Silver 70 PPO AI-AN

This plan is only available to eligible Native Americans*

Uniform Health Plan Benefits and Coverage Matrix

Blue Shield of California

Effective January 1, 2016

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE *EVIDENCE OF COVERAGE* SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

This health plan uses the Exclusive PPO Provider Network.

	Native American Providers[1]	Participating Providers[2]	Non-Participating Providers[2]
Calendar Year Medical Deductible[2] (Services received from Native American providers are not subject to a deductible. Services received from all other providers are subject to a deductible. For family coverage, an individual is responsible for satisfying their own individual deductible and that amount accumulates to the family deductible.) (Deductibles for Participating and Non-Participating Providers accrue separately.)	$0	$2,250 per individual / $4,500 per family	$4,500 per individual / $9,000 per family
Calendar Year Out-of-Pocket Maximum[3] (Services received from Native American providers are not subject to a calendar year out-of-pocket maximum. Services received from all other providers are subject to a calendar year out-of-pocket maximum. Any calendar year medical deductible and any calendar year pharmacy deductible accrues to the calendar year out-of-pocket maximum. Copayments or coinsurance for covered services from participating providers accrues to both the participating and non-participating provider calendar year out-of-pocket maximum amounts.)	$0	$6,250 per individual / $12,500 per family	$9,250 per individual / $18,500 per family
Calendar Year Pharmacy Deductible (Drugs received from Native American pharmacies are not subject to the calendar year pharmacy deductible. Does not apply to contraceptive drugs and devices. Otherwise applicable to covered drugs in Tiers 2, 3 and 4. Separate from the calendar year medical deductible. Accrues to the calendar year out-of-pocket maximum)	$0	$250 per individual / $500 per family	Not Covered
Lifetime Benefit Maximum	None		

Covered Services	**Member Copayments**		
	Native American Providers[1]	**Participating Providers[2]**	**Non-Participating Providers[2]**
PROFESSIONAL SERVICES			
Professional Benefits			
Primary care physician office visit	$0	$45	50% (subject to the calendar year medical deductible)
Other practitioner office visit	$0	$45	50% (subject to the calendar year medical deductible)
Specialist physician office visit	$0	$70	50% (subject to the calendar year medical deductible)
Allergy Testing and Treatment Benefits			
Primary care physician office visits (includes visits for allergy serum injections)	$0	$45	50% (subject to the calendar year medical deductible)

Covered Services	Member Copayments		
	Native American Providers[1]	Participating Providers[2]	Non-Participating Providers[2]
Specialist physician office visits (includes visits for allergy serum injections)	$0	$70	50% (subject to the calendar year medical deductible)
Allergy serum purchased separately for treatment	$0	20%	50% (subject to the calendar year medical deductible)
Preventive Health Benefits[17]			
Preventive health services (as required by applicable Federal and California law)	$0	$0	Not covered
OUTPATIENT SERVICES			
Hospital Benefits (Facility Services)			
Outpatient surgery performed at a free-standing ambulatory surgery center	$0	20%	50%[6] (subject to the calendar year medical deductible) The maximum allowed amount for non-participating providers is $300 per day. Members are responsible for 50% of this $300 per day, plus all charges in excess of $300
Outpatient surgery performed in a hospital or hospital affiliated ambulatory surgery center	$0	20%	50%[4] (subject to the calendar year medical deductible) The maximum allowed amount for non-participating providers is $500 per day. Members are responsible for 50% of this $500 per day, plus all charges in excess of $500
Outpatient visit	$0	20%	50%[4] (subject to the calendar year medical deductible) The maximum allowed amount for non-participating providers is $500 per day. Members are responsible for 50% of this $500 per day, plus all charges in excess of $500
Outpatient services for treatment of illness or injury and necessary supplies (except as described under "Rehabilitation Benefits" and "Speech Therapy Benefits")	$0	20%	50%[4] (subject to the calendar year medical deductible) The maximum allowed amount for non-participating providers is $500 per day. Members are responsible for 50% of this $500 per day, plus all charges in excess of $500
CT scans, MRIs, MRAs, PET scans, and cardiac diagnostic procedures utilizing nuclear medicine performed in a hospital[19] (prior authorization is required)	$0	$250	50%[4] (subject to the calendar year medical deductible) The maximum allowed amount for non-participating providers is $500 per day. Members are responsible for 50% of this $500 per day, plus all charges in excess of $500

