Members age 13 or older.
D4261	Osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant	once per quadrant every 36 months and limited to Members age 13 or older.
D4263	Bone replacement graft – retained natural tooth – first site in quadrant	not a Benefit.
D4264	Bone replacement graft – retained natural tooth – each additional site in quadrant	not a Benefit.
D4265	Biologic materials to aid in soft and osseous tissue regeneration	for Members age 13 or older.
D4266	Guided tissue regeneration - resorbable barrier, per site	not a Benefit.
D4267	Guided tissue regeneration - nonresorbable barrier, per site (includes membrane removal)	not a Benefit.
D4270	Pedicle soft tissue graft procedure	not a Benefit.
D4273	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft	not a Benefit.
D4283	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	not a Benefit.
D4285	Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) – each additional contiguous tooth, implant or edentulous tooth position in same graft site	not a Benefit.
D4341	Periodontal scaling and root planing – four or more teeth per quadrant	once per quadrant every 24 months and limited to Members age 13 or older.
D4342	Periodontal scaling and root planing – one to three teeth per quadrant	once per quadrant every 24 months and limited to Members age 13 or older.

Code	Description	Limitation
D4346	Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	for Members age 13 or older.
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	for Members age 13 or older.
D4910	Periodontal maintenance	once in a calendar quarter and only in the 24 month period following the last periodontal scaling and root planning (D4341-D4342). This procedure must be preceded by a periodontal scaling and root planning and will be a Benefit only after completion of all necessary scaling and root planning and only for Members residing in a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF). Not a Benefit in the same calendar quarter as scaling and root planning.
D4920	Unscheduled dressing change (by someone other than treating dentist or their staff)	once per Member per provider; for Members age 13 or older only; must be performed within 30 days of the date of service of gingivectomy or gingivoplasty (D4210 and D4211) and osseous surgery (D4260 and D4261).
D4999	Unspecified periodontal procedure, by report	for Members age 13 or older.
Prosthodontics (Removable) Procedures (D5000-D5899)		
D5110	Complete denture – maxillary	once in a 5 year period from a previous complete, immediate or overdenture-complete denture. A laboratory reline (D5750) or chairside reline (D5730) is a Benefit 12 months after the date of service for this procedure.
D5120	Complete denture – mandibular	once in a 5 year period from a previous complete, immediate or overdenture-complete denture. A laboratory reline (D5751) or chairside reline (D5731) is a Benefit 12 months after the date of service for this procedure.
D5130	Immediate denture – maxillary	once per Member. Not a Benefit as a

Code	Description	Limitation
		temporary denture. Subsequent complete dentures are not a Benefit within a 5 year period of an immediate denture. A laboratory reline (D5750) or chairside reline (D5730) is a Benefit 6 months after the date of service for this procedure.
D5140	Immediate denture – mandibular	once per Member. Not a Benefit as a temporary denture. Subsequent complete dentures are not a Benefit within a 5 year period of an immediate denture.
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	
D5221	Immediate maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	<p>once in a 5 year period and when replacing a permanent anterior tooth/ teeth and/or the arch lacks posterior balanced occlusion. Lack of posterior balanced occlusion is defined as follows:</p> <ul style="list-style-type: none"> a. 5 posterior permanent teeth are missing, (excluding 3rd molars), or b. all 4 1st and 2nd permanent molars are missing, or c. the 1st and 2nd permanent molars and 2nd bicuspid are missing on the same side. <p>Not a Benefit for replacing missing 3rd molars. Includes limited follow-up care only; does not include future rebasing / relining procedures(s).</p>

Code	Description	Limitation
D5222	Immediate mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	<p>once in a 5 year period and when replacing a permanent anterior tooth/ teeth and/or the arch lacks posterior balanced occlusion. Lack of posterior balanced occlusion is defined as follows:</p> <ul style="list-style-type: none"> a. 5 posterior permanent teeth are missing, (excluding 3rd molars), or b. all 4 1st and 2nd permanent molars are missing, or c. the 1st and 2nd permanent molars and 2nd bicuspid are missing on the same side. <p>Not a Benefit for replacing missing 3rd molars.</p> <p>Includes limited follow-up care only; does not include future rebasing / relining procedures(s).</p>
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	<p>once in a 5 year period and when opposing a full denture and the arch lacks posterior balanced occlusion. Lack of posterior balanced occlusion is defined as follows:</p> <ul style="list-style-type: none"> a. 5 posterior permanent teeth are missing, (excluding 3rd molars), or b. all 4 1st and 2nd permanent molars are missing, or c. the 1st and 2nd permanent molars and 2nd bicuspid are missing on the same side. <p>Not a Benefit for replacing missing 3rd molars.</p> <p>Includes limited follow-up care only; does not include future rebasing / relining procedures(s).</p>
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	<p>once in a 5 year period and when opposing a full denture and the arch lacks posterior balanced occlusion. Lack of posterior balanced occlusion is defined as follows:</p> <ul style="list-style-type: none"> a. 5 posterior permanent teeth are missing, (excluding 3rd molars), or b. all 4 1st and 2nd permanent molars are missing, or c. the 1st and 2nd permanent molars and 2nd bicuspid are missing on the same side. <p>Not a Benefit for replacing missing 3rd</p>

Code	Description	Limitation
		<p>molars.</p> <p>Includes limited follow-up care only; does not include future rebasing / relining procedures(s).</p>
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	not a Benefit.
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	not a Benefit.
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth)	not a Benefit.
D5410	Adjust complete denture – maxillary	<p>once per date of service per provider and no more than twice in a 12 month period per provider.</p> <p>Not a Benefit:</p> <p>a. same date of service or within 6 months of the date of service of a complete denture-maxillary (D5110), immediate denture-maxillary (D5130) or overdenture-complete (D5860);</p> <p>b. same date of service or within 6 months of the date of service of a reline complete maxillary denture (chairside) (D5730), reline complete maxillary denture (laboratory) (D5750) and tissue conditioning, maxillary (D5850); and</p> <p>c. same date of service or within 6 months of the date of service of repair broken complete denture base (D5510) and replace missing or broken teeth complete denture (D5520).</p>
D5411	Adjust complete denture – mandibular	<p>once per date of service per provider and no more than twice in a 12 month period per provider.</p> <p>Not a Benfit:</p> <p>a. same date of service or within 6 months of the date of service of a complete denture-mandibular (D5120), immediate denture-mandibular (D5140) or overdenture-complete (D5860);</p> <p>b. same date of service or within 6 months of</p>

Code	Description	Limitation
		<p>the date of service of a reline complete mandibular denture (chairside) (D5731), reline complete mandibular denture (laboratory) (D5751) and tissue conditioning, mandibular (D5851); and</p> <p>c. same date of service or within 6 months of the date of service of repair broken complete denture base (D5510) and replace missing or broken teeth complete denture (D5520).</p>
D5421	Adjust partial denture – maxillary	<p>once per date of service per provider and no more than twice in a 12 month period per provider.</p> <p>Not a Benefit:</p> <p>a. Same date of service or within 6 months of the date of service of a maxillary partial resin base (5211) or maxillary partial denture cast metal framework with resin denture bases (D5213);</p> <p>b. same date of service or within 6 months of the date of service of a reline maxillary partial denture (chairside) (D5740), reline maxillary partial denture (laboratory) (D5760) and tissue conditioning, maxillary (D5850); and</p> <p>c. same date of service or within 6 months of the date of service of repair resin denture base (D5610), repair cast framework (D5620), repair or replace broken clasp (D5630), replace broken teeth per tooth (D5640), add tooth to existing partial denture (D5650) and add clasp to existing partial denture (D5660).</p>
D5422	Adjust partial denture – mandibular	<p>once per date of service per provider and no more than twice in a 12month period per provider.</p> <p>Not a Benefit:</p> <p>a. same date of service or within 6 months of the date of service of a mandibular partial-resin base (D5212) or mandibular partial denture- cast metal framework with resin</p>

Code	Description	Limitation
		<p>denture bases (D5214);</p> <p>b. same date of service or within 6 months of the date of service of a reline mandibular partial denture (chairside) (D5741), reline mandibular partial denture (laboratory) (D5761) and tissue conditioning, mandibular (D5851); and</p> <p>c. same date of service or within 6 months of the date of service of repair resin denture base (D5610), repair cast framework (D5620), repair or replace broken clasp (D5630), replace broken teeth per tooth (D5640), add tooth to existing partial denture (D5650) and add clasp to existing partial denture (D5660).</p>
D5510	Repair broken complete denture base	once per arch per date of service per provider and no more than twice in a 12 month period per provider. Not a Benefit on the same date of service as reline complete maxillary denture (chairside) (D5730), reline complete mandibular denture (chairside) (D5731), reline complete maxillary denture (laboratory) (D5750) and reline complete mandibular denture (laboratory) (D5751).
D5511	Repair broken complete denture base, mandibular	once per date of service per provider and no more than twice in a 12 month period per provider. Not a Benefit on the same date of service as reline complete maxillary denture (chairside) (D5730), reline complete mandibular denture (chairside) (D5731), reline complete maxillary denture (laboratory) (D5750) and reline complete mandibular denture (laboratory) (D5751).
D5512	Repair broken complete denture base, maxillary	once per date of service per provider and no more than twice in a 12 month period per provider. Not a Benefit on the same date of service as reline complete maxillary denture (chairside) (D5730), reline complete mandibular denture (chairside) (D5731), reline complete maxillary denture (laboratory) (D5750) and reline complete mandibular denture (laboratory) (D5751).

Code	Description	Limitation
D5520	Replace missing or broken teeth – complete denture (each tooth)	up to a maximum of 4, per arch, per date of service per provider and no more than twice per arch, in a 12 month period per provider.
D5610	Repair resin denture base	once per arch, per date of service per provider; no more than twice per arch, in a 12 month period per provider; and for partial dentures only. Not a Benefit same date of service as reline maxillary partial denture (chairside) (D5740), reline mandibular partial denture (chairside) (D5741), reline maxillary partial denture (laboratory) (D5760) and reline mandibular partial denture (laboratory) (D5761).
D5611	Repair resin denture base, mandibular	once per date of service per provider; no more than twice in a 12 month period per provider; and for partial dentures only. Not a Benefit same date of service as reline maxillary partial denture (chairside) (D5740), reline mandibular partial denture (chairside) (D5741), reline maxillary partial denture (laboratory) (D5760) and reline mandibular partial denture (laboratory) (D5761).
D5612	Repair resin denture base, maxillary	once per date of service per provider; no more than twice in a 12 month period per provider; and for partial dentures only. Not a Benefit same date of service as reline maxillary partial denture (chairside) (D5740), reline mandibular partial denture (chairside) (D5741), reline maxillary partial denture (laboratory) (D5760) and reline mandibular partial denture (laboratory) (D5761).
D5620	Repair cast framework	once per arch, per date of service per provider and no more than twice per arch, in a 12 month period per provider.
D5621	Repair cast framework, mandibular	once per date of service per provider and no more than twice in a 12 month period per provider.
D5622	Repair cast framework, maxillary	once per date of service per provider and no more than twice in a 12 month period per

Code	Description	Limitation
		provider.
D5630	Repair or replace broken clasp - per tooth	up to a maximum of 3, per date of service per provider and no more than twice per arch, in a 12 month period per provider.
D5640	Replace broken teeth – per tooth	up to a maximum of 4, per arch, per date of service per provider; no more than twice per arch, in a 12 month period per provider; and for partial dentures only.
D5650	Add tooth to existing partial denture	once per tooth and up to a maximum of 3, per date of service per provider. Not a Benefit for adding 3rd molars.
D5660	Add clasp to existing partial denture - per tooth	up to a maximum of 3, per date of service per provider and no more than twice per arch, in a 12 month period per provider.
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	not a Benefit.
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	not a Benefit.
D5710	Rebase complete maxillary denture	not a Benefit.
D5711	Rebase complete mandibular denture	not a Benefit.
D5720	Rebase maxillary partial denture	not a Benefit.
D5721	Rebase mandibular partial denture	not a Benefit.
D5730	Reline complete maxillary denture (chairside)	once in a 12 month period; 6 months after the date of service for an immediate denture-maxillary (D5130) or immediate overdenture- complete (D5860) that required extractions; 12 months after the date of service for a complete (remote) denture maxillary (D5110) or overdenture (remote complete (D5860) that did not require extractions. Not a Benefit within 12 months

Code	Description	Limitation
		of a reline complete maxillary denture (laboratory) (D5750).
D5731	Reline complete mandibular denture (chairside)	once in a 12 month period; 6 months after the date of service for a immediate denture-mandibular (D5140) or immediate overdenture- complete (D5860) that required extractions; or 12 months after the date of service for a complete (remote) denture-mandibular (D5120) or overdenture (remote) complete (D5860) that did not require extractions. Not a Benefit within 12 months of a reline complete mandibular denture (laboratory) (D5751).
D5740	Reline maxillary partial denture (chairside)	once in a 12 month period; 6 months after the date of service for maxillary partial denture-resin base (D5211) or maxillary partial denture- cast metal framework with resin denture bases (D5213) that required extractions; or 12 months after the date of service for maxillary partial denture- resin base (D5211) or maxillary partial denture cast metal framework with resin denture bases (D5213) that did not require extractions. Not a Benefit within 12 months of a reline maxillary partial denture (laboratory) (D5760).
D5741	Reline mandibular partial denture (chairside)	once in a 12 month period; 6 months after the date of service for mandibular partial denture- resin base (D5212) or mandibular partial denture- cast metal framework with resin denture bases (D5214) that required extractions; or 12 months after the date of service for mandibular partial denture resin base (D5212) or mandibular partial denture cast metal framework with resin denture bases (D5214) that did not require extractions. Not a Benefit within 12 months of a reline mandibular partial denture (laboratory) (D5761).

Code	Description	Limitation
D5750	Reline complete maxillary denture (laboratory)	once in a 12 month period; 6 months after the date of service for a immediate denture-maxillary (D5130) or immediate overdenture- complete (D5860) that required extractions; or 12 months after the date of service for a complete (remote) denture-maxillary (D5110) or overdenture (remote) complete (D5860) that did not require extractions. Not a Benefit within 12 months of a reline complete maxillary denture (chairside) (D5730).
D5751	Reline complete mandibular denture (laboratory)	once in a 12 month period; 6 months after the date of service for a immediate denture-mandibular (D5140) or immediate overdenture- complete (D5860) that required extractions; or 12 months after the date of service for a complete (remote) denture - mandibular (D5120) or overdenture (remote) complete (D5860) that did not require extractions. Not a Benefit within 12 months of a reline complete mandibular denture (chairside) (D5731).
D5760	Reline maxillary partial denture (laboratory)	once in a 12 month period and 6 months after the date of service for maxillary partial denture cast metal framework with resin denture bases (D5213) that required extractions, or 12 months after the date of service for maxillary partial denture cast metal framework with resin denture bases (D5213) that did not require extractions. Not a Benefit: a. within 12 months of a reline maxillary partial denture (chairside) (D5740); and b. for maxillary partial denture resin base (D5211).
D5761	Reline mandibular partial denture (laboratory)	once in a 12 month period; 6 months after the date of service for mandibular partial denture- cast metal framework with resin denture bases (D5214) that required extractions; or 12 months after the date of service for mandibular partial denture cast metal framework with resin denture bases

Code	Description	Limitation
		(D5214) that did not require extractions. Not a Benefit: a. within 12 months of a reline mandibular partial denture (chairside) (D5741); and b. for a mandibular partial denture resin base (D5212).
D5850	Tissue conditioning, maxillary	twice per prosthesis in a 36 month period. Not a Benefit: a. same date of service as reline complete maxillary denture (chairside) (D5730), reline maxillary partial denture (chairside) (D5740), reline complete maxillary denture (laboratory) (D5750) and reline maxillary partial denture (laboratory) (D5760); and b. same date of service as a prosthesis that did not require extractions.
D5851	Tissue conditioning, mandibular	twice per prosthesis in a 36 month period. Not a Benefit: a. same date of service as reline complete mandibular denture (chairside) (D5731), reline mandibular partial denture (chairside) (D5741), reline complete mandibular denture (laboratory) (D5751) and reline mandibular partial denture (laboratory) (D5761); and b. same date of service as a prosthesis that did not require extractions.
D5862	Precision attachment, by report	
D5863	Overdenture – complete maxillary	once in a 5 year period.
D5864	Overdenture – partial maxillary	once in a 5 year period.
D5865	Overdenture – complete mandibular	once in a 5 year period.
D5866	Overdenture – partial mandibular	once in a 5 year period.
D5899	Unspecified removable prosthodontic procedure, by report	
Maxillofacial Prosthetics Procedures (D5900-D5999)		
D5911	Facial moulage (sectional)	

Code	Description	Limitation
D5912	Facial moulage (complete)	
D5913	Nasal prosthesis	
D5914	Auricular prosthesis	
D5915	Orbital prosthesis	
D5916	Ocular prosthesis	not a Benefit on the same date of service as ocular prosthesis, interim (D5923).
D5919	Facial prosthesis	
D5922	Nasal septal prosthesis	
D5923	Ocular prosthesis, interim	not a Benefit on the same date of service as ocular prosthesis, interim (D5923).
D5924	Cranial prosthesis	
D5925	Facial augmentation implant prosthesis	
D5926	Nasal prosthesis, replacement	
D5927	Auricular prosthesis, replacement	
D5928	Orbital prosthesis, replacement	
D5929	Facial prosthesis, replacement	
D5931	Obturator prosthesis, surgical	not a Benefit on the same date of service as obturator prosthesis, definitive (D5932) and obturator prosthesis, interim (D5936).
D5932	Obturator prosthesis, definitive	not a Benefit on the same date of service as obturator prosthesis, surgical (D5931) and obturator prosthesis, interim (D5936).
D5933	Obturator prosthesis, modification	twice in a 12 month period. Not a Benefit on the same date of service as obturator prosthesis, surgical (D5931), obturator prosthesis, definitive (D5932) and obturator prosthesis, interim (D5936).
D5934	Mandibular resection prosthesis with guide flange	
D5935	Mandibular resection prosthesis without guide flange	
D5936	Obturator prosthesis, interim	not a Benefit on the same date of service as obturator prosthesis, surgical (D5931) and obturator prosthesis, definitive (D5932).

Code	Description	Limitation
D5937	Trismus appliance (not for TMD treatment)	
D5951	Feeding aid	for Members under the age of 18 only.
D5952	Speech aid prosthesis, pediatric	for Members under the age of 18 only.
D5953	Speech aid prosthesis, adult	for Members under the age of 18 only.
D5954	Palatal augmentation prosthesis	
D5955	Palatal lift prosthesis, definitive	not a Benefit on the same date of service as palatal lift prosthesis, interim (D5958).
D5958	Palatal lift prosthesis, interim	not a Benefit on the same date of service with palatal lift prosthesis, definitive (D5955).
D5959	Palatal lift prosthesis, modification	twice in a 12 month period. Not a Benefit on the same date of service as palatal lift prosthesis, definitive (D5955) and palatal lift prosthesis, interim (D5958).
D5960	Speech aid prosthesis, modification	twice in a 12 month period. not a Benefit on the same date of service as speech aid prosthesis, pediatric (D5952) and speech aid prosthesis, adult (D5953).
D5982	Surgical stent	
D5983	Radiation carrier	
D5984	Radiation shield	
D5985	Radiation cone locator	
D5986	Fluoride gel carrier	a Benefit only in conjunction with radiation therapy directed at the teeth, jaws or salivary glands.
D5987	Commissure splint	
D5988	Surgical splint	
D5991	Vesiculobullous disease medicament carrier	
D5999	Unspecified maxillofacial prosthesis, by report	
Implant Service Procedures (D6000-D6199)		
D6010	Surgical placement of implant body: endosteal implant	
D6011	Second stage implant surgery	

Code	Description	Limitation
D6013	Surgical placement of mini implant	
D6040	Surgical placement: eposteal implant	
D6050	Surgical placement: transosteal implant	
D6052	Semi-precision attachment abutment	
D6055	Connecting bar - implant supported or abutment supported	
D6056	Prefabricated abutment - includes modification and placement	
D6057	Custom fabricated abutment - includes placement	
D6058	Abutment supported porcelain/ceramic crown	
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	
D6061	Abutment supported porcelain fused to metal crown (noble metal)	
D6062	Abutment supported cast metal crown (high noble metal)	
D6063	Abutment supported cast metal crown (predominantly base metal)	
D6064	Abutment supported cast metal crown (noble metal)	
D6065	Implant supported porcelain/ceramic crown	
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)	
D6068	Abutment supported retainer for porcelain/ceramic FPD	
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base	

Code	Description	Limitation
	metal)	
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	
D6074	Abutment supported retainer for cast metal FPD (noble metal)	
D6075	Implant supported retainer for ceramic FPD	
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)	
D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)	
D6080	Implant maintenance procedures when prosthesis are removed and reinserted, including cleansing of prosthesis and abutments	
D6081	Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure	
D6085	Provisional implant crown	
D6090	Repair implant supported prosthesis, by report	
D6091	Replacement of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment	
D6092	Re-cement or re-bond implant/abutment supported crown	not a Benefit within 12 months of a previous recementation by the same provider.
D6093	Re-cement or re-bond implant/abutment supported fixed partial denture	not a Benefit within 12 months of a previous recementation by the same provider.
D6094	Abutment supported crown (titanium)	

Code	Description	Limitation
D6095	Repair implant abutment, by report	
D6100	Implant removal, by report	
D6110	Implant/abutment supported removable denture for edentulous arch - maxillary	
D6111	Implant/abutment supported removable denture for edentulous arch - mandibular	
D6112	Implant/abutment supported removable denture for partially edentulous arch - maxillary	
D6113	Implant/abutment supported removable denture for partially edentulous arch - mandibular	
D6114	Implant/abutment supported fixed denture for edentulous arch - maxillary	
D6115	Implant/abutment supported fixed denture for edentulous arch - mandibular	
D6116	Implant/abutment supported fixed denture for partially edentulous arch - maxillary	
D6117	Implant/abutment supported fixed denture for partially edentulous arch - mandibular	
D6190	Radiographic/surgical implant index, by report	
D6194	Abutment supported retainer crown for FPD (titanium)	
D6199	Unspecified implant procedure, by report	
Fixed Prosthodontic Procedures (D6200-D6999)		
D6205	Pontic - indirect resin based composite	not a Benefit.
D6210	Pontic - cast high noble metal	not a Benefit.
D6211	Pontic – cast predominately base metal	once in a 5 year period; only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214); and only when billed on the

Code	Description	Limitation
		same date of service with fixed partial denture retainers (abutments) (D6721, D6740, D6751, D6781, D6783 and D6791). Not a Benefit for Members under the age of 13.
D6212	Pontic - cast noble metal	not a Benefit.
D6214	Pontic - titanium	not a Benefit.
D6240	Pontic - porcelain fused to high noble metal	not a Benefit.
D6241	Pontic – porcelain fused to predominantly base metal	once in a 5 year period; only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214); and only when billed on the same date of service with fixed partial denture retainers (abutments) (D6721, D6740, D6751, D6781, D6783 and D6791). Not a Benefit for Members under the age of 13.
D6242	Pontic - porcelain fused to noble metal	not a Benefit.
D6245	Pontic – porcelain/ceramic	once in a 5 year period; only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214); and only when billed on the same date of service with fixed partial denture retainers (abutments) (D6721, D6740, D6751, D6781, D6783 and D6791). Not a Benefit for Members under the age of 13.

Code	Description	Limitation
D6250	Pontic - resin with high noble metal	not a Benefit.
D6251	Pontic - resin with predominantly base metal	once in a 5 year period; only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214); and only when billed on the same date of service with fixed partial denture retainers (abutments) (D6721, D6740, D6751, D6781, D6783 and D6791). Not a Benefit for Members under the age of 13.
D6252	Pontic - resin with noble metal	not a Benefit.
D6545	Retainer - cast metal for resin bonded fixed prosthesis	not a Benefit.
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis	not a Benefit.
D6549	Retainer – for resin bonded fixed prosthesis	not a Benefit.
D6608	Retainer onlay - porcelain/ceramic, two surfaces	not a Benefit.
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces	not a Benefit.
D6610	Retainer onlay - cast high noble metal, two surfaces	not a Benefit.
D6611	Retainer onlay - cast high noble metal, three or more surfaces	not a Benefit.
D6612	Retainer onlay - cast predominantly base metal, two surfaces	not a Benefit.
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	not a Benefit.
D6614	Retainer onlay - cast noble metal, two surfaces	not a Benefit.
D6615	Retainer onlay - cast noble metal, three or more surfaces	not a Benefit.
D6634	Retainer onlay - titanium	not a Benefit.

Code	Description	Limitation
D6710	Retainer crown - indirect resin based composite	not a Benefit.
D6720	Retainer crown - resin with high noble metal	not a Benefit.
D6721	Retainer crown – resin with predominantly base metal	once in a 5 year period and only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214). Not a Benefit for Members under the age of 13.
D6722	Retainer crown - resin with noble metal	not a Benefit.
D6740	Retainer crown – porcelain/ceramic	once in a 5 year period and only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214). Not a Benefit for Members under the age of 13.
D6751	Retainer crown – porcelain fused to predominantly base metal	once in a 5 year period and only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214). Not a Benefit for Members under the age of 13.
D6781	Retainer crown – 3/4 cast predominantly base metal	once in a 5 year period and only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214). Not a Benefit for Members under the age of 13.
D6782	Retainer crown - 3/4 cast noble metal	not a Benefit.
D6783	Retainer crown – 3/4 porcelain/ceramic	once in a 5 year period and only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214). Not a Benefit for Members under the age of 13.
D6791	Retainer crown – full cast predominantly	once in a 5 year period and only when the criteria are met for a resin partial denture or

Code	Description	Limitation
	base metal	cast partial denture (D5211, D5212, D5213 and D5214). Not a Benefit for Members under the age of 13.
D6930	Re-cement or re-bond fixed partial denture	The original provider is responsible for all re- cementations within the first 12 months following the initial placement of a fixed partial denture. Not a Benefit within 12 months of a previous re- cementation by the same provider.
D6980	Fixed partial denture repair necessitated by restorative material failure	not a Benefit within 12 months of initial placement or previous repair, same provider.
D6999	Unspecified fixed prosthodontic procedure, by report	
Oral and Maxillofacial Surgery Procedures (D7000-D7999)		
D7111	Extraction, coronal remnants – deciduous tooth	not a Benefit for asymptomatic teeth.
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	not a Benefit when removed by the same provider who performed the initial tooth extraction.
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	a Benefit when the removal of any erupted tooth requires the elevation of a mucoperiosteal flap and the removal of substantial alveolar bone or sectioning of the tooth.
D7220	Removal of impacted tooth – soft tissue	a Benefit when the major portion or the entire occlusal surface is covered by mucogingival soft tissue.
D7230	Removal of impacted tooth – partially bony	a Benefit when the removal of any impacted tooth requires the elevation of a mucoperiosteal flap and the removal of substantial alveolar bone. One of the proximal heights of contour of the crown shall be covered by bone.
D7240	Removal of impacted tooth – completely bony	a Benefit when the removal of any impacted tooth requires the elevation of a mucoperiosteal flap and the removal of substantial alveolar bone covering most or all of the crown.

Code	Description	Limitation
D7241	Removal of impacted tooth – completely bony, with unusual surgical complications	a Benefit when the removal of any impacted tooth requires the elevation of a mucoperiosteal flap and the removal of substantial alveolar bone covering most or all of the crown. Difficulty or complication shall be due to factors such as nerve dissection or aberrant tooth position.
D7250	Removal of residual tooth roots (cutting procedure)	a Benefit when the root is completely covered by alveolar bone. Not a Benefit to the same provider who performed the initial tooth extraction.
D7260	Oroantral fistula closure	a Benefit for the excision of a fistulous tract between the maxillary sinus and oral cavity.
D7261	Primary closure of a sinus perforation	a Benefit in the absence of a fistulous tract requiring the repair or immediate closure of the oroantral or oralnasal communication, subsequent to the removal of a tooth.
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	once per arch regardless of the number of teeth involved and for permanent anterior teeth only.
D7280	Exposure of an unerupted tooth	not a Benefit: a. for Members age 21 or older, or b. for 3rd molars.
D7283	Placement of device to facilitate eruption of impacted tooth	only for Members in active orthodontic treatment. Not a Benefit: a. for Members age 21 years or older; and b. for 3rd molars unless the 3rd molar occupies the 1st or 2nd molar position.
D7285	Incisional biopsy of oral tissue – hard (bone, tooth)	for the removal of the specimen only and once per arch, per date of service regardless of the areas involved. Not a Benefit with an apicoectomy/ periradicular surgery (D3410-D3426), an extraction (D7111-D7250) and an excision of any soft tissues or intraosseous lesions (D7410-D7461) in the same area or region on the same date of service.
D7286	Incisional biopsy of oral tissue – soft	for the removal of the specimen only and up to a maximum of 3 per date of service.

Code	Description	Limitation
		Not a Benefit with an apicoectomy/ periradicular surgery (D3410-D3426), an extraction (D7111-D7250) and an excision of any soft tissues or intraosseous
D7287	Exfoliative cytological sample collection	not a Benefit.
D7288	Brush biopsy - transepithelial sample collection	not a Benefit.
D7290	Surgical repositioning of teeth	for permanent teeth only; once per arch; and only for Members in active orthodontic treatment.
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	once per arch and only for Members in active orthodontic treatment.
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	a Benefit on the same date of service with 2 or more extractions (D7140-D7250) in the same quadrant. Not a Benefit when only one tooth is extracted in the same quadrant on the same date of service.
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	a Benefit regardless of the number of teeth or tooth spaces.
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	
D7340	Vestibuloplasty – ridge extension (secondary epithelialization)	once in a 5 year period per arch.
D7350	Vestibuloplasty – ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	once per arch. Not a Benefit: a. on the same date of service with a vestibuloplasty – ridge extension (D7340) same arch; and b. on the same date of service with extractions (D7111- D7250) same arch.
D7410	Excision of benign lesion up to 1.25 cm	

Code	Description	Limitation
D7411	Excision of benign lesion greater than 1.25 cm	
D7412	Excision of benign lesion, complicated	a Benefit when there is extensive undermining with advancement or rotational flap closure.
D7413	Excision of malignant lesion up to 1.25 cm	
D7414	Excision of malignant lesion greater than 1.25 cm	
D7415	Excision of malignant lesion, complicated	a Benefit when there is extensive undermining with advancement or rotational flap closure.
D7440	Excision of malignant tumor – lesion diameter up to 1.25 cm	
D7441	Excision of malignant tumor – lesion diameter greater than 1.25 cm	
D7450	Removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 cm	
D7451	Removal of benign odontogenic cyst or tumor – lesion diameter greater than 1.25 cm	
D7460	Removal of benign nonodontogenic cyst or tumor – lesion diameter up to 1.25 cm	
D7461	Removal of benign nonodontogenic cyst or tumor – lesion diameter greater than 1.25 cm	
D7465	Destruction of lesion(s) by physical or chemical method, by report	
D7471	Removal of lateral exostosis (maxilla or mandible)	once per quadrant and for the removal of buccal or facial exostosis only.
D7472	Removal of torus palatinus	once in the Member's lifetime.
D7473	Removal of torus mandibularis	once per quadrant.
D7485	Reduction of osseous tuberosity	once per quadrant.
D7490	Radical resection of maxilla or mandible	
D7510	Incision and drainage of abscess – intraoral soft tissue	once per quadrant, same date of service.
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	once per quadrant, same date of service.

Code	Description	Limitation
D7520	Incision and drainage of abscess – extraoral soft tissue	
D7521	Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	once per date of service. Not a Benefit when associated with the removal of a tumor, cyst (D7440- D7461) or tooth (D7111- D7250).
D7540	Removal of reaction producing foreign bodies, musculoskeletal system	once per date of service. Not a Benefit when associated with the removal of a tumor, cyst (D7440- D7461) or tooth (D7111- D7250).
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	once per quadrant per date of service and only for the removal of loose or sloughed off dead bone caused by infection or reduced blood supply. Not a Benefit within 30 days of an associated extraction (D7111-D7250).
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	not a Benefit when a tooth fragment or foreign body is retrieved from the tooth socket.
D7610	Maxilla – open reduction (teeth immobilized, if present)	
D7620	Maxilla – closed reduction (teeth immobilized, if present)	
D7630	Mandible – open reduction (teeth immobilized, if present)	
D7640	Mandible – closed reduction (teeth immobilized, if present)	
D7650	Malar and/or zygomatic arch – open reduction	
D7660	Malar and/or zygomatic arch – closed reduction	
D7670	Alveolus – closed reduction, may include stabilization of teeth	

Code	Description	Limitation
D7671	Alveolus – open reduction, may include stabilization of teeth	
D7680	Facial bones – complicated reduction with fixation and multiple surgical approaches	for the treatment of simple fractures only.
D7710	Maxilla – open reduction	
D7720	Maxilla – closed reduction	
D7730	Mandible – open reduction	
D7740	Mandible – closed reduction	
D7750	Malar and/or zygomatic arch – open reduction	
D7760	Malar and/or zygomatic arch – closed reduction	
D7770	Alveolus – open reduction stabilization of teeth	
D7771	Alveolus – closed reduction stabilization of teeth	
D7780	Facial bones – complicated reduction with fixation and multiple approaches	for the treatment of compound fractures only.
D7810	Open reduction of dislocation	
D7820	Closed reduction of dislocation	
D7830	Manipulation under anesthesia	
D7840	Condylectomy	
D7850	Surgical discectomy, with/without implant	
D7852	Disc repair	
D7854	Synovectomy	
D7856	Myotomy	
D7858	Joint reconstruction	
D7860	Arthrotomy	
D7865	Arthroplasty	
D7870	Arthrocentesis	
D7871	Non-arthroscopic lysis and lavage	
D7872	Arthroscopy – diagnosis, with or without biopsy	

Code	Description	Limitation
D7873	Arthroscopy – lavage and lysis of adhesions	
D7874	Arthroscopy – disc repositioning and stabilization	
D7875	Arthroscopy – synovectomy	
D7876	Arthroscopy – discectomy	
D7877	Arthroscopy – debridement	
D7880	Occlusal orthotic device, by report	not a Benefit for the treatment of bruxism.
D7881	Occlusal orthotic device adjustment	
D7899	Unspecified TMD therapy, by report	not a Benefit for procedures such as acupuncture, acupressure, biofeedback and hypnosis.
D7910	Suture of recent small wounds up to 5 cm	not a Benefit for the closure of surgical incisions.
D7911	Complicated suture – up to 5 cm	not a Benefit for the closure of surgical incisions.
D7912	Complicated suture – greater than 5 cm	not a Benefit for the closure of surgical incisions.
D7920	Skin graft (identify defect covered, location and type of graft)	not a Benefit for periodontal grafting.
D7940	Osteoplasty – for orthognathic deformities	
D7941	Osteotomy – mandibular rami	
D7943	Osteotomy – mandibular rami with bone graft; includes obtaining the graft	
D7944	Osteotomy – segmented or subapical	
D7945	Osteotomy – body of mandible	
D7946	LeFort I (maxilla – total)	
D7947	LeFort I (maxilla – segmented)	
D7948	LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) – without bone graft	
D7949	LeFort II or LeFort III – with bone graft	
D7950	Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla – autogenous or nonautogenous, by report	not a Benefit for periodontal grafting.