Covered Services	Member Copayments		
	Native American Providers[1]	Participating Providers[2]	Non-Participating Providers[2]
Outpatient diagnostic X-ray and imaging performed in a hospital[19]	$0	$65	50%[4] (subject to the calendar year medical deductible) The maximum allowed amount for non-participating providers is $500 per day. Members are responsible for 50% of this $500 per day, plus all charges in excess of $500
Outpatient diagnostic laboratory and pathology performed in a hospital[19]	$0	$35	50%[4] (subject to the calendar year medical deductible) The maximum allowed amount for non-participating providers is $500 per day. Members are responsible for 50% of this $500 per day, plus all charges in excess of $500
Bariatric surgery[7] (prior authorization is required; medically necessary surgery for weight loss, for morbid obesity only)	$0	20% (subject to the calendar year medical deductible)	Not covered
HOSPITALIZATION SERVICES			
Hospital Benefits (Facility Services)			
Inpatient physician fee	$0	20% (subject to the calendar year medical deductible)	50% (subject to the calendar year medical deductible)
Inpatient non-emergency facility fee (semi-private room and board, and medically necessary services and supplies, including subacute care)	$0	20% (subject to the calendar year medical deductible)	50%[4] (subject to the calendar year medical deductible) The maximum allowed amount for non-participating providers is $2000 per day. Members are responsible for 50% of this $2000 per day, plus all charges in excess of $2000
Bariatric surgery[7] (prior authorization is required; medically necessary surgery for weight loss is for morbid obesity only)	$0	20% (subject to the calendar year medical deductible)	Not covered
Inpatient Skilled Nursing Benefits[20,5] (combined maximum of up to 100 days per benefit period; prior authorization is required; semi-private accommodations)			
Services by a free-standing skilled nursing facility	$0	20% (subject to the calendar year medical deductible)	20% (subject to the calendar year medical deductible)
Skilled nursing unit of a hospital	$0	20% (subject to the calendar year medical deductible)	50%[4] (subject to the calendar year medical deductible) The maximum allowed amount for non-participating providers is $2000 per day. Members are responsible for 50% of this $2000 per day, plus all charges in excess of $2000
EMERGENCY HEALTH COVERAGE			
Emergency room visit not resulting in admission- facility fee (copayment does not apply if the member is directly admitted to the hospital for inpatient services)	$0	$250 (subject to the calendar year medical deductible)	$250 (subject to the calendar year medical deductible)

Covered Services	Member Copayments		
	Native American Providers[1]	Participating Providers[2]	Non-Participating Providers[2]
Emergency room visit resulting in admission – facility fee (when the member is admitted directly from the ER)	$0	20% (subject to the calendar year medical deductible)	20% (subject to the calendar year medical deductible)
Emergency room visit not resulting in admission – physician fee (copayment does not apply if the member is directly admitted to the hospital for inpatient services)	$0	$50 (subject to the calendar year medical deductible)	$50 (subject to the calendar year medical deductible)
Emergency room visit resulting in admission – physician fee	$0	20% (subject to the calendar year medical deductible)	20% (subject to the calendar year medical deductible)
Urgent care	$0	$90	50% (subject to the calendar year medical deductible)
AMBULANCE SERVICES			
Emergency or authorized transport (ground or air)	$0	$250 (subject to the calendar year medical deductible)	$250 (subject to the calendar year medical deductible)
PRESCRIPTION DRUG (PHARMACY) COVERAGE [8,9,10,12,18,21]	**Native American Pharmacy**	**Participating Pharmacy**	**Non-Participating Pharmacy**
Retail Pharmacies (up to a 30-day supply)			
Contraceptive drugs and devices[9]	$0	$0	Not Covered
Tier 1 Drugs	$0	$15 per prescription	Not Covered
Tier 2 Drugs	$0	$50 per prescription (subject to the calendar year pharmacy deductible)	Not Covered
Tier 3 Drugs	$0	$70 per prescription (subject to the calendar year pharmacy deductible)	Not Covered
Tier 4 Drugs (excluding Specialty Drugs)	$0	20% up to $250 maximum per prescription (Subject to the calendar year pharmacy deductible)	Not Covered
Mail Service Pharmacies (up to a 90-day supply)			
Contraceptive drugs and devices[9]	$0	$0	Not Covered
Tier 1 Drugs	$0	$45 per prescription	Not Covered
Tier 2 Drugs	$0	$150 per prescription (subject to the calendar year pharmacy deductible)	Not Covered
Tier 3 Drugs	$0	$210 per prescription (subject to the calendar year pharmacy deductible)	Not Covered
Tier 4 Drugs (excluding Specialty Drugs)	$0	20% up to $750 maximum per prescription (Subject to the calendar year pharmacy deductible)	Not Covered
Network Specialty Pharmacies[12,18,21] (up to a 30-day supply)			