Code	Description	Limitation
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach	only for Members with authorized implant services.
D7952	Sinus augmentation via a vertical approach	only for Members with authorized implant services.
D7955	Repair of maxillofacial soft and/or hard tissue defect	not a Benefit for periodontal grafting.
D7960	Frenulectomy also known as frenectomy or frenotomy – separate procedure not incidental to another procedure	once per arch per date of service and only when the permanent incisors and cuspids have erupted.
D7963	Frenuloplasty	once per arch per date of service and only when the permanent incisors and cuspids have erupted. Not a Benefit for drug induced hyperplasia or where removal of tissue requires extensive gingival recontouring.
D7970	Excision of hyperplastic tissue – per arch	once per arch per date of service.
D7971	Excision of pericoronal gingiva	
D7972	Surgical reduction of fibrous tuberosity	once per quadrant per date of service.
D7979	Non-surgical Sialolithotomy	
D7980	Sialolithotomy	
D7981	Excision of salivary gland, by report	
D7982	Sialodochoplasty	
D7983	Closure of salivary fistula	
D7990	Emergency tracheotomy	
D7991	Coronoidectomy	
D7995	Synthetic graft – mandible or facial bones, by report	not a Benefit for periodontal grafting.
D7997	Appliance removal (not by dentist who placed appliance), includes removal of archbar	once per arch per date of service and for the removal of appliances related to surgical procedures only. Not a Benefit for the removal of orthodontic appliances and space maintainers.
D7999	Unspecified oral surgery procedure, by report	
Orthodontics Procedures (D8000-D8999)		

Code	Description	Limitation
D8080	Comprehensive orthodontic treatment of the adolescent dentition	once per Member per phase of treatment; for handicapping malocclusion, cleft palate and facial growth management cases; and for permanent dentition (unless the Member is age 13 or older with primary teeth still present or has a cleft palate or craniofacial anomaly).
D8210	Removable appliance therapy	once per Member and for Members ages 6 through 12.
D8220	Fixed appliance therapy	once per Member and for Members ages 6 through 12.
D8660	Pre-orthodontic treatment examination to monitor growth and development	once every 3 months for a maximum of 6 and must be done prior to comprehensive orthodontic treatment of the adolescent dentition (D8080) for the initial treatment phase for facial growth management cases regardless of how many dentition phases are required.
D8670	Periodic orthodontic treatment visit handicapping malocclusion	once per calendar quarter and for permanent dentition (unless the Member is age 13 or older with primary teeth still present or has a cleft palate or craniofacial anomaly).
D8670	Periodic orthodontic treatment visit cleft palate - primary dentition	up to a maximum of 4 quarterly visits. (2 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity).
D8670	Periodic orthodontic treatment visit cleft palate - mixed dentition	up to a maximum of 5 quarterly visits. (3 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity).
D8670	Periodic orthodontic treatment visit cleft palate - permanent dentition	up to a maximum of 10 quarterly visits. (5 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity)
D8670	Periodic orthodontic treatment visit facial growth management - primary dentition	up to a maximum of 4 quarterly visits. (2 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity).
D8670	Periodic orthodontic treatment visit facial growth management - mixed dentition	up to a maximum of 5 quarterly visits. (3 additional quarterly visits shall be authorized when documentation and photographs justify

Code	Description	Limitation
		the medical necessity).
D8670	Periodic orthodontic treatment visit facial growth management - permanent dentition	up to a maximum of 8 quarterly visits. (4 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity).
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	once per arch for each authorized phase of orthodontic treatment and for permanent dentition (unless the Member is age 13 or older with primary teeth still present or has a cleft palate or craniofacial anomaly). Not a Benefit until the active phase of orthodontic treatment (D8670) is completed. If fewer than the authorized number of periodic orthodontic treatment visit(s) (D8670) are necessary because the active phase of treatment has been completed early, then this shall be documented on the claim for orthodontic retention (D8680).
D8681	Removable orthodontic retainer adjustment	
D8691	Repair of orthodontic appliance	once per appliance. Not a Benefit to the original provider for the replacement and/or repair of brackets, bands, or arch wires.
D8692	Replacement of lost or broken retainer	once per arch and only within 24 months following the date of service of orthodontic retention (D8680).
D8693	Re-cement or re-bond fixed retainer	once per provider.
D8694	Repair of fixed retainers, includes reattachment	
D8999	Unspecified orthodontic procedure, by report	
Adjunctive Services Procedures (D9000-D9999)		
D9110	Palliative (emergency) treatment of dental pain – minor procedure	once per date of service per provider regardless of the number of teeth and/or areas treated. Not a Benefit when any other treatment is performed on the same date of service, except when radiographs/ photographs are needed of the affected area to diagnose and

Code	Description	Limitation
		document the emergency condition.
D9120	Fixed partial denture sectioning	a Benefit when at least one of the abutment teeth is to be retained.
D9210	Local anesthesia not in conjunction with operative or surgical procedures	once per date of service per provider and only for use in order to perform a differential diagnosis or as a therapeutic injection to eliminate or control a disease or abnormal state. Not a Benefit when any other treatment is performed on the same date of service, except when radiographs/ photographs are needed of the affected area to diagnose and document the emergency condition.
D9211	Regional block anesthesia	
D9212	Trigeminal division block anesthesia	
D9215	Local anesthesia in conjunction with operative or surgical procedures	
D9222	Deep sedation/analgesia - first 15 minutes	Not a benefit: a. on the same date of service as analgesia, anxiolysis, inhalation of nitrous oxide (D9230), intravenous conscious sedation/analgesia (D9241 and D9242) or non-intravenous conscious sedation (D9248); and b. when all associated procedures on the same date of service by the same provider are denied.
D9223	Deep sedation/general anesthesia - each 15 minute increment	
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	for uncooperative Members under the age of 13, or for Members age 13 or older when documentation specifically identifies the physical, behavioral, developmental or emotional condition that prohibits the Member from responding to the provider's attempts to perform treatment. Not a Benefit: a. on the same date of service as deep

Code	Description	Limitation
		sedation/general anesthesia (D9223), intravenous conscious sedation/ analgesia (D9243) or non- intravenous conscious sedation (D9248); and b. when all associated procedures on the same date of service by the same provider are denied.
D9239	Intravenous moderate (conscious) sedation/anesthesia - first 15 minutes	Not a benefit: a. on the same date of service as deep sedation/general anesthesia (D9220 and D9221), analgesia, anxiolysis, inhalation of nitrous oxide (D9230) or non-intravenous conscious sedation (D9248); and b. when all associated procedures on the same date of service by the same provider are denied.
D9243	Intravenous moderate (conscious) sedation/analgesia - each 15 minute increment	not a Benefit: a. on the same date of service as deep sedation/general anesthesia (D9223), analgesia, anxiolysis, inhalation of nitrous oxide (D9230) or non- intravenous conscious sedation (D9248); and b. when all associated procedures on the same date of service by the same provider are denied.
D9248	Non-intravenous conscious sedation	once per date of service; for uncooperative Members under the age of 13, or for Members age 13 or older when documentation specifically identifies the physical, behavioral, developmental or emotional condition that prohibits the Member from responding to the provider's attempts to perform treatment; for oral, patch, intramuscular or subcutaneous routes of administration. Not a Benefit: a. on the same date of service as deep sedation/general anesthesia (D9223), analgesia, anxiolysis, inhalation of nitrous oxide (D9230) or intravenous conscious

Code	Description	Limitation
		sedation/ analgesia (D9243); and b. when all associated procedures on the same date of service by the same provider are denied.
D9310	Consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician	
D9311	Consultation with a medical health professional	
D9410	House/extended care facility call	once per Member per date of service and only in conjunction with procedures that are payable.
D9420	Hospital or ambulatory surgical center call	a Benefit for each hour or fraction thereof as documented on the operative report.
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	once per date of service per provider. Not a Benefit: a. when procedures other than necessary radiographs and/or photographs are provided on the same date of service; and b. for visits to Members residing in a house/ extended care facility.
D9440	Office visit – after regularly scheduled hours	once per date of service per provider and only with treatment that is a Benefit.
D9450	Case presentation, detailed and extensive treatment planning	not a Benefit.
D9610	Therapeutic parenteral drug, single administration	up to a maximum of 4 injections per date of service. Not a Benefit: a. for the administration of an analgesic or sedative when used in conjunction with deep sedation/general anesthesia (D9223), analgesia, anxiolysis, inhalation of nitrous oxide (D9230), intravenous conscious sedation/ analgesia (D9243) or non-intravenous conscious sedation (D9248); and b. when all associated procedures on the same date of service by the same provider are denied.

Code	Description	Limitation
D9612	Therapeutic parenteral drugs, two or more administrations, different medications	
D9910	Application of desensitizing medicament	once in a 12 month period per provider and for permanent teeth only.
D9930	Treatment of complications (post-surgical) – unusual circumstances, by report	once per date of service per provider; for the treatment of a dry socket or excessive bleeding within 30 days of the date of service of an extraction; and for the removal of bony fragments within 30 days of the date of service of an extraction. Not a Benefit: a. for the removal of bony fragments on the same date of service as an extraction; and b. for routine post- operative visits.
D9940	Occlusal guard, by report	not a Benefit.
D9942	Repair and/or reline of occlusal guard	not a Benefit.
D9943	Occlusal guard adjustment	not a Benefit.
D9950	Occlusion analysis – mounted case	once in a 12 month period; for Members age 13 and older only; for diagnosed TMJ dysfunction only; and for permanent dentition. Not a Benefit for bruxism only.
D9951	Occlusal adjustment – limited	once in a 12 month period per quadrant per provider; for Members age 13 and older; and for natural teeth only. Not a Benefit within 30 days following definitive restorative, endodontic, removable and fixed prosthodontic treatment in the same or opposing quadrant.
D9952	Occlusal adjustment – complete	once in a 12 month period following occlusion analysis-mounted case (D9950); for Members age 13 and older; for diagnosed TMJ dysfunction only; and for permanent dentition.
D9999	Unspecified adjunctive procedure, by report	

Pediatric Vision Benefits

Principal Benefits and Coverages for Pediatric Vision Benefits –

Blue Shield covers pediatric vision Benefits for individuals through the end of the month in which the Member turns 19 years of age. Blue Shield's pediatric vision Benefits are administered by a contracted Vision Plan Administrator (VPA). The VPA is a vision care service plan licensed by the California Department of Managed Health Care, which contracts with Blue Shield to administer delivery of eyewear and eye exams covered under this pediatric vision Benefit.

For Covered Services rendered by Non-Participating Providers, Blue Shield will pay up to the Allowable Amount as shown in the Summary of Benefits. Members will be responsible for all charges in excess of those amounts.

The following is a complete list of Covered Services provided under this pediatric vision Benefit:

- 1) One comprehensive eye examination in a Calendar Year. A comprehensive examination represents a level of service in which a general evaluation of the complete visual system is made. The comprehensive services constitute a single service entity but need not be performed at one session. The service includes history, general medical observation, external and ophthalmoscopic examination, gross visual fields and basic sensorimotor examination. It often includes, as indicated: biomicroscopy, examination for cycloplegia or mydriasis, tonometry, and, usually, a determination of the refractive state unless known, or unless the condition of the media precludes this or it is otherwise contraindicated, as in the presence of trauma or severe inflammation. In addition, it includes dilation if professionally indicated.

When contact lenses are selected in lieu of eyeglasses, the comprehensive examination Benefit and Allowance covers in full the fitting, evaluation and follow-up care fees for Non-

Elective (Medically Necessary) Contact Lenses or standard Elective Contact Lenses by VPA Participating Providers. For non-standard specialty contact lenses (including, but not limited to, toric, multifocal and gas permeable lenses), the comprehensive examination Benefit and Allowance covers the fitting and evaluation equal to the standard contact lenses fitting and evaluation by VPA Participating Providers. The Member is responsible for the difference between the amount Blue Shield pays and the amount billed by the VPA Participating Provider.

- 2) One of the following in a Calendar Year:
 - a) One pair of spectacle lenses, which include choice of glass, plastic or polycarbonate lenses, all lens powers (single vision, bifocal, trifocal, lenticular), fashion and gradient tinting, ultraviolet protective coating, and oversized and glass-grey #3 prescription sunglass lenses (Note: Polycarbonate lenses are covered in full for children, monocular patients and patients with prescriptions > +/- 6.00 diopters),
 - b) Elective Contact Lenses up to the Benefit (for cosmetic reasons or for convenience), or
 - c) Non-Elective (Medically Necessary) Contact Lenses up to the Benefit, which are lenses following cataract surgery, or when contact lenses are the only means to correct visual acuity to 20/40 for keratoconus, 20/60 for anisometropia, or for certain conditions of myopia (12 or more diopters), hyperopia (7 or more diopters) astigmatism (over 3 diopters), or other conditions as listed in the definition of Non-Elective Contact Lenses.

A report from the provider and prior authorization from the contracted VPA is required.

- 3) One frame in a Calendar Year.
- 4) The need for Low Vision Testing is triggered during a comprehensive eye exam. This testing

may only be obtained from VPA Participating Providers and only once in a consecutive five Calendar Year period. VPA Participating Providers specializing in low vision care may prescribe optical devices, such as high-power spectacles, magnifiers and telescopes, to maximize the remaining usable vision. One aid per Calendar Year is covered. A report from the provider conducting the initial examination and prior authorization from the VPA is required for both the exam and any prescribed device. Low vision is a bilateral impairment to vision that is so significant that it cannot be corrected with ordinary eyeglasses, contact lenses, or intraocular lens implants. Although reduced central or reading vision is common, low vision may also result from decreased peripheral vision, a reduction or loss of color vision, or the eye's inability to properly adjust to light, contrast, or glare. It can be measured in terms of visual acuity of 20/70 to 20/200.

- 5) One diabetic management referral per calendar year to a Blue Shield disease management program. The contracted VPA will notify Blue Shield's disease management program subsequent to the annual comprehensive eye exam, when the Member is known to have or be at risk for diabetes.

Important Information on the Pediatric Vision Benefits –

Pediatric vision services are covered when provided by a vision provider and when necessary and customary as determined by the standards of generally accepted vision practice. Coverage for these services is subject to any conditions or limitations set forth in the Benefit descriptions above, and to all terms, conditions, limitations and exclusions listed in this Evidence of Coverage and Health Service Agreement.

Payments for pediatric vision services are based on Blue Shield's Allowable Amount and are subject to any applicable Deductibles, Copayments, Coinsurance and Benefit maximums as specified in the Summary of Benefits. Vision providers do not

receive financial incentives or bonuses from Blue Shield or the VPA.

Exclusions and Limitations for Pediatric Vision Benefits

Unless exemptions are specifically made elsewhere in this Evidence of Coverage and Health Service Agreement, these pediatric vision Benefits exclude the following:

- 1) Orthoptics or vision training, subnormal vision aids or non-prescription lenses for glasses when no prescription change is indicated;
- 2) Replacement or repair of lost or broken lenses or frames, except as provided under this Evidence of Coverage and Health Service Agreement;
- 3) Any eye examination required by the employer as a condition of employment;
- 4) Medical or surgical treatment of the eyes (see the *Ambulatory Surgery Center Benefits*, *Hospital Benefits (Facility Services)* and *Professional Benefits* sections of the Evidence of Coverage and Health Service Agreement);
- 5) Contact lenses, except as specifically provided under this Evidence of Coverage and under this Evidence of Coverage and in the Summary of Benefits;

See the *Principal Limitations, Exceptions, Exclusions and Reductions* section of this Evidence of Coverage and Health Service Agreement for complete information on plan general exclusions, limitations, exceptions and reductions.

Payment of Benefits for Pediatric Vision Benefits

Prior to service, the Subscriber should review his or her Benefit information for coverage details. The Subscriber may identify a VPA Participating Provider by calling the VPA's Customer Service Department at 1-877-601-9083 or online at www.blueshieldca.com. When an appointment is made with a VPA Participating Provider, the

Subscriber should identify the Member as a Blue Shield /VPA Member.

The VPA Participating Provider will submit a claim for Covered Services online or by claim form obtained from the VPA after services have been received. The VPA will make payment on behalf of Blue Shield directly to the VPA Participating Provider. VPA Participating Providers have agreed to accept Blue Shield's payment as payment in full except as noted in the Summary of Benefits.

When services are provided by a Non-Participating Provider, a Vision Service Report (claim form C-4669-61) should be submitted to the VPA. This form may be obtained at www.blueshieldca.com and must be completed in full and submitted with all related receipts to:

Blue Shield of California
Vision Plan Administrator
P O Box 25208
Santa Ana, CA 92799-5208

Information regarding the Member's Non-Participating Provider Benefits is available in the Summary of Benefits or by calling Blue Shield / VPA Customer Service at 1-877-601-9083.

When the Member receives Covered Services from a Non-Participating Provider, the Subscriber or the provider may submit a claim for payment after services have been received. The VPA will make payment directly to the Subscriber. The Subscriber is responsible for any applicable Deductible, Copayment and Coinsurance amounts and for amounts billed in excess of the Allowable Amount. The Subscriber is also responsible for making payment to the Non-Participating Provider.

A listing of VPA Participating Providers may be obtained by calling the VPA at the telephone number listed in the *Customer Service* section of this Evidence of Coverage and Health Service Agreement.

Payment of Claims

VPA Participating Providers will submit a claim for Covered Services on line or by claim form obtained from the VPA and are paid directly by Blue Shield of California.

If the Member receives services from a Non-Participating Provider, payment will be made directly to the Subscriber, and the Member is responsible for payment to the Non-Participating Provider.

Choice of Providers for Pediatric Vision Benefits

Members may select any licensed ophthalmologist, optometrist, or optician to provide Covered Services under this pediatric vision Benefit, including providers outside of California. However, Members will usually pay more for services from a Non-Participating Provider. A list of VPA Participating Providers in the Member's local area can be obtained by contacting the VPA at 1-877-601-9083. The Subscriber may also obtain a list of VPA Participating Providers online at www.blueshieldca.com.

Customer Service for Pediatric Vision Benefits

For questions about these pediatric vision Benefits, information about pediatric vision providers, pediatric vision services, or to discuss concerns regarding the quality of care or access to care experienced, the Subscriber may contact:

Blue Shield of California
Vision Plan Administrator
Customer Service Department
P. O. Box 25208
Santa Ana, CA 92799-5208

The Subscriber may also contact the VPA at the following telephone numbers:

1-714-619-4660 or
1-877-601-9083

The VPA has established a procedure for Subscribers to request an expedited authorization decision. A Subscriber, Member, Physician, or representative of a Member may request an expedited decision when the routine decision making process might seriously jeopardize the life or health of a Member, or when the Member is experiencing severe pain. The VPA shall make a decision and notify the Subscriber and Physician as soon as possible to accommodate the Member's condition, not to exceed 72 hours following the receipt of the request. For additional information regarding the expedited decision process, or if the Subscriber believes a particular situation qualifies for an expedited decision, please contact the VPA Customer Service Department at the number listed above.

Grievance Process for Pediatric Vision Benefits

Subscribers, a designated representative, or a provider on behalf of the Subscriber, may contact the Vision Customer Service Department by telephone, letter or online to request a review of an initial determination concerning a claim for services. Subscribers may contact the Vision Customer Service Department at the telephone number noted below. If the telephone inquiry to the Vision Customer Service Department does not resolve the question or issue to the Subscriber's satisfaction, the Subscriber may request a grievance at that time, which the Vision Customer Service Representative will initiate on the Subscriber's behalf.

The Subscriber, a designated representative, or a provider on behalf of the Subscriber, may also initiate a grievance by submitting a letter or a completed "Grievance Form". The Subscriber may request this Form from the Vision Customer Service Department. If the Subscriber wishes, the Vision Customer Service staff will assist in completing the grievance form. Completed grievance forms should be mailed to the VPA at the address provided below. The Subscriber may also submit the grievance to the Vision Customer Service Department online at www.blueshieldca.com.

1-877-601-9083

Vision Plan Administrator

P. O. Box 25208

Santa Ana, CA 92799-5208

The VPA will acknowledge receipt of a written grievance within five (5) calendar days. Grievances are resolved within 30 days.

The grievance system allows Subscribers to file grievances for at least 180 days following any incident or action that is the subject of the Subscriber's dissatisfaction. See the previous *Customer Service* section for information on the expedited decision process.

Definitions for Pediatric Vision Benefits

Elective Contact Lenses — prescription lenses that are chosen for cosmetic or convenience purposes. Elective Contact Lenses are not medically necessary

Non-Elective (Medically Necessary) Contact Lenses — lenses following cataract surgery, or when contact lenses are the only means to correct visual acuity to 20/40 for keratoconus or 20/60 for anisometropia, or for certain conditions of myopia (12 or more diopters), hyperopia (7 or more diopters) or astigmatism (over 3 diopters).

Contact lenses may also be medically necessary in the treatment of the following conditions: keratoconus, pathological myopia, aphakia, anisometropia, aniseikonia, aniridia, corneal disorders, post-traumatic disorders and irregular astigmatism.

Prescription Change – any of the following:

- 1) Change in prescription of 0.50 diopter or more; or
- 2) Shift in axis of astigmatism of 15 degrees; or
- 3) Difference in vertical prism greater than 1 prism diopter; or
- 4) Change in lens type (for example contact lenses to glasses or single vision lenses to bifocal lenses).

Vision Plan Administrator (VPA) – Blue Shield contracts with the Vision Plan Administrator (VPA) to administer delivery of eyewear and eye exams covered under this Benefit through a network of VPA Participating Providers.

VPA Participating Provider – For purposes of this pediatric vision Benefit, participating provider refers to a provider that has contracted with the VPA to provide vision services to Blue Shield Members.

Principal Limitations, Exceptions, Exclusions and Reductions

General Exclusions and Limitations

No Benefits are provided for the following:

- 1) routine physical examinations, immunizations and vaccinations by any mode of administration solely for the purpose of travel, licensure, employment, insurance, court order, parole, or probation. 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;
- 2) 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; special footwear required for foot disfigurement (e.g., non-custom made or over-the-counter shoe inserts or arch supports), except as specifically listed under Orthotics Benefits and Diabetes Care Benefits; bunions; or muscle trauma due to exertion; or any type of massage procedure on the foot;
- 4) services for or incident to hospitalization or confinement in a pain management center to treat or cure chronic pain, except as may be provided through a Participating Hospice Agency or through a palliative care program offered by Blue Shield;
- 5) home services, hospitalization or confinement in a health facility primarily for rest, Custodial, Maintenance, or domiciliary care, except as provided under *Hospice Program Benefits*;
- 6) services in connection with private duty nursing, except as provided under Home Health Care Benefits, Home Infusion/Home Injectable Therapy Benefits, and except as provided through a Participating Hospice Agency;
- 7) prescription and non-prescription food and nutritional supplements, except as provided under Home Infusion/Home Injectable Therapy Benefits, PKU-Related Formulas and Special Food Products Benefits, or as provided through a Participating Hospice Agency;
- 8) hearing aids;
- 9) eye exams and refractions, lenses and frames for eyeglasses, lens options and treatments and contact lenses for Members 19 years of age and over, and video-assisted visual aids or video magnification equipment for any purpose;
- 10) surgery to correct refractive error (such as but not limited to radial keratotomy, refractive keratoplasty);
- 11) any type of communicator, voice enhancer, voice prosthesis, electronic voice producing machine, or any other language assistive devices, except as specifically listed under Prosthetic Appliances Benefits;
- 12) dental care or services incident to the treatment, prevention, or relief of pain or

- dysfunction of the Temporomandibular Joint and/or muscles of mastication, except as specifically provided under the Medical Treatment of the Teeth, Gums, Jaw Joints or Jaw Bones Benefits and Hospital Benefits (Facility Services);
- 13) for or incident to services and supplies for treatment of the teeth and gums (except for tumors, preparation of the Member's jaw for radiation therapy to treat cancer in the head or neck, and dental and orthodontic services that are an integral part of Reconstructive Surgery for cleft palate procedures) and associated periodontal structures, including but not limited to diagnostic, preventive, orthodontic and other services such as dental cleaning, tooth whitening, X-rays, imaging, laboratory services, topical fluoride treatment except when used with radiation therapy to the oral cavity, fillings, and root canal treatment; treatment of periodontal disease or periodontal surgery for inflammatory conditions; tooth extraction; dental implants, braces, crowns, dental orthoses and prostheses; except as specifically provided under Medical Treatment of the Teeth, Gums, Jaw Joints or Jaw Bones Benefits, Pediatric Dental Benefits, and Hospital Benefits (Facility Services);
 - 14) Cosmetic Surgery except for Medically Necessary treatment of resulting complications (e.g., infections or hemorrhages).
 - 15) 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) 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 Pregnancy and Maternity Care Benefits;
 - 22) mammographies, Pap Tests or other FDA (Food and Drug Administration) approved cervical cancer screening tests, family planning and consultation services, colorectal cancer screenings, Annual Health Appraisal Exams by Non-Participating Providers;
 - 23) services performed in a Hospital by house officers, residents, interns, and other

- professionals in training without the supervision of an attending physician in association with an accredited clinical education program;
- 24) services performed by a Close Relative or by a person 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 health care services, or is not operating within the scope of such license or certification, except for services received under the Behavioral Health Treatment benefit under Mental Health, Behavioral Health, and Substance Use Disorder Benefits;
 - 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 or Preventive Health Services. 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) 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) 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 worker's

compensation law, occupational disease law or similar legislation. However, if Blue Shield provides payment for such services, it will be entitled to establish a lien upon such other benefits up to the amount paid by Blue Shield for the treatment of such injury or disease;

- 36) For spinal manipulation and adjustment, except as specifically provided under Professional Benefits (other than for Mental Health, Behavioral Health, and Substance Use Disorder Benefits) in the Plan Benefits section;
- 37) For transportation services other than provided under Ambulance Benefits in the Plan Benefits section;
- 38) For inpatient and Other Outpatient Mental Health, Behavioral Health, and 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. 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.

See the *Grievance Process* section for information on filing a grievance, the Member's right to seek assistance from the Department of Managed Health Care, and the Member's right to independent medical review.

Medical Necessity Exclusion

The Benefits of this health plan are provided only for services that are Medically Necessary. Because a Physician or other provider may prescribe, order, recommend, or approve a service or supply does not, in itself, make it Medically Necessary even though it is not specifically listed as an exclusion or limitation. Blue Shield reserves the right to review all claims to determine if a service or

supply is Medically Necessary and may use the services of Physician consultants, peer review committees of professional societies or Hospitals and other consultants to evaluate claims.

Limitation for Duplicate Coverage

Medicare Eligible Members

- 1) After this coverage in this plan has begun, Blue Shield will provide benefits if the Member is enrolled under Medicare but Medicare will be the primary payor and Blue Shield will:
 - a) Estimate what Medicare would have paid for services received (based upon the reasonable value or Blue Shield's Allowable Amount) and
 - b) Provide the Member's Blue Shield Benefits as if the Member was enrolled to receive benefits from Medicare.

The combined benefits from Medicare and the Blue Shield plan will equal but not exceed what Blue Shield would have paid if the Member were not eligible to receive Medicare benefits. Payment will be based on an amount that may be lower but will not exceed the Medicare allowed amount. The Blue Shield plan applicable Deductible, Copayments, and Coinsurance will be applied before plan Benefits are provided.

Medi-Cal Eligible Members

Medi-Cal always provides benefits last.

Qualified Veterans

If the Member is a qualified veteran Blue Shield will pay the reasonable value or Blue Shield's Allowable Amount for Covered Services provided to at a Veterans Administration facility for a condition that is not related to military service. If the Member is a qualified veteran who is not on active duty, Blue Shield will pay the reasonable value or Blue Shield's Allowable Amount for Covered Services provided to at a Department of Defense facility, even if provided for conditions related to military service.

Members Covered by Another Government Agency

If the Member is entitled to benefits under any other federal or state governmental agency, or by any municipality, county or other political subdivision, the combined benefits from that coverage and this Blue Shield plan will equal, but not exceed, what Blue Shield would have paid if the Member was not eligible to receive benefits under that coverage (based on the reasonable value or Blue Shield's Allowable Amount).

Exception for other Coverage

Participating Providers may seek reimbursement from other third party payers for the balance of their reasonable charges for services rendered under this plan.

Claims Review

Blue Shield reserves the right to review all claims to determine if any exclusions or limitations apply, and may use the services of Physician consultants, peer review committees of professional societies or hospitals, and other consultants.

Reductions – Third Party Liability

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

Blue Shield's right to restitution, reimbursement or other available remedy is against any recovery the Member receives as a result of the injury or illness, including any amount awarded to or received by way of court judgment, arbitration award,

settlement or any other arrangement, from any third party or third party insurer, or from uninsured or underinsured motorist coverage, related to the illness or injury (the "Recovery"), without regard to whether the Member has been "made whole" by the Recovery. The amount Blue Shield seeks as restitution, reimbursement or other available remedy will be calculated in accordance with California Civil Code section 3040.

The Member is required to:

- 1) Notify Blue Shield in writing of any actual or potential claim or legal action which the Member expects to bring or has brought against the third party arising from the alleged acts or omissions causing the injury or illness, not later than 30 days after submitting or filing a claim or legal action against the third party;
- 2) Cooperate with Blue Shield to execute any forms or documents needed to enable Blue Shield to enforce its right to restitution, reimbursement or other available remedies;
- 3) Agree in writing to reimburse Blue Shield for Benefits paid by Blue Shield from any Recovery when the Recovery is obtained from or on behalf of the third party or the insurer of the third party, or from uninsured or underinsured motorist coverage;
- 4) Provide Blue Shield with a lien in the amount of Benefits actually paid. The lien may be filed with the third party, the third party's agent or attorney, or the court, unless otherwise prohibited by law; and,
- 5) Periodically respond to information requests regarding the claim against the third party, and notify Blue Shield, in writing, within ten (10) days after any Recovery has been obtained.

A Member's failure to comply with items one (1) through five (5) above, shall not in any way act as a waiver, release, or relinquishment of the rights of Blue Shield.

Further, if the Member received services from a Participating Hospital for such injuries or illness, the Hospital has the right to collect from the

Member the difference between the amount paid by Blue Shield and the Hospital's reasonable and necessary charges for such services when payment or reimbursement is received by the Member for medical expenses. The Hospital's right to collect shall be in accordance with California Civil Code Section 3045.1.

Conditions of Coverage

Eligibility and Enrollment

To enroll and continue enrollment, a Subscriber must meet all of the eligibility requirements of this plan. Subscribers must reside in a Blue Shield service area for this plan within California to be eligible to enroll in coverage.

A Subscriber or Dependent may enroll during the annual Open Enrollment Period. Under certain circumstances, an individual or Dependent may qualify for a Special Enrollment Period. Other than during the annual Open Enrollment Period, or a Special Enrollment Period, a Subscriber or Dependent may not enroll in this health plan.

Blue Shield will provide the Subscriber with a notice of the annual Open Enrollment Period each year. For additional information on enrollment periods, please contact Blue Shield.

Dependent children of the Subscriber, spouse, or his or her Domestic Partner, including children adopted or placed for adoption, will be covered immediately after birth, adoption or the placement of adoption for a period of 31 days. In order to have coverage continue beyond the first 31 days, an application must be received by Blue Shield within 60 days from the date of birth, adoption or placement for adoption. Please contact Blue Shield to determine what evidence needs to be provided to enroll a child.

Enrolled disabled Dependent children who would normally lose their coverage under this health plan solely because of age, may continue to be eligible for coverage if they continue to meet the definition of Dependent in this Evidence of Coverage and

Health Service Agreement. See the Definition of Dependent for additional information.

Effective Date of Coverage

Blue Shield will notify the Subscriber of the Effective Date of coverage for the Subscriber and his or her Dependents. Coverage starts at 12:01 a.m. Pacific Time on the Effective Date.

Other than during the annual Open Enrollment Period, a Subscriber or Dependent may not enroll in health coverage in the individual market unless the Subscriber or Dependent qualifies for a Special Enrollment Period. If an individual qualifies for a Special Enrollment Period, he or she must apply within the time limits applicable to the event that qualified the applicant for a Special Enrollment Period. If a Subscriber enrolls mid-year during a Special Enrollment Period, his or her plan benefit year will end December 31.

Effective dates will vary based on the circumstances of the Special Enrollment Period according to the guidelines established by federal and state law. In general, if a Subscriber or Dependent qualifies for a Special Enrollment Period (see Definitions), and the Subscriber submits a Premium payment that is delivered or postmarked within the first 15 days of the month, coverage will be effective on the first of the month after receipt of payment. If the Subscriber submits a Premium payment that is delivered or postmarked after the 15th of the month, coverage will be effective on the first of the second month after receipt of payment.

However, if the Subscriber qualifies for a Special Enrollment Period as a result of a birth, adoption, foster care, guardianship, marriage, or Domestic Partnership, and enrollment is requested within 60 days of the event, the Subscriber may request enrollment for those Dependents within 60 days. The effective date of enrollment will be as follows:

- 1) For the case of a birth, adoption, placement for adoption, placement in foster care, or guardianship, the coverage shall be effective on the date of birth, adoption, placement for

adoption, placement in foster care or court order of guardianship.

- 2) For marriage or Domestic Partnership, the coverage effective date shall be the first day of the month following the date the request for special enrollment is received.

Premiums (Dues)

Monthly Premiums are stated in the Appendix and are set for a rating period that runs for the Calendar Year. Blue Shield offers a variety of options and methods by which Members may pay Premiums. Please call Customer Service to discuss these options or visit www.blueshieldca.com.

Payments by mail are to be sent to:

Blue Shield of California
P.O. Box 51827
Los Angeles, CA 90051-6127

Additional Premiums may be charged in the event that a Federal, State or any other taxing or licensing authority imposes upon Blue Shield any tax or fee based on Premiums, gross receipts, enrollment or any other basis. In the case of Federal excise taxes, Blue Shield may also amend the Premiums to include any increased Federal income taxes to Blue Shield associated with such Federal excise taxes. Premiums may also increase from time to time as determined by Blue Shield in accordance with federal and state law and regulations. Relocating to a different geographic rating area may lead to a change in Premium based on rating differences between geographic areas. Blue Shield will provide 60 days written notice of any changes in the monthly Premiums for this plan.

Term of the Agreement

This Agreement shall be renewed upon receipt of prepaid Premiums by Blue Shield unless otherwise terminated as described herein. Renewal is subject to Blue Shield's right to amend this Agreement. Any change in Premiums or Benefits is effective

after 60 days notice to the Subscriber's address of record with Blue Shield of California.

This Agreement has a benefit year that runs for the Calendar Year. Subscribers and their Dependents will have an annual Open Enrollment Period established each year by California law to select a different or new plan.

Blue Shield will offer to renew the Agreement except in the following instances:

- 1) Non-payment of Premiums;
- 2) Fraud, misrepresentations, or omissions;
- 3) Termination of plan type by Blue Shield;
- 4) Blue Shield determines that the individual is no longer eligible for coverage in this plan; or
- 5) Subscriber relocates outside of California.

Termination of Benefits (Cancellation and Rescission of Coverage)

Cancellation at Member Request

A Subscriber may cancel this Agreement by providing Blue Shield 30 days' written notice.

Cancellation of Member's Enrollment by Blue Shield

Blue Shield may cancel a Member's coverage in this plan in the following circumstances:

- 1) The Member is no longer eligible for coverage in the plan.
- 2) Non-payment of Premiums following expiration of any grace periods for payment.
- 3) Termination of this Blue Shield plan.
- 4) The Subscriber changes from one health plan to another during the annual Open Enrollment Period or during a Special Enrollment Period.

Blue Shield may cancel the Subscriber and any Dependent's coverage for cause for the following conduct; cancellation is effective immediately upon giving written notice to the Subscriber:

- 1) Providing false or misleading material information on the enrollment application or

otherwise to Blue Shield; see the Cancellation/Rescission for Fraud or Intentional Misrepresentations of Material Fact provision;

- 2) Permitting use of a Member identification card by someone other than the Subscriber or Dependents to obtain Covered Services; or
- 3) Obtaining or attempting to obtain Covered Services under the Agreement by means of false, materially misleading, or fraudulent information, acts or omissions.

Date Coverage Ends

Coverage for a Subscriber and all of his or her Dependents terminates at 11:59 p.m. Pacific Time on a date as determined by the reason for termination.

- 1) For non-payment of Premiums, see Cancellation for Subscriber's Nonpayment of Premiums provision.
- 2) For termination by Blue Shield if Subscriber moves out of service area:

Blue Shield may cancel this Agreement upon thirty (30) days written notice if the Subscriber moves out of California.

Within 30 days of the notice of cancellation, Blue Shield shall refund the Premiums, if any, that Blue Shield determines will not have been earned as of the termination date. Blue Shield of California reserves the right to subtract from any such Premium refund any amounts paid by Blue Shield for benefits paid or payable by Blue Shield after the termination date.

- 3) Termination by Blue Shield due to withdrawal of the Agreement from the market:

Blue Shield may terminate this Agreement together with all like Agreements to withdraw it from the market. In such instances the Subscriber will be given 90 days written notice and the opportunity to enroll on any other individual agreement.

- 4) For changes from one plan to another during the annual Open Enrollment or a Special

Enrollment Period, the Subscriber's last day of coverage will be the day before the effective date of coverage in his or her new plan.

Even if a Subscriber remains covered, his or her Dependent's coverage may end if a Dependent becomes ineligible. A Dependent spouse becomes ineligible following legal separation from the Subscriber, entry of a final decree of divorce, annulment or dissolution of marriage from the Subscriber; coverage terminates on the last day of the month in which the Dependent spouse became ineligible. A Dependent Domestic Partner becomes ineligible upon termination of the domestic partnership; coverage terminates on the last day of the month in which the Domestic Partner becomes ineligible. A Dependent child who reaches age 26 becomes ineligible, unless the Dependent child is disabled and qualifies for continued coverage as described in the definition of Dependent. Coverage ends on the last day of the month in which the Dependent child becomes ineligible.

In addition, if a request for the addition of a newborn or a newborn child placed for adoption or adopted is not submitted to and received by Blue Shield within the 60 days following that Dependent's birth, Benefits under this health plan for that newborn child will be terminated on the 31st day at 11:59 p.m. Pacific Time.

Cancellation for Subscriber's Nonpayment of Premiums

Blue Shield may cancel this Agreement for failure to pay the required Premiums when due:

- 1) If the Agreement is being cancelled because the Subscriber failed to pay the required Premiums when due, then coverage will end 30 days after the date for which the Premiums are due. Subscriber will be liable for all Premiums accrued while this Agreement continues in force including those accrued during this 30 day grace period.
- 2) Notice. Within five business days of canceling or not renewing the Agreement, the Plan will mail Subscriber a Notice Confirming

Termination of Coverage, which will inform of the following:

- a) That the Agreement has been cancelled, and the reasons for cancellation;
- b) The specific date and time when coverage for the Subscriber and all Dependents ended.

Cancellation/Rescission for Fraud or Intentional Misrepresentations of Material Fact

Blue Shield has the right to rescind this Agreement if the information contained in the application or otherwise provided to Blue Shield by the Subscriber or anyone acting the Subscriber's behalf in connection with the application was intentionally and materially inaccurate or incomplete. This Agreement also may be rescinded if the Subscriber or anyone acting on his or her behalf failed to disclose to Blue Shield any new or changed facts arising after the application was submitted but before this Agreement was issued, when those facts pertained to matters inquired about in the application. However, after 24 months following the issuance of the Agreement, Blue Shield will not rescind the Agreement for any reason. If after enrollment, Blue Shield investigates the application information, Blue Shield will not rescind this Agreement without first notifying the Subscriber of the investigation and offering an opportunity to respond.

If this Agreement is rescinded, it means that the Agreement is voided retroactive to its inception as if it never existed. This means that the Subscriber and Dependents will lose coverage back to the original Effective Date. If the Agreement is properly rescinded, Blue Shield will refund any Premium payments made, but, to the extent permitted by applicable law, may reduce that refund by the amount of any medical expenses that Blue Shield paid under the Agreement or is otherwise obligated to pay. In addition, Blue Shield may, to the extent permitted by California law, be entitled to recoup from the Subscriber all amounts paid by Blue Shield under the Agreement.

If this Agreement is rescinded, Blue Shield will provide a 30-day advance written notice that will: (1) explain the basis of the decision and appeal rights, including the right to request assistance from the California Department of Managed Health Care; (2) clarify that those Members whose application information was not false or incomplete are entitled to new coverage, and will explain how those Members may obtain this coverage; and (3) explain that the monthly Premiums for those Members will be determined based on the number of individuals that remain Blue Shield Members.

Transfer of Coverage

- 1) If a Subscriber moves out of California, coverage under this Agreement will terminate. If a Subscriber moves to an area served by another Blue Cross and/or Blue Shield plan and notifies Blue Shield of his new address, the Subscriber's coverage may be transferred to the plan serving his new address.
- 2) The new plan must offer the Subscriber at least its group conversion policy. This is a type of policy normally provided to subscribers who leave a group and apply for new coverage as individuals.
- 3) Conversion policies provide coverage without a medical examination or health statement.
- 4) If the Subscriber accepts the conversion policy, the new plan will credit the Subscriber for the length of his enrollment in this plan toward any of the new plan's waiting periods. Any physical or mental conditions covered by this plan will be covered by the new plan without a new waiting period if the new plan offers this feature to others carrying the same type of coverage.
- 5) The required Dues or Premium amount and benefits available from the new plan may vary significantly from this plan.
- 6) In addition, the new plan may offer other types of coverage outside the transfer program which may:

- a) Require a medical examination or health statement to exclude coverage for pre-existing conditions; and
- b) Not credit the time enrolled in this Agreement.

General Provisions

Liability of Subscribers in the Event of Non-Payment by Blue Shield

In accordance with Blue Shield's established policies, and by statute, every contract between Blue Shield and its Participating Providers stipulates that the Subscriber shall not be responsible to the Participating Provider for compensation for any services to the extent that they are provided in the Member's Agreement. Participating Providers have agreed to accept the Blue Shield's payment as payment-in-full for Covered Services, except for Deductibles, Copayments, and Coinsurance, amounts in excess of specified Benefit maximums, or as provided under the *Exception for Other Coverage and Reductions - Third Party Liability* sections.

If services are provided by a Non-Participating Provider, the Member is responsible for all amounts Blue Shield does not pay.

When a Benefit specifies a Benefit maximum and that Benefit maximum has been reached, the Member is responsible for any charges above the Benefit maximums.

No Maximum Aggregate Payment Amount

There is no maximum limit on the aggregate payments by Blue Shield for Covered Services provided under the Agreement.

No Annual Dollar Limit On Essential Health Benefits

This health plan contains no annual dollar limits on essential health benefits as defined by federal law.

Independent Contractors

Providers are neither agents nor employees of Blue Shield but are independent contractors. In no instance shall Blue Shield be liable for the negligence, wrongful acts, or omissions of any person receiving or providing services, including any Physician, Hospital, or other provider or their employees.

Assignability

Coverage or any Benefits of this Agreement may not be assigned without the written consent of Blue Shield.

Possession of a Blue Shield ID card confers no right to Covered Services or other Benefits of this Agreement. To be entitled to services, the Member must be a Subscriber who has been enrolled by Blue Shield and who has maintained enrollment under the terms of this Agreement.

Participating Providers are paid directly by Blue Shield.

If the Member receives Covered Services from a Non-Participating Provider, Blue Shield at its sole discretion, may make payment to the Subscriber or directly to the Non-Participating Provider. If Blue Shield pays the Non-Participating Provider directly, such payment does not create a third party beneficiary or other legal relationship between Blue Shield and the Non-Participating Provider. In addition, whether Blue Shield pays the Subscriber of the Non-Participating Provider, the Subscriber remains responsible for all charges up to the Non-Participating Provider's billed amount.

Plan Interpretation

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

Public Policy Participation Procedure

This procedure enables Members to participate in establishing the public policy of Blue Shield. It is not to be used as a substitute for the grievance procedure complaints, inquiries or requests for information.

Public policy means acts performed by a plan or its employees and staff to assure the comfort, dignity, and convenience of patients who rely on the plan's facilities to provide health care services to them, their families, and the public (California Health and Safety Code, Section 1369).

At least one third of the Board of Directors of Blue Shield is comprised of Subscribers who are not employees, providers, subcontractors or group contract brokers and who do not have financial interests in Blue Shield. The names of the members of the Board of Directors may be obtained from:

Sr. Manager, Regulatory Filings
Blue Shield of California
50 Beale Street
San Francisco, CA 94105
Phone: 1-415-229-5065

Please follow the following procedure:

- 1) Recommendations, suggestions or comments should be submitted in writing to the Sr. Manager, Regulatory Filings, at the above address, who will acknowledge receipt of your letter.
- 2) Please include name, address, phone number, and Subscriber number with each communication.
- 3) The public policy issue should be stated so that it will be readily understood. Submit all relevant information and reasons for the policy issue with your letter.
- 4) Public policy issues will be heard at least quarterly as agenda items for meetings of the Board of Directors. Minutes of Board meetings

will reflect decisions on public policy issues that were considered. Members who have initiated a public policy issue will be furnished with the appropriate extracts of the minutes within 10 business days after the minutes have been approved.

Confidentiality of Personal and Health Information

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

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

Blue Shield's "Notice of Privacy Practices" can be obtained either by calling Customer Service at the number listed in the back of this Evidence of Coverage, or by accessing Blue Shield's internet site at www.blueshieldca.com and printing a copy.

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

Correspondence Address:

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

Access to Information

Blue Shield may need information from medical providers, from other carriers or other entities, or

from the Member, in order to administer the Benefits and eligibility provisions of this Agreement. By enrolling in this health plan, each Member agrees that any provider or entity can disclose to Blue Shield that information that is reasonably needed by Blue Shield. Members also agree to assist Blue Shield in obtaining this information, if needed, (including signing any necessary authorizations) and to cooperate by providing Blue Shield with information in the Member's possession. Failure to assist Blue Shield in obtaining necessary information or refusal to provide information reasonably needed may result in the delay or denial of Benefits until the necessary information is received. Any information received for this purpose by Blue Shield will be maintained as confidential and will not be disclosed without consent, except as otherwise permitted by law.

Legal Process

Legal process or service upon Blue Shield must be served upon Blue Shield's Registered Agent for Service of Process or upon Blue Shield at Blue Shield's corporate offices at 50 Beale Street, San Francisco, California 94105.

Organ and Tissue Donation

Many residents in the state of California are eligible to become organ and tissue donors. Donors can affect the well-being of one or more of the estimated 100,000 people in the United States of America who must face death daily while waiting for an organ transplant. One person on this list dies about every three hours – all the while waiting for an organ or tissue donation.

For more information on organ and tissue donation, or to register as a donor, visit the California Transplant Doctor Network's internet site at www.donornetworkwest.org or Donate Life California's internet site at www.donatelifecalifornia.org. Potential donors can also call the regional organ procurement agency in the nearest city nearest for additional information on organ and tissue donation.

Notice of Participating Provider Inability to Perform, Breach, or Termination

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

Entire Agreement: Changes

This Agreement, including the appendices, constitutes the entire agreement between parties. Any statement made by a Member shall, in the absence of fraud, be deemed a representation and not a warranty. No change in this Agreement shall be valid unless approved by a corporate officer of Blue Shield and a written endorsement issued. No representative has authority to change this Agreement or to waive any of its provisions. The terms of this Agreement, including but not limited to Benefits, Deductibles, Copayments, Coinsurance, Out-of-Pocket Maximums and Premiums are subject to change at any time. Blue Shield will provide at least 60 days written notice of changes relating to Premium rates or coverage.

Benefits provided after the effective date of any change will be subject to the change. There is no vested right to obtain Benefits.

Right of Recovery

Whenever payment on a claim has been made in error, Blue Shield will have the right to recover such payment from the Subscriber or Member or, if applicable, the provider or another health benefit plan, in accordance with applicable laws and regulations. Blue Shield reserves the right to deduct or offset any amounts paid in error from any pending or future claim to the extent permitted by law. Circumstances that might result in payment of a claim in error include, but are not

limited to, payment of benefits in excess of the benefits provided by the health plan, payment of amounts that are the responsibility of the Subscriber or Member (deductibles, copayments, coinsurance or similar charges), payment of amounts that are the responsibility of another payor, payments made after termination of the Subscriber or Member's eligibility, or payments on fraudulent claims.

Endorsements and Appendices

Attached to and incorporated in this Agreement by reference are appendices pertaining to Deductibles and Premiums. Endorsements may be issued from time to time subject to the notice provisions in the section entitled Duration of the Agreement. Nothing contained in any endorsement shall affect this Agreement, except as expressly provided in the endorsement.

Notices

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

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

Commencement or Termination of Coverage

Whenever this Agreement provides for a date of commencement or termination of any part or all of the coverage herein, such commencement or termination shall be effective at 12:01 a.m. Pacific Time of the commencement date and as of 11:59 p.m. Pacific Time of the termination date.

Identification Cards

Identification cards will be issued by Blue Shield to all Subscribers.

Statutory Requirements

This Agreement is subject to the Knox-Keene Health Care Service Plan Act, Chapter 2.2 of Division 2 of the California Health and Safety Code and Title 28 of the California Code of Regulations. Any provision required to be in this Agreement by reason of such Codes shall be binding upon Blue Shield whether or not such provision is actually included in this Agreement. In addition, this Agreement is subject to applicable state and federal statutes and regulations, which may include the Health Insurance Portability and Accountability Act. Any provision required to be in this Agreement by reason of such state and federal statutes shall bind the Subscriber and Blue Shield whether or not such provision is actually included in this Agreement.

Blue Cross and Blue Shield Association Disclosure

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

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

Customer Service

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

For all Mental Health Services, Behavioral Health Treatment, and Substance Use Services Blue Shield has contracted with a Mental Health Service Administrator (MHSA). The MHSA should be contacted for questions about Mental Health Services, Behavioral Health Treatment and Substance Use Services, MHSA Participating Providers, or Mental Health, Behavioral Health, and Substance Use Benefits. Members may contact the MHSA at the telephone number or address which appear below:

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

Grievance Process

Blue Shield has established a grievance procedure for receiving, resolving and tracking Members' grievances with Blue Shield.

Medical Services

The Member, a designated representative, or a provider on behalf of the Member, may contact the Customer Service Department by telephone, letter, or online to request a review of an initial determination concerning a claim or service. Members may contact the plan at the telephone number as noted on the back page of this Evidence of Coverage and Health Service Agreement. If the telephone inquiry to Customer Service does not resolve the question or issue to the Member's satisfaction, the Member may request a grievance at that time, which the Customer Service

Representative will initiate on the Member's behalf.

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

For all grievances except denial of coverage for a Non-Formulary Drug: Blue Shield will acknowledge receipt of a grievance within five calendar days. Grievances are resolved within 30 days.

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

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

For all grievances: The grievance system allows Subscribers to file grievances within 180 days

following any incident or action that is the subject of the Member's dissatisfaction.

Mental Health, Behavioral Health, and Substance Use Disorder Services

Members, a designated representative, or a provider on behalf of the Member may contact the MHSA by telephone, letter, or online to request a review of an initial determination concerning a claim or service. Members may contact the MHSA at the telephone number provided below. If the telephone inquiry to the MHSA's Customer Service Department does not resolve the question or issue to the Member's satisfaction, the Member may submit a grievance at that time, which the Customer Service Representative will initiate on the Member's behalf.

The Member, a designated representative, or a provider on behalf of the Member may also initiate a grievance by submitting a letter or a completed "Grievance Form". The Member may request this Form from the MHSA's Customer Service Department. If the Member wishes, the MHSA's Customer Service staff will assist in completing the Grievance Form. Completed Grievance Forms should be mailed to the MHSA at the address provided below. The Member may also submit the grievance to the MHSA online by visiting <http://www.blueshieldca.com>.

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

The MHSA will acknowledge receipt of a grievance within five calendar days. Grievances are resolved within 30 days. The grievance system allows Subscribers to file grievances for at least 180 days following any incident or action that is the subject of the Member's dissatisfaction. See the previous Customer Service section for information on the expedited decision process.

If the grievance involves an MHSA Non-Participating Provider, the Member should contact

the Blue Shield Customer Service Department as shown on the back page of this Evidence of Coverage and Health Service Agreement.

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

External Independent Medical Review

For grievances involving claims or services for which coverage was denied by Blue Shield or by a contracting provider in whole or in part on the grounds that the service is not Medically Necessary or is experimental/investigational (including the external review available under the Friedman-Kowles Experimental Treatment Act of 1996), Members may choose to make a request to the Department of Managed Health Care to have the matter submitted to an independent agency for external review in accordance with California law.

Members normally must first submit a grievance to Blue Shield and wait for at least 30 days before requesting external review; however, if the matter would qualify for an expedited decision as described above or involves a determination that the requested service is experimental/investigational, a Member may immediately request an external review following receipt of notice of denial. A Member may initiate this review by completing an application for external review, a copy of which can be obtained by contacting Customer Service.

The Department of Managed Health Care will review the application and, if the request qualifies

for external review, will select an external review agency and have the Member's records submitted to a qualified specialist for an independent determination of whether the care is Medically Necessary. Members may choose to submit additional records to the external review agency for review. There is no cost to the Member for this external review.

The Member and the Member's physician will receive copies of the opinions of the external review agency. The decision of the external review agency is binding on Blue Shield; if the external reviewer determines that the service is Medically Necessary, Blue Shield will promptly arrange for the service to be provided or the claim in dispute to be paid. This external review process is in addition to any other procedures or remedies available and is completely voluntary; Members are not obligated to request external review. However, failure to participate in external review may cause the Member to give up any statutory right to pursue legal action against Blue Shield regarding the disputed service. For more information regarding the external review process, or to request an application form, please contact Customer Service.

Department of Managed Health Care Review

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at 1-888-256-3650 and use your health plan's grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the

IMR process will provide an impartial review of medical decisions made by a health plan related to the Medical Necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services.

The Department also has a toll-free telephone number **(1-888-HMO-2219) and a TDD line (1-877-688-9891)** for the hearing and speech impaired. The Department's Internet Web site (**<http://www.hmohelp.ca.gov>**) has complaint forms, IMR application forms and instructions online.

In the event that Blue Shield should cancel or refuse to renew the enrollment for you or your Dependents and you feel that such action was due to reasons of health or utilization of benefits, you or your Dependents may request a review by the Department of Managed Health Care Director.

Definitions

When the following terms are capitalized in this Evidence of Coverage and Health Service Agreement, they will have the meaning set forth below:

Accidental Injury — a definite trauma, resulting from a sudden, unexpected and unplanned event, occurring by chance, and caused by an independent external source.

Activities of Daily Living (ADL) — mobility skills required for independence in normal everyday living. Recreational, leisure, or sports activities are not considered ADL.

Agreement (Evidence of Coverage and Health Service Agreement) — this contract, including this Evidence of Coverage and Health Service Agreement, Summary of Benefits, all endorsements, and all applications for coverage.

Allowable Amount (Allowance) — the total amount Blue Shield allows for Covered Service(s) rendered, or the provider's billed charge for those Covered Services, whichever is less. The

Allowable Amount, unless specified for a particular service elsewhere in this Evidence of Coverage, is:

- 1) For a Participating Provider: the amount that the provider and Blue Shield have agreed by contract will be accepted as payment in full for the Covered Service(s) rendered.
- 2) For a Non-Participating Provider who provides Emergency Services, anywhere within or outside of the United States:
 - a) Physicians and Hospitals – the amount is the Reasonable and Customary Charge; or
 - b) All other providers – the amount is the provider’s billed charge for Covered Services, unless the provider and the local Blue Cross and/or Blue Shield Plan have agreed upon some other amount.
- 3) For a Non-Participating Provider in California (including an Other Provider), who provides services (other than Emergency Services): the amount Blue Shield would have allowed for a Participating Provider performing the same service in the same geographical area; or
 - a) Non-Participating dialysis center – for services prior authorized by Blue Shield, the amount is the Reasonable and Customary Charge.
- 4) For a provider outside of California (within or outside of the United States), that has a contract with the local Blue Cross and/or Blue Shield Plan: the amount that the provider and the local Blue Cross and/or Blue Shield Plan have agreed by contract will be accepted as payment in full for the Covered Service(s) rendered.
- 5) For a Non-Participating Provider outside of California (within or outside of the United States) that does not contract with a local Blue Cross and/or Blue Shield Plan, who provides services (other than Emergency Services): the amount that the local Blue Cross and/or Blue Shield Plan would have allowed for a non-participating provider performing the same

services. Or, if the local Blue Cross and/or Blue Shield Plan has no non-participating provider allowance, the Allowable Amount is the amount for a Non-Participating Provider in California.

Alternate Care Services Provider —refers to a supplier of Durable Medical Equipment, or a certified orthotist, prosthetist, or prosthetist-orthotist.

Ambulatory Surgery Center — an outpatient surgery facility providing outpatient services which:

- 1) is either licensed by the state of California as an ambulatory surgery center, or is a licensed facility accredited by an ambulatory surgery center accrediting body; and
- 2) provides services as a free-standing ambulatory surgery center, which is licensed separately and bills separately from a Hospital, and is not otherwise affiliated with a Hospital.

Anticancer Medications- Drugs used to kill or slow the growth of cancerous cells.

Bariatric Surgery Services Provider — a Participating Hospital, Ambulatory Surgery Center, or a Physician that has been designated by Blue Shield to provide bariatric surgery services to Members who are residents of designated counties in California (described in the Covered Services section of this Agreement).

Behavioral Health Treatment – professional services and treatment programs, including applied behavior analysis and evidence-based intervention programs which develop or restore to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism.

Benefits (Covered Services) — those Medically Necessary services and supplies which a Member is entitled to receive pursuant to this Agreement.

Blue Shield of California – a California not-for-profit corporation, licensed as a health care service plan, and referred to throughout this Evidence of Coverage, as Blue Shield.

Brand Drugs — Drugs which are FDA approved after a new drug application and/or registered under a brand or trade name by its manufacturer.

Calendar Year — the 12-month consecutive period beginning on January 1 and ending on December 31 of the same calendar year.

Close Relative — the spouse, Domestic Partner, children, brothers, sisters, or parents of a Member.

Coinsurance — the percentage amount that a Member is required to pay for Covered Services after meeting any applicable Deductible.

Copayment — the specific dollar amount that a Member is required to pay for Covered Services after meeting any applicable Deductible.

Cosmetic Surgery — surgery that is performed to alter or reshape normal structures of the body to improve appearance.

Covered Services (Benefits) — those Medically Necessary services and supplies which a Member is entitled to receive pursuant to the terms of this Agreement.

Creditable Coverage -

1) Any individual or group policy, contract or program, that is written or administered by a disability insurer, health care service plan, fraternal benefits society, self-insured employer plan, or any other entity, in this state or elsewhere, and that arranges or provides medical, hospital, and surgical coverage not designed to supplement other private or governmental plans. The term includes continuation or conversion coverage, but does not include accident only, credit, coverage for onsite medical clinics, disability income, Medicare supplement, long-term care insurance, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in

any liability insurance policy or equivalent self-insurance.

- 2) The Medicare Program pursuant to Title XVIII of the Social Security Act.
- 3) The Medicaid Program pursuant to Title XIX of the Social Security Act (referred to as Medical in California).
- 4) Any other publicly sponsored program of medical, hospital or surgical care, provided in this state or elsewhere.
- 5) The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) pursuant to 10 U.S.C. Chapter 55, Section 1071, et seq..
- 6) A medical care program of the Indian Health Service or of a tribal organization.
- 7) A state health benefits high risk pool.
- 8) The Federal Employees Health Benefits Program, which is a health plan offered under 5 U.S.C. Chapter 89, Section 8901 et seq.
- 9) A public health plan as defined by the Health Insurance Portability and Accountability Act of 1996 pursuant to Section 2701(c)(1)(I) of the Public Health Service Act, and amended by Public Law 104-191.
- 10) A health benefit plan under Section 5(e) of the Peace Corps Act, pursuant to 22 U.S.C. 2504(e).
- 11) Any other creditable coverage as defined by subsection (c) of Section 2704 of Title XXVII of the federal Public Health Service Act (42 U.S.C. Sec 300gg-3(c)).

Custodial Care or Maintenance Care — care furnished in the home primarily for supervisory care or supportive services, or in a facility primarily to provide room and board (which may or may not include nursing care, training in personal hygiene and other forms of self care or supervisory care by a Doctor of Medicine); or care furnished to a person who is mentally or physically disabled, and:

- 1) who is not under specific medical, surgical or psychiatric treatment to reduce the disability to the extent necessary to enable the individual to live outside an institution providing such care; or
- 2) when, despite such treatment, there is no reasonable likelihood that the disability will be so reduced.

Deductible – the Calendar Year amount which the Member must pay for specific Covered Services before Blue Shield pays for Covered Services pursuant to this Agreement.

Dependent — an individual who is enrolled and maintains coverage under this Agreement, and who meets one of the following eligibility requirements, as:

- 1) A Dependent spouse is an individual who is legally married to the Subscriber, and who is not legally separated from the Subscriber.
- 2) A Dependent Domestic Partner is an individual who meets the definition of Domestic Partner as defined in this Agreement.
- 3) A Dependent child is a child of, adopted by, or in legal guardianship of the Subscriber, spouse, or Domestic Partner, and who is not covered as a Subscriber. A child includes any stepchild, child placed for adoption, or any other child for whom the Subscriber, spouse, or Domestic Partner has been appointed as a non-temporary legal guardian by a court of appropriate legal jurisdiction. A child is an individual less than 26 years of age (or less than 18 years of age if the child has been enrolled as a result of a court-ordered non-temporary legal guardianship. A child does not include any children of a Dependent child (i.e., grandchildren of the Subscriber, spouse, or Domestic Partner), unless the Subscriber, spouse, or Domestic Partner has adopted or is the legal guardian of the grandchild.
- 4) If coverage for a Dependent child would be terminated because of the attainment of age 26, and the Dependent child is disabled and

incapable of self-sustaining employment, Benefits for such Dependent child will be continued upon the following conditions:

- a) the child must be chiefly dependent upon the Subscriber, spouse, or Domestic Partner for support and maintenance;
- b) the Subscriber, spouse, or Domestic Partner must submit to Blue Shield a Physician's written certification of disability within 60 days from the date of Blue Shield's request; and
- c) thereafter, certification of continuing disability and dependency from a Physician must be submitted to Blue Shield on the following schedule:
 - (i) within 24 months after the month when the Dependent child's coverage would otherwise have been terminated; and
 - (ii) annually thereafter on the same month when certification was made in accordance with item (1) above. In no event will coverage be continued beyond the date when the Dependent child becomes ineligible for coverage for any reason other than attained age.

Doctor of Medicine – a licensed Medical Doctor (M.D.) or Doctor of Osteopathic Medicine (D.O.).

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

Drugs — Drugs are:

- 1) FDA-approved medications that require a prescription either by California or Federal law;
- 2) Insulin, and disposable hypodermic insulin needles and syringes;
- 3) Pen delivery systems for the administration of insulin, as Medically Necessary;
- 4) Diabetic testing supplies (including lancets, lancet puncture devices, blood and urine testing strips, and test tablets);
- 5) Over-the-counter (OTC) drugs with a United States Preventive Services Task Force (USPSTF) rating of A or B;
- 6) Contraceptive drugs and devices, including:
 - diaphragms,
 - cervical caps,
 - contraceptive rings,
 - contraceptive patches,
 - oral contraceptives,
 - emergency contraceptives, and
 - female OTC contraceptive products when ordered by a Physician or Health Care Provider;
- 7) Inhalers and inhaler spacers for the management and treatment of asthma.

Effective Date — the date an applicant meets all enrollment and prepayment requirements and is accepted by Blue Shield.

Emergency Services — services provided for an unexpected medical condition, including a psychiatric emergency medical condition, manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- 1) placing the Member’s health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

- 2) serious impairment to bodily functions;
- 3) serious dysfunction of any bodily organ or part.

Emergency Services means the following with respect to an emergency medical condition:

- 1) A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the emergency medical condition; and
- 2) Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, to stabilize the Member.

“Stabilize” means to provide medical treatment of the condition as may be necessary to assure, with reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to a pregnant woman who is having contractions, when there is inadequate time to safely transfer her to another hospital before delivery (or the transfer may pose a threat to the health or safety of the woman or unborn child), Stabilize means to deliver (including the placenta).

“Post-Stabilization Care” means Medically Necessary services received after the treating physician determines the emergency medical condition is stabilized.

Experimental or Investigational in Nature — any treatment, therapy, procedure, drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supplies which are not recognized in accordance with generally accepted professional medical standards as being safe and effective for use in the treatment of the illness, injury, or condition at issue. Services which require approval by the Federal government or any agency thereof, or by any state government agency, prior to use and where such approval has not been granted at the

time the services or supplies were rendered, shall be considered experimental or investigational in nature.

Services or supplies which themselves are not approved or recognized in accordance with accepted professional medical standards, but nevertheless are authorized by law or by a government agency for use in testing, trials, or other studies on human patients, shall be considered experimental or investigational in nature.

Family — the Subscriber and all enrolled Dependents.

Formulary — A list of preferred Generic and Brand Drugs maintained by Blue Shield's Pharmacy & Therapeutics Committee. It is designed to assist Physicians and Health Care Providers in prescribing Drugs that are Medically Necessary and cost-effective. The Formulary is updated periodically.

Generic Drugs — Drugs that are approved by the Food Drug Administration (FDA) or other authorized government agency as a therapeutic equivalent (i.e. contain the same active ingredient(s)) to the Brand Drug

Habilitative Services – Health care services and devices that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient or outpatient settings, or both.

Health Care Provider – An appropriately licensed or certified independent practitioner including: licensed vocational nurse; registered nurse; nurse practitioner; physician assistant; psychiatric/mental health registered nurse; registered dietician; certified nurse midwife; licensed midwife; occupational therapist; acupuncturist; registered respiratory therapist; speech therapist or pathologist; physical therapist; pharmacist; naturopath; podiatrist; chiropractor;

optometrist; nurse anesthetist (CRNA); clinical nurse specialist; optician; audiologist; hearing aid supplier; licensed clinical social worker; psychologist; marriage and family therapist; board certified behavior analyst (BCBA), licensed professional clinical counselor (LPCC); massage therapist.

Participating Hemophilia Infusion Provider — a provider that furnishes blood factor replacement products and services for in-home treatment of blood disorders such as hemophilia.

Note: A participating home infusion agency may not be a Participating Hemophilia Infusion Provider if it does not have an agreement with Blue Shield to furnish blood factor replacement products and services.

Home Health Aide – an individual who has successfully completed a state-approved training program, is employed by a home health agency or Hospice program, and provides personal care services in the patient's home.

Hospice or Hospice Agency — an entity which provides hospice services to persons with a Terminal Disease or Illness and holds a license, currently in effect as a hospice pursuant to California Health and Safety Code Section 1747, or a home health agency licensed pursuant to California Health and Safety Code Sections 1726 and 1747.1 which has Medicare certification.

Hospital — an entity which is:

- 1) a licensed institution primarily engaged in providing medical, diagnostic and surgical facilities for the care and treatment of sick and injured persons on an inpatient basis, under the supervision of an organized medical staff, and which provides 24-hour a day nursing service by registered nurses;
- 2) a psychiatric hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations; or
- 3) a psychiatric health care facility as defined in Section 1250.2 of the California Health and Safety Code.

A facility which is principally a rest home, nursing home, or home for the aged, is not included in this definition.

Infertility —

- 1) a demonstrated condition recognized by a licensed physician and surgeon as a cause for infertility; or
- 2) the inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year of regular sexual relations without contraception.

Intensive Outpatient Program — an outpatient mental health, behavioral health, or substance use disorder treatment program utilized when a patient’s condition requires structure, monitoring, and medical/psychological intervention at least three hours per day, three days per week.

Medical Necessity (Medically Necessary) -

Benefits are provided only for services that are Medically Necessary.

- 1) Services that are Medically Necessary include only those which have been established as safe and effective, are furnished under generally accepted professional standards to treat illness, injury or medical condition, and which, as determined by Blue Shield, are:
 - a) consistent with Blue Shield medical policy;
 - b) consistent with the symptoms or diagnosis;
 - c) not furnished primarily for the convenience of the patient, the attending Physician or other provider; and
 - d) furnished at the most appropriate level which can be provided safely and effectively to the patient.
- 2) If there are two or more Medically Necessary services that may be provided for the illness, injury or medical condition, Blue Shield will provide Benefits based on the most cost-effective service.
- 3) Hospital inpatient services which are Medically Necessary include only those

services which satisfy the above requirements, require the acute bed-patient (overnight) setting, and which could not have been provided in the Physician’s office, the outpatient department of a Hospital, or in another lesser facility without adversely affecting the patient’s condition or the quality of medical care rendered. Inpatient services that are not Medically Necessary include hospitalization:

- a) for diagnostic studies that could have been provided on an outpatient basis;
 - b) for medical observation or evaluation;
 - c) for personal comfort;
 - d) in a pain management center to treat or cure chronic pain; and
 - e) for inpatient Rehabilitation that can be provided on an outpatient basis.
- 4) Blue Shield reserves the right to review all claims to determine whether services are Medically Necessary, and may use the services of Physician consultants, peer review committees of professional societies or Hospitals, and other consultants.

Member— an individual who is enrolled and maintains coverage in the plan pursuant to this Agreement as either a Subscriber or a Dependent.

Mental Health Condition — mental disorders listed in the “Diagnostic & Statistical Manual of Mental Disorders Fourth Edition (DSM-IV)”, including Severe Mental Illnesses and Serious Emotional Disturbances of a Child.

Mental Health Service Administrator (MHSA) — The MHSA is a specialized health care service plan licensed by the California Department of Managed Health Care. Blue Shield contracts with the MHSA to underwrite and deliver Blue Shield’s Mental Health Services, Behavioral Health Treatment, and Substance Use Disorder Services through a separate network of MHSA Participating Providers.

Mental Health Services — services provided to treat a Mental Health Condition.

MHSA Non-Participating Provider — a provider who does not have an agreement in effect with the MHSA for the provision of Mental Health Services, Behavioral Health Treatment, or Substance Use Disorder Services to Members of this Plan.

MHSA Participating Provider — a provider who has an agreement in effect with the MHSA for the provision of Mental Health Services, Behavioral Health Treatment, or Substance Use Disorder Services to Members of this Plan.

Network Specialty Pharmacy – select Participating Pharmacies contracted by Blue Shield to provide covered Specialty Drugs.

Non-Participating Pharmacy – a pharmacy which does not participate in the Blue Shield Pharmacy Network. These pharmacies are not contracted to provide services to Blue Shield Members.

Non-Participating (Non-Participating Provider) — refers to any provider who has not contracted with Blue Shield to accept Blue Shield’s payment, plus any applicable Member Deductible, Copayment, Coinsurance, or amounts in excess of specified Benefit maximums, as payment in full for Covered Services provided to Members of this Plan.

This definition does not apply to providers of Mental Health Services, Behavioral Health Treatment, and Substance Use Disorder Services, which is defined separately under the MHSA Non-Participating Provider definition.

Non-Preferred Drugs — Drugs determined by Blue Shield’s Pharmacy and Therapeutics Committee as products that do not have a clear advantage over Formulary Drug alternatives. Benefits may be provided for Non-Preferred Drugs and are always subject to the Non-Preferred Copayment or Coinsurance.

Occupational Therapy — treatment under the direction of a Doctor of Medicine and provided by

an occupational therapist or other appropriately licensed or certified Health Care Provider, utilizing arts, crafts, or specific training in daily living skills, to improve and maintain a patient’s ability to function.

Office Visits for Outpatient Mental Health Services and Behavioral Health Treatment – professional office visits for Behavioral Health Treatment and the diagnosis and treatment of Mental Health Conditions, including the individual, family, or group setting.

Open Enrollment Period – the yearly period during which an individual may enroll or change coverage. The Open Enrollment Period is established each year by California law.

Orthosis (Orthotics) — an orthopedic appliance or apparatus used to support, align, prevent, or correct deformities or to improve the function of movable body parts.

Other Outpatient Mental Health Services and Behavioral Health Treatment– Outpatient Facility and professional services for Behavioral Health Treatment and the diagnosis and treatment of Mental Health Conditions, including but not limited, to the following:

- 1) Partial Hospitalization
- 2) Intensive Outpatient Program
- 3) Electroconvulsive Therapy
- 4) Transcranial Magnetic Stimulation
- 5) Behavioral Health Treatment
- 6) Psychological Testing
- 7) Other outpatient items and services

These services may also be provided in the office, home, or other non-institutional setting.

Outpatient Substance Use Disorder Services – Outpatient Facility and professional services for the diagnosis and treatment of Mental Health Conditions and Substance Use Disorder Conditions, including, but not limited to the following:

- 1) Partial Hospitalization
- 2) Intensive Outpatient Program
- 3) Office-Based Opioid Detoxification and/or Maintenance Therapy.

These services may also be provided in the office, home or other non-institutional setting.

Other Providers —

- 1) Independent Practitioners — licensed vocational nurses; licensed practical nurses; registered nurses; nurse practitioners; licensed psychiatric nurses; licensed clinical social worker; marriage and family therapist; applied behavior analyst, acupuncture practitioners; registered dietitians and other nutrition advisors; certified nurse midwives; licensed occupational therapists; physical therapist; licensed acupuncturists; certified respiratory therapists; enterostomal therapists; licensed speech and language therapists or pathologists; dental technicians lab technicians, and any other practitioners included in (28 CCR 1300.50(I)(1)).
- 2) A provider who does not participate with this Plan’s network, but does have a contract with Blue Shield to participate in the network for another Blue Cross and/or Blue Shield plan or plans.
- 3) Healthcare Organizations — nurses registry; licensed mental health, freestanding public health, rehabilitation, and outpatient clinics not MD-owned; portable X-ray companies; independent laboratories; blood banks; speech and hearing centers; dental laboratories; dental supply companies; nursing homes; ambulance companies; Easter Seal Society; American Cancer Society, and Catholic Charities.

Out-of-Pocket Maximum - the highest Deductible, Copayment and Coinsurance amount an individual or Family is required to pay for designated Covered Services each year as indicated in the Summary of Benefits. Charges for services that are not covered, charges in excess of the Allowable Amount or contracted rate do not

accrue to the Calendar Year Out-of-Pocket Maximum.

Outpatient Facility — a licensed facility which provides medical and/or surgical services on an outpatient basis. The term does not include a Physician’s office or a Hospital.

Partial Hospitalization Program (Day Treatment) — an outpatient treatment program that may be free-standing or Hospital-based and provides services at least five hours per day, four days per week. Patients may be admitted directly to this level of care, or transferred from acute inpatient care following stabilization.

Participating (Participating Provider) – refers to a provider who has contracted with Blue Shield to accept Blue Shield’s payment, plus any applicable Member Deductible, Copayment, Coinsurance, or amounts in excess of specified Benefit maximums, as payment in full for Covered Services provided to Members of this Plan.

This definition does not apply to providers of Mental Health Services, Behavioral Health Treatment, and Substance Use Disorder Services, which is defined separately under the MHSA Participating Provider definition.

Participating Pharmacy — a pharmacy which has agreed to a contracted rate for covered Drugs for Blue Shield Members. These pharmacies participate in the Blue Shield Pharmacy Network.

Period of Care – the timeframe the Participating Provider certifies or recertifies that the Member requires and remains eligible for Hospice care, even if the Member lives longer than one year. A Period of Care begins the first day the Member receives Hospice services and ends when the certified timeframe has elapsed.

Physical Therapy — treatment provided by a physical therapist, occupational therapist, or other appropriately licensed or certified Health Care Provider. Treatment utilizes physical agents and therapeutic procedures, such as ultrasound, heat, range of motion testing, and massage, to improve

a patient's musculoskeletal, neuromuscular and respiratory systems.

Physician — a licensed Doctor of Medicine, clinical psychologist, research psychoanalyst, dentist, licensed clinical social worker, optometrist, chiropractor, podiatrist, audiologist, registered physical therapist, or licensed marriage and family therapist.

Plan – this Blue Shield PPO Plan.

Preferred Drugs – Drugs listed on Blue Shield's Formulary and determined by Blue Shield's Pharmacy and Therapeutics Committee as products that have a clear advantage over Non-Formulary Drug alternatives.

Premium (Dues) — the monthly prepayment made to Blue Shield on behalf of each Member by the Contractholder for coverage under this Agreement.

Preventive Health Services — mean those primary preventive medical Covered Services, including related laboratory services, for early detection of disease as specifically described in the *Preventive Health Benefits* section of this Evidence of Coverage.

Prosthesis(es) (Prosthetics) — an artificial part, appliance, or device used to replace a missing part of the body.

Psychological Testing — testing to diagnose a Mental Health Condition when referred by an MHSA Participating Provider.

Reasonable and Customary Charge —

1) In California: The lower of: (a) the provider's billed charge, or (b) the amount determined by Blue Shield to be the reasonable and customary value for the services rendered by a Non-Participating Provider based on statistical information that is updated at least annually and considers many factors including, but not limited to, the provider's training and experience, and the geographic area where the services are rendered.

2) Outside of California: The lower of: (a) the provider's billed charge, or, (b) the amount, if any, established by the laws of the state to be paid for Emergency Services.

Reconstructive Surgery — surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following: (1) to improve function; or (2) to create a normal appearance to the extent possible; dental and orthodontic services that are an integral part of surgery for cleft palate procedures.

Rehabilitation — inpatient or outpatient care furnished to an individual disabled by injury or illness, including Severe Mental Illness and Severe Emotional Disturbances of a Child, in order to restore an individual's ability to function to the maximum extent practical. Rehabilitation services may consist of Physical Therapy, Occupational Therapy, and/or Respiratory Therapy.

Resident of California - an individual who spends in the aggregate more than 180 days each year within the State of California and has not established a permanent residence in another state or country.

Residential Care — Mental Health Services, Behavioral Health Treatment, or Substance Use Disorder Services provided in a facility or a free-standing residential treatment center that provides overnight/extended-stay services for Members who do not require acute inpatient care.

Respiratory Therapy — treatment, under the direction of a Doctor of Medicine and provided by a respiratory therapist or other appropriately licensed or certified Health Care Provider to preserve or improve a patient's pulmonary function.

Serious Emotional Disturbances of a Child — refers to individuals who are minors under the age of 18 years who:

1) have one or more mental disorders in the most recent edition of the Diagnostic and Statistical manual of Mental Disorders (other than a

primary substance use disorder or developmental disorder), that results in behavior inappropriate for the child's age according to expected developmental norms; and

- 2) meet the criteria in paragraph (2) of subdivision (a) of Section 5600.3 of the Welfare and Institutions Code. This section states that members of this population shall meet one or more of the following criteria:
 - a) As a result of the mental disorder the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either of the following has occurred: the child is at risk of removal from home or has already been removed from the home or the mental disorder and impairments have been present for more than 6 months or are likely to continue for more than one year without treatment;
 - b) The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder.

Severe Mental Illnesses — conditions with the following diagnoses: schizophrenia, schizoaffective disorder, bipolar disorder (manic depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, bulimia nervosa.

Skilled Nursing - services performed by a licensed nurse (either a registered nurse or a licensed vocational nurse).

Skilled Nursing Facility — a facility with a valid license issued by the California Department of Public Health as a Skilled Nursing Facility or any similar institution licensed under the laws of any other state, territory, or foreign country. Also included in a Skilled Nursing unit within a Hospital.

Special Enrollment Period – a period during which an individual who experiences certain qualifying events may enroll in, or change enrollment in, a health plan outside of the Open Enrollment Period. An individual and/or his or her Dependents has a 60-day Special Enrollment Period if any of the following occurs:

- 1) An individual or Dependent loses minimum essential coverage for a reason other than failure to pay Premiums on a timely basis.
- 2) An individual or Dependent has lost or will lose coverage under an employer health benefit plan as a result of (a) termination of his or her employment; (b) termination of employment of the individual through whom he or she was covered as a Dependent; (c) change in his or her employment status or of the individual through whom he or she was covered as a Dependent, (d) termination of the other plan's coverage, (e) exhaustion of COBRA or Cal-COBRA continuation coverage, (f) cessation of an employer's contribution toward his or her coverage, (g) death of the individual through whom he or she was covered as a Dependent, or (h) legal separation, divorce or termination of a Domestic Partnership.
- 3) A Dependent is mandated to be covered as a Dependent pursuant to a valid state or federal court order. The health benefit plan shall enroll such a Dependent child within 60 days of presentation of a court order by the district attorney, or upon presentation of a court order or request by a custodial party, as described in Section 3751.5 of the Family Code.
- 4) An individual or Dependent who was eligible for coverage under the Healthy Families Program or Medi-Cal has lost coverage as a result of the loss of such eligibility.
- 5) An individual or Dependent who becomes eligible for the Healthy Families Program or the Medi-Cal Premium assistance program and requests enrollment within 60 days of the notice of eligibility for these Premium assistance programs.

- 6) An individual acquires Dependents through marriage, establishment of Domestic Partnership, birth, adoption, placement for adoption or placement in foster care.
- 7) An individual's or Dependent's enrollment or non-enrollment in a health plan is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of Covered California, HHS, or any of their instrumentalities as evaluated and determined by Covered California. In such cases, Covered California may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction;
- 8) An individual or Dependent demonstrates to the department that he or she did not enroll in a health benefit plan during the immediately preceding enrollment period available to the individual because he or she was misinformed that he or she was covered under minimum essential coverage.
- 9) An individual or Dependent adequately demonstrates that the health plan in which he or she is enrolled substantially violated a material provision of its contract in relation to the individual or Dependent
- 10) An individual or Dependent gains access to new health plans as a result of a permanent move;
- 11) An individual or Dependent is determined newly eligible or newly ineligible for advance payments of the Premium tax credit or has a change in eligibility for cost-sharing reductions.
- 12) An individual or Dependent has been released from incarceration.
- 13) An individual or Dependent was receiving services from a contracting provider under another health benefit plan, as defined in Section 1399.845 of the Health & Safety Code or Section 10965 of the Insurance Code, for one of the conditions described in California Health & Safety Code Section 1373.96(c) and that provider is no longer participating in the health benefit plan.
- 14) An individual or Dependent is a member of the reserve forces of the United States military returning from active duty or a member of the California National Guard returning from active duty service under Title 32 of the United States Code.
- 15) An individual or Dependent is enrolled in an eligible employer-sponsored plan that is not qualifying coverage in an eligible employer-sponsored plan and is allowed to terminate existing coverage. Such an individual must be permitted to access this special enrollment period 60 days prior to the end of his or her coverage through such eligible employer-sponsored plan.
- 16) An individual or Dependent experiences a qualifying event, as defined under section 603 of the Employee Retirement Income Security Act of 1974, as amended, including:
 - a) With respect to the Subscriber:
 - i) the termination of employment (other than by reason of gross misconduct); or
 - ii) the reduction of hours of employment to less than the number of hours required for eligibility.
 - b) With respect to the Dependent spouse or Dependent Domestic Partner and Dependent children
 - i) the death of the Subscriber; or
 - ii) the termination of the Subscriber's employment (other than by reason of such Subscriber's gross misconduct); or
 - iii) the reduction of the Subscriber's hours of employment to less than the number of hours required for eligibility; or
 - iv) the divorce or legal separation of the Subscriber from the Dependent spouse or termination of the domestic partnership; or

- v) the Subscriber's entitlement to benefits under Title XVIII of the Social Security Act ("Medicare"); or
 - vi) a Dependent child's loss of Dependent status under this plan.
- c) For COBRA only, with respect to a Subscriber who is covered as a retiree, that retiree's Dependent spouse and De-pendent children, the Employer's filing for reorganization under Title XI, United States Code, commencing on or after July 1, 1986.

NOTE: Contact Blue Shield to determine when the Special Enrollment Period begins.

Special Food Products — a food product which is both of the following:

- 1) Prescribed by a physician or Nurse practitioner for the treatment of phenylketonuria (PKU) and is consistent with the recommendations and best practices of qualified health professionals with expertise germane to, and experience in the treatment and care of, phenylketonuria (PKU). It does not include a food that is naturally low in protein, but may include a food product that is specially formulated to have less than one gram of protein per serving.
- 2) Used in place of normal food products, such as grocery store foods, used by the general population.

Specialist - Specialists include physicians with a specialty as follows: allergy, anesthesiology, dermatology, cardiology and other internal medicine specialists, neonatology, neurology, oncology, ophthalmology, orthopedics, pathology, psychiatry, radiology, any surgical specialty, otolaryngology, urology, and other designated as appropriate.

Specialty Drugs - Drugs requiring coordination of care, close monitoring, or extensive patient training that cannot be met by a retail pharmacy and are available exclusively through a Network Specialty Pharmacy. Specialty Drugs may also

require special handling or manufacturing processes, restriction to certain Physicians or pharmacies, or reporting of certain clinical events to the FDA. Specialty Drugs are generally high cost.

Speech Therapy — treatment, under the direction of a Doctor of Medicine and provided by a licensed speech pathologist or speech therapist, or other appropriately licensed or certified Health Care Provider to improve or retrain a patient's vocal or swallowing skills which have been impaired by a diagnosed illness or injury.

Subacute Care — skilled nursing or skilled rehabilitation provided in a hospital or skilled nursing facility to patients who require skilled care such as nursing services, physical, occupational or speech therapy, a coordinated program of multiple therapies or who have medical needs that require daily Registered Nurse monitoring. A facility that is primarily a rest-home, convalescent facility, or home for the aged is not included.

Subscriber — an individual who is a Resident of California and has made application individually or also on behalf of eligible Dependents, has been enrolled by Blue Shield, and has maintained Blue Shield membership in accord with this Agreement.

Substance Use Disorder Condition — drug or alcohol abuse or dependence.

Substance Use Disorder Services — services provided to treat a Substance Use Condition.

Terminal Disease or Terminal Illness (Terminally Ill) – a medical condition resulting in a life expectancy of one year or less, if the disease follows its natural course.



Notice Informing Individuals about Nondiscrimination and Accessibility Requirements

Discrimination is against the law

Blue Shield of California complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Blue Shield of California does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Blue Shield of California:

- Provides aids and services at no cost to people with disabilities to communicate effectively with us such as:
 - Qualified sign language interpreters
 - Written information in other formats (including large print, audio, accessible electronic formats and other formats)
- Provides language services at no cost to people whose primary language is not English such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact the Blue Shield of California Civil Rights Coordinator.

If you believe that Blue Shield of California has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:

Blue Shield of California
Civil Rights Coordinator

P.O. Box 629007

El Dorado Hills, CA 95762-9007

Phone: (844) 831-4133 (TTY: 711)

Fax: (916) 350-7405

Email: BlueShieldCivilRightsCoordinator@blueshieldca.com

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW.
Room 509F, HHH Building Washington, DC 20201
(800) 368-1019; TTY: (800) 537-7697

Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

Notice of the Availability of Language Assistance Services

IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For help at no cost, please call right away at the Member/Customer Service telephone number on the back of your Blue Shield ID card, or (866) 346-7198.

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

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

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

MAHALAGA: Nababasa mo ba ang sulat na ito? Kung hindi, maari kaming kumuha ng isang tao upang matulungan ka upang mabasa ito. Maari ka ring makakuha ng sulat na ito na nakasulat sa iyong wika. Para sa libreng tulong, mangyaring tumawag kaagad sa numerong telepono ng Miyembro/Customer Service sa likod ng iyong Blue Shield ID kard, o (866) 346-7198. (Tagalog)

Baa' ákohwíndzindooígí: Díí naaltsoosish yíiníłta'go bíiníghah? Doo bíiníghahgóó éí, naaltsoos nich'í' yiidóolta'hígíí ła' níhee hółó. Díí naaltsoos aldó' t'áá Diné k'ehjí ádoolníł nínízingo bíighah. Doo bąąh ílínígó shíká' adoowoł nínízingó nihich'í' béesh bee hodiłłnih dóó námboo éí díí Blue Shield bee néiho'dilzinígí bine'déé' bikáá' éí doodagó éí (866) 346-7198 jí' hodiłłnih. (Navajo)

중요: 이 서신을 읽을 수 있으세요? 읽으실 수 경우, 도움을 드릴 수 있는 사람이 있습니다. 또한 다른 언어로 작성된 이 서신을 받으실 수도 있습니다. 무료로 도움을 받으시려면 Blue Shield ID 카드 뒷면의 회원/고객 서비스 전화번호 또는 (866) 346-7198로 지금 전화하세요. (Korean)

ԿԱՐԵՎՈՐ Է: Կարողանում ե՞ք կարդալ այս նամակը: Եթե ոչ, սպաս մենք կօգնենք ձեզ: Դուք պետք է նաև կարողանաք ստանալ այս նամակը ձեր լեզվով: Օտարությունն անվճար է: Խնդրում ենք անմիջապես զանգահարել Հաճախորդների սպասարկման բաժնի հեռախոսահամարով, որը նշված է ձեր Blue Shield ID քարտի ետևի մասում, կամ (866) 346-7198 համարով: (Armenian)

ВАЖНО: Не можете прочесть данное письмо? Мы поможем вам, если необходимо. Вы также можете получить это письмо написанное на вашем родном языке. Позвоните в Службу клиентской/членской поддержки прямо сейчас по телефону, указанному сзади идентификационной карты Blue Shield, или по телефону (866) 346-7198, и вам помогут совершенно бесплатно. (Russian)

重要: お客様は、この手紙を読むことができますか? もし読むことができない場合、弊社が、お客様をサポートする人物を手配いたします。また、お客様の母国語で書かれた手紙をお送りすることも可能です。無料のサポートを希望される場合は、Blue Shield IDカードの裏面に記載されている会員/お客様サービスの電話番号、または、(866) 346-7198にお電話をおかけください。 (Japanese)

مهم: آیا می‌توانید این نامه را بخوانید؟ اگر یاسختان منفی است، می‌توانیم کسی را برای کمک به شما در اختیارتان قرار دهیم. حتی می‌توانید نسخه مکتوب این نامه را به زبان خودتان دریافت کنید. برای دریافت کمک رایگان، لطفاً بدون فوت وقت از طریق شماره تلفنی که در پشت کارت شناسی Blue Shieldتان درج شده است و یا از طریق شماره تلفن (866) 346-7198 با خدمات اعضا/مشتری تماس بگیرید. (Persian)

ਮਹੱਤਵਪੂਰਨ: ਕੀ ਤੁਸੀਂ ਇਸ ਪੱਤਰ ਨੂੰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇ ਨਹੀਂ ਤਾਂ ਇਸ ਨੂੰ ਪੜ੍ਹਨ ਵਿਚ ਮਦਦ ਲਈ ਅਸੀਂ ਕਿਸੇ ਵਿਅਕਤੀ ਦਾ ਪ੍ਰਬੰਧ ਕਰ ਸਕਦੇ ਹਾਂ। ਤੁਸੀਂ ਇਹ ਪੱਤਰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਲਿਖਿਆ ਹੋਇਆ ਵੀ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਮੁਫਤ ਵਿਚ ਮਦਦ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ ਤੁਹਾਡੇ Blue Shield ID ਕਾਰਡ ਦੇ ਪਿੱਛੇ ਦਿੱਤੇ ਮੈਂਬਰ/ਕਸਟਮਰ ਸਰਵਿਸ ਟੈਲੀਫੋਨ ਨੰਬਰ ਤੇ, ਜਾਂ (866) 346-7198 ਤੇ ਕਾਲ ਕਰੋ। (Punjabi)

ប្រការសំខាន់៖ តើអ្នកអាចលិខិតនេះ បានដែរឬទេ? បើមិនអាចទេ យើងអាចឱ្យគេជួយអ្នកក្នុងការអានលិខិតនេះ។ អ្នកក៏អាចទទួលបានលិខិតនេះជាភាសារបស់អ្នកផងដែរ។ សម្រាប់ជំនួយដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទភ្លាមៗទៅកាន់លេខទូរស័ព្ទសេវាសមាជិក/អតិថិជនដែលមាននៅលើខ្នងប័ណ្ណសម្គាល់ Blue Shield របស់អ្នក ឬតាមរយៈលេខ (866) 346-7198។ (Khmer)

المهم: هل تستطيع قراءة هذا الخطاب؟ أن لم تستطع قراءته، يمكننا إحضار شخص ما ليساعدك في قراءته. قد تحتاج أيضاً إلى الحصول على هذا الخطاب مكتوباً بلغتك. للحصول على المساعدة بدون تكلفة، يرجى الاتصال الآن على رقم هاتف خدمة العملاء/أحد الأعضاء المدون على الجانب الخلفي من بطاقة الهوية Blue Shield أو على الرقم (866) 346-7198. (Arabic)

TSEEM CEEB: Koj pos tuaj yeem nyeem tau tsab ntawv no? Yog hais tias nyeem tsis tau, peb tuaj yeem nrhiav ib tug neeg los pab nyeem nws rau koj. Tej zaum koj kuj yuav tau txais muab tsab ntawv no sau ua koj hom lus. Rau kev pab txhais dawb, thov hu kiag rau tus xov tooj Kev Pab Cuam Tub Koom Xeeb/Tub Lag Luam uas nyob rau sab nraum nrob qaum ntawm koj daim npav Blue Shield ID, los yog hu rau tus xov tooj (866) 346-7198. (Hmong)

สำคัญ: คุณอ่านจดหมายฉบับนี้ได้หรือไม่ หากไม่ได้ โปรดขอความช่วยเหลือจากผู้ช่วยเหลือ คุณอาจได้รับจดหมายฉบับนี้เป็นภาษาของคุณ หากต้องการความช่วยเหลือโดยไม่มีค่าใช้จ่าย โปรดติดต่อฝ่ายบริการลูกค้า/สมาชิกทางเบอร์โทรศัพท์ในบัตรประจำตัว Blue Shield ของคุณ หรือโทร (866) 346-7198 (Thai)

महत्वपूर्ण: क्या आप इस पत्र को पढ़ सकते हैं? यदि नहीं, तो हम इसे पढ़ने में आपकी मदद के लिए किसी व्यक्ति का प्रबंध कर सकते हैं। आप इस पत्र को अपनी भाषा में भी प्राप्त कर सकते हैं। निःशुल्क मदद प्राप्त करने के लिए अपने Blue Shield ID कार्ड के पीछे दिए गये मੈਂबर/कस्टमर सर्विस टेलीफोन नंबर, या (866) 346-7198 पर कॉल करें। (Hindi)

IN WITNESS WHEREOF, this Agreement is executed by Blue Shield of California through its duly authorized Officer, to take effect on the Subscriber's Effective Date.

A handwritten signature in black ink, appearing to read "Jeff Smith". The signature is fluid and cursive, with the first name "Jeff" and last name "Smith" clearly distinguishable.

Jeff Smith, Vice President and General Manager
Individual and Family Plans
Blue Shield of California

Contacting Blue Shield of California

For information, including information about claims submission:

Members may call Customer Service toll free at 1-888-256-3650.

The hearing impaired may call Customer Service through Blue Shield's toll-free TTY number at 711.

For prior authorization:

Please call the Customer Service telephone number listed above.

For prior authorization of Benefits Management Program radiological services:

Please call 1-888-642-2583.

For prior authorization of inpatient Mental Health, Behavioral Health, and Substance Use Disorder Services:

Please contact the Mental Health Service Administrator at 1-877-263-9952.

Please refer to the *Benefits Management Program* section of this Evidence of Coverage for additional information on prior authorization.

Please direct correspondence to:

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

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 - Qualified sign language interpreters
 - Written information in other formats (including large print, audio, accessible electronic formats and other formats)
- Provides language services at no cost to people whose primary language is not English such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact the Blue Shield of California Civil Rights Coordinator.

If you believe that Blue Shield of California has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:

Blue Shield of California
Civil Rights Coordinator
P.O. Box 629007
El Dorado Hills, CA 95762-9007

Phone: (844) 831-4133 (TTY: 711)

Fax: (916) 350-7405

Email: BlueShieldCivilRightsCoordinator@blueshieldca.com

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW.
Room 509F, HHH Building
Washington, DC 20201
(800) 368-1019; TTY: (800) 537-7697

Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For help at no cost, please call right away at the Member/Customer Service telephone number on the back of your Blue Shield ID card, or (866) 346-7198.

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

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

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

MAHALAGA: Nababasa mo ba ang sulat na ito? Kung hindi, maari kaming kumuha ng isang tao upang matulungan ka upang mabasa ito. Maari ka ring makakuha ng sulat na ito na nakasulat sa iyong wika. Para sa libreng tulong, mangyaring tumawag kaagad sa numerong telepono ng Miyembro/Customer Service sa likod ng iyong Blue Shield ID kard, o (866) 346-7198. (Tagalog)

Baa' ákohwiindzindooígí: Díí naaltsoosish yíiniłta'go bíníghah? Doo bíníghahgóó éí, naaltsoos nich'í' yiidóoltahígíí ła' nihee hółó. Díí naaltsoos áłdó' t'áá Diné k'ehjí ádoolníł nínízingo bíghah. Doo ąąąh ílínígó shíká' adoowoł nínízingó nihich'í' béesh bee hodíłnih dóó námboo éí díí Blue Shield bee néłho'díłzinígí bine'dée' bikáá' éí doodagó éí (866) 346-7198 jí' hodíłnih. (Navajo)

중요: 이 서신을 읽을 수 있으세요? 읽으실 수 경우, 도움을 드릴 수 있는 사람이 있습니다. 또한 다른 언어로 작성된 이 서신을 받으실 수도 있습니다. 무료로 도움을 받으시려면 Blue Shield ID 카드 뒷면의 회원/고객 서비스 전화번호 또는 (866) 346-7198로 지금 전환하세요. (Korean)

ԿԱՐԵՎՈՐ Է: Կարողանում ե՞ք կարդալ այս նամակը: Եթե ոչ, ապա մենք կօգնենք ձեզ: Դուք պետք է նաև կարողանաք ստանալ այս նամակը ձեր լեզվով: Օտարությունն անվճար է: Խնդրում ենք անմիջապես զանգահարել Հաճախորդների սպասարկման բաժնի հեռախոսահամարով, որը նշված է ձեր Blue Shield ID քարտի ետևի մասում, կամ (866) 346-7198 համարով: (Armenian)

ВАЖНО: Не можете прочесть данное письмо? Мы поможем вам, если необходимо. Вы также можете получить это письмо написанное на вашем родном языке. Позвоните в Службу клиентской/членской поддержки прямо сейчас по телефону, указанному сзади идентификационной карты Blue Shield, или по телефону (866) 346-7198, и вам помогут совершенно бесплатно. (Russian)

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مهم: آیا می‌توانید این نامه را بخوانید؟ اگر پاسختان منفی است، می‌توانیم کسی را برای کمک به شما در اختیارتان قرار دهیم. حتی می‌توانید نسخه مکتوب این نامه را به زبان خودتان دریافت کنید. برای دریافت کمک رایگان، لطفاً بدون فوت وقت از طریق شماره تلفنی که در پشت کارت شناسی Blue Shieldتان درج شده است و یا از طریق شماره تلفن (866) 346-7198 با خدمات مشتریان تماس بگیرید. (Persian)

ਮਹੱਤਵਪੂਰਨ: ਕੀ ਤੁਸੀਂ ਇਸ ਪੱਤਰ ਨੂੰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇ ਨਹੀਂ ਤਾਂ ਇਸ ਨੂੰ ਪੜ੍ਹਨ ਵਿਚ ਮਦਦ ਲਈ ਅਸੀਂ ਕਿਸੇ ਵਿਅਕਤੀ ਦਾ ਪ੍ਰਬੰਧ ਕਰ ਸਕਦੇ ਹਾਂ। ਤੁਸੀਂ ਇਹ ਪੱਤਰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਲਿਖਿਆ ਹੋਇਆ ਵੀ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਮੁਫਤ ਵਿਚ ਮਦਦ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ ਤੁਹਾਡੇ Blue Shield ID ਕਾਰਡ ਦੇ ਪਿੱਛੇ ਦਿੱਤੇ ਮੈਂਬਰ/ਕਸਟਮਰ ਸਰਵਿਸ ਟੈਲੀਫੋਨ ਨੰਬਰ ਤੇ, ਜਾਂ (866) 346-7198 ਤੇ ਕਾਲ ਕਰੋ। (Punjabi)

ប្រការសំខាន់៖ តើអ្នកអាចលិខិតនេះ បានដែរឬទេ? បើមិនអាចទេ យើងអាចឱ្យគេជួយអ្នកក្នុងការអានលិខិតនេះ។ អ្នកក៏អាចទទួលបានលិខិតនេះជាភាសារបស់អ្នកផងដែរ។ សម្រាប់ជំនួយដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទភ្លាមៗទៅកាន់លេខទូរស័ព្ទសេវាសមាជិក/អតិថិជនដែលមាននៅលើខ្នងប័ណ្ណសម្គាល់ Blue Shield របស់អ្នក ឬតាមរយៈលេខ (866) 346-7198។ (Khmer)

المهم: هل تستطيع قراءة هذا الخطاب؟ أن لم تستطع قراءته، يمكننا إحضار شخص ما ليساعدك في قراءته. قد تحتاج أيضاً إلى الحصول على هذا الخطاب مكتوباً بلغتك. للحصول على المساعدة بدون تكلفة، يرجى الاتصال الآن على رقم هاتف خدمة العملاء/أحد الأعضاء المدون على الجانب الخلفي من بطاقة الهوية Blue Shield أو على الرقم (866) 346-7198. (Arabic)

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Email: BlueShieldCivilRightsCoordinator@blueshieldca.com

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW.
Room 509F, HHH Building
Washington, DC 20201
(800) 368-1019; TTY: (800) 537-7697

Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For help at no cost, please call right away at the Member/Customer Service telephone number on the back of your Blue Shield ID card, or (866) 346-7198.

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

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

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

MAHALAGA: Nababasa mo ba ang sulat na ito? Kung hindi, maari kaming kumuha ng isang tao upang matulungan ka upang mabasa ito. Maari ka ring makakuha ng sulat na ito na nakasulat sa iyong wika. Para sa libreng tulong, mangyaring tumawag kaagad sa numerong telepono ng Miyembro/Customer Service sa likod ng iyong Blue Shield ID kard, o (866) 346-7198. (Tagalog)

Baa' ákohwiindzindooígí: Díí naaltsoosish yíiniłta'go bíníghah? Doo bíníghahgóó éí, naaltsoos nich'í' yiidóoltahígíí ła' nihee hółó. Díí naaltsoos áłdó' t'áá Diné k'ehjí ádoolníł nínízingo bíghah. Doo ąąąh ílínígó shíká' adoowoł nínízingó nihich'í' béesh bee hodíłnih dóó námboo éí díí Blue Shield bee néłho'díłzinígí bine'dée' bikáá' éí doodagó éí (866) 346-7198 jí' hodíłnih. (Navajo)

중요: 이 서신을 읽을 수 있으세요? 읽으실 수 경우, 도움을 드릴 수 있는 사람이 있습니다. 또한 다른 언어로 작성된 이 서신을 받으실 수도 있습니다. 무료로 도움을 받으시려면 Blue Shield ID 카드 뒷면의 회원/고객 서비스 전화번호 또는 (866) 346-7198로 지금 전환하세요. (Korean)

ԿԱՐԵՎՈՐ Է: Կարողանում ե՞ք կարդալ այս նամակը: Եթե ոչ, ապա մենք կօգնենք ձեզ: Դուք պետք է նաև կարողանաք ստանալ այս նամակը ձեր լեզվով: Օտարությունն անվճար է: Խնդրում ենք անմիջապես զանգահարել Հաճախորդների սպասարկման բաժնի հեռախոսահամարով, որը նշված է ձեր Blue Shield ID քարտի ետևի մասում, կամ (866) 346-7198 համարով: (Armenian)

ВАЖНО: Не можете прочесть данное письмо? Мы поможем вам, если необходимо. Вы также можете получить это письмо написанное на вашем родном языке. Позвоните в Службу клиентской/членской поддержки прямо сейчас по телефону, указанному сзади идентификационной карты Blue Shield, или по телефону (866) 346-7198, и вам помогут совершенно бесплатно. (Russian)

重要: お客様は、この手紙を読むことができますか? もし読むことができない場合、弊社が、お客様をサポートする人物を手配いたします。また、お客様の母国語で書かれた手紙をお送りすることも可能です。無料のサポートを希望される場合は、Blue Shield IDカードの裏面に記載されている会員/お客様サービスの電話番号、または、(866) 346-7198にお電話をおかけください。 (Japanese)

مهم: آیا می‌توانید این نامه را بخوانید؟ اگر پاسختان منفی است، می‌توانیم کسی را برای کمک به شما در اختیارتان قرار دهیم. حتی می‌توانید نسخه مکتوب این نامه را به زبان خودتان دریافت کنید. برای دریافت کمک رایگان، لطفاً بدون فوت وقت از طریق شماره تلفنی که در پشت کارت شناسی Blue Shieldتان درج شده است و یا از طریق شماره تلفن (866) 346-7198 با خدمات مشتری تماس بگیرید. (Persian)

ਮਹੱਤਵਪੂਰਨ: ਕੀ ਤੁਸੀਂ ਇਸ ਪੱਤਰ ਨੂੰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇ ਨਹੀਂ ਤਾਂ ਇਸ ਨੂੰ ਪੜ੍ਹਨ ਵਿਚ ਮਦਦ ਲਈ ਅਸੀਂ ਕਿਸੇ ਵਿਅਕਤੀ ਦਾ ਪ੍ਰਬੰਧ ਕਰ ਸਕਦੇ ਹਾਂ। ਤੁਸੀਂ ਇਹ ਪੱਤਰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਲਿਖਿਆ ਹੋਇਆ ਵੀ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਮੁਫਤ ਵਿਚ ਮਦਦ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ ਤੁਹਾਡੇ Blue Shield ID ਕਾਰਡ ਦੇ ਪਿੱਛੇ ਦਿੱਤੇ ਮੈਂਬਰ/ਕਸਟਮਰ ਸਰਵਿਸ ਟੈਲੀਫੋਨ ਨੰਬਰ ਤੇ, ਜਾਂ (866) 346-7198 ਤੇ ਕਾਲ ਕਰੋ। (Punjabi)

ប្រការសំខាន់៖ តើអ្នកអាចលិខិតនេះ បានដែរឬទេ? បើមិនអាចទេ យើងអាចឱ្យគេជួយអ្នកក្នុងការអានលិខិតនេះ។ អ្នកក៏អាចទទួលបានលិខិតនេះជាភាសារបស់អ្នកផងដែរ។ សម្រាប់ជំនួយដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទភ្លាមៗទៅកាន់លេខទូរស័ព្ទសេវាសមាជិក/អភិវឌ្ឍន៍ដែលមាននៅលើខ្នងប័ណ្ណសម្គាល់ Blue Shield របស់អ្នក ឬតាមរយៈលេខ (866) 346-7198។ (Khmer)

المهم: هل تستطيع قراءة هذا الخطاب؟ أن لم تستطع قراءته، يمكننا إحضار شخص ما ليساعدك في قراءته. قد تحتاج أيضاً إلى الحصول على هذا الخطاب مكتوباً بلغتك. للحصول على المساعدة بدون تكلفة، يرجى الاتصال الآن على رقم هاتف خدمة العملاء/أحد الأعضاء المدون على الجانب الخلفي من بطاقة الهوية Blue Shield أو على الرقم (866) 346-7198. (Arabic)

TSEEM CEEB: Koj pos tuaj yeem nyeem tau tsab ntawv no? Yog hais tias nyeem tsis tau, peb tuaj yeem nrhiv ib tug neeg los pab nyeem nws rau koj. Tej zaum koj kuj yuav tau txais muab tsab ntawv no sau ua koj hom lus. Rau kev pab txhais dawb, thov hu kiag rau tus xov tooj Kev Pab Cuam Tub Koom Xeeb/Tub Lag Luam uas nyob rau sab nraum nrob qaum ntawm koj daim npav Blue Shield ID, los yog hu rau tus xov tooj (866) 346-7198. (Hmong)

สำคัญ: คุณอ่านจดหมายฉบับนี้ได้หรือไม่ หากไม่ได้ โปรดขอความช่วยเหลือจากผู้อ่านได้ คุณอาจได้รับจดหมายฉบับนี้เป็นภาษาของคุณ หากต้องการความช่วยเหลือโดยไม่มีค่าใช้จ่าย โปรดติดต่อฝ่ายบริการลูกค้า/สมาชิกทางเบอร์โทรศัพท์ในบัตรประจำตัว Blue Shield ของคุณ หรือโทร (866) 346-7198 (Thai)

महत्वपूर्ण: क्या आप इस पत्र को पढ़ सकते हैं? यदि नहीं, तो हम इसे पढ़ने में आपकी मदद के लिए किसी व्यक्ति का प्रबंध कर सकते हैं। आप इस पत्र को अपनी भाषा में भी प्राप्त कर सकते हैं। निःशुल्क मदद प्राप्त करने के लिए अपने Blue Shield ID कार्ड के पीछे दिए गये मੈਂबर/कस्टमर सर्विस टेलीफोन नंबर, या (866) 346-7198 पर कॉल करें। (Hindi)