Covered Services	Member Copayments		
	Native American Providers[1]	**Participating Providers[2]**	**Non-Participating Providers[2]**
Tier 4 Drugs	$0	20% up to $250 maximum per admission (subject to the calendar year pharmacy deductible)	Not Covered
Oral anti-cancer medications	$0	20% up to a maximum of $200 per prescription (subject to the calendar year pharmacy deductible)	Not Covered
	Native American Providers[1]	**Participating Providers[2]**	**Non-Participating Providers[2]**
PROSTHETICS/ORTHOTICS			
Prosthetic equipment and devices (separate office visit copayment may apply)	$0	20%	50% (subject to the calendar year medical deductible)
Orthotic equipment and devices (separate office visit copayment may apply)	$0	20%	50% (subject to the calendar year medical deductible)
DURABLE MEDICAL EQUIPMENT			
Breast pump	$0	$0	Not covered
Other durable medical equipment	$0	20%	50% (subject to the calendar year medical deductible)
MENTAL HEALTH AND BEHAVIORAL HEALTH SERVICES[11]			
Inpatient hospital facility fee (prior authorization required)	$0	20% (subject to the calendar year medical deductible)	50%[4] (subject to the calendar year medical deductible) The maximum allowed amount for non-participating providers is $2000 per day. Members are responsible for 50% of this $2000 per day, plus all charges in excess of $2000
Residential care (prior authorization required)	$0	20% (subject to the calendar year medical deductible)	50%[4] (subject to the calendar year medical deductible) The maximum allowed amount for non-participating providers is $2000 per day. Members are responsible for 50% of this $2000 per day, plus all charges in excess of $2000
Inpatient professional (physician) services (prior authorization required)	$0	20% (subject to the calendar year medical deductible)	$50 (subject to the calendar year medical deductible)
Routine outpatient mental health and behavioral health services (includes professional/physician visits; some services may require prior authorization and facility charges)	$0	$45	50% (subject to the calendar year medical deductible)

Covered Services	Member Copayments		
	Native American Providers[1]	Participating Providers[2]	Non-Participating Providers[2]
Non-routine outpatient mental health and behavioral health services (includes behavioral health treatment, electroconvulsive therapy, intensive outpatient programs, partial hospitalization programs, transcranial magnetic stimulation, post discharge ancillary care and psychological testing. For partial hospitalization programs, a higher copayment and facility charges may apply per episode of care. Some services may require prior authorization and facility charges)	$0	20%	50% (subject to the calendar year medical deductible)
SUBSTANCE USE DISORDER SERVICES[11]			
Inpatient facility fee for medical acute detoxification (prior authorization required)	$0	20% (subject to the calendar year medical deductible)	50%[4] (subject to the calendar year medical deductible) The maximum allowed amount for non-participating providers is $2000 per day. Members are responsible for 50% of this $2000 per day, plus all charges in excess of $2000
Residential care (prior authorization required)	$0	20% (subject to the calendar year medical deductible)	50%[4] (subject to the calendar year medical deductible) The maximum allowed amount for non-participating providers is $2000 per day. Members are responsible for 50% of this $2000 per day, plus all charges in excess of $2000
Inpatient professional (physician) services (prior authorization required)	$0	20% (subject to the calendar year medical deductible)	50% (subject to the calendar year medical deductible)
Routine outpatient substance use disorder services (includes professional/physician visits; some services may require prior authorization and facility charges)	$0	$45	50% (subject to the calendar year medical deductible)
Non-routine outpatient substance use disorder services (services may require prior authorization; includes partial hospitalization program, intensive outpatient program, post-discharge ancillary care and office-based opioid treatment. Higher copayment and facility charges per episode of care may apply for partial hospitalization programs.)	$0	20%	50% (subject to the calendar year medical deductible)
HOME HEALTH SERVICES			
Home health care agency services[20] (up to 100 prior authorized visits per calendar year)	$0	$45	Not Covered
Home infusion/home intravenous injectable therapy and infusion nursing visits provided by a home infusion agency[20] (up to 100 prior authorized visits per calendar year)	$0	$45	Not Covered
HOSPICE PROGRAM BENEFITS			
Routine home care	No Charge	No Charge	Not Covered
Inpatient respite care	No Charge	No Charge	Not Covered
24-hour continuous home care	No Charge	No Charge	Not Covered
Short-term inpatient care for pain and symptom management	No Charge	No Charge	Not Covered
CHIROPRACTIC BENEFITS			
Chiropractic services	Not covered	Not Covered	Not Covered
ACUPUNCTURE BENEFITS			
Acupuncture services (benefits provided are for the treatment of nausea or as part of a comprehensive pain management program for the treatment of chronic pain only)	$0	$45	50% (subject to the calendar year medical deductible)

Covered Services	Member Copayments		
	Native American Providers[1]	Participating Providers[2]	Non-Participating Providers[2]
REHABILITATION AND HABILITATION BENEFITS (Physical, Occupational and Respiratory Therapy)			
Office location	$0	$45	50% (subject to the calendar year medical deductible)
SPEECH THERAPY BENEFITS			
Office location	$0	$45	50% (subject to the calendar year medical deductible)
PREGNANCY AND MATERNITY CARE BENEFITS			
Prenatal and preconception physician office visits (for inpatient hospital services, see "Hospitalization Services")	$0	$0	50% (subject to the calendar year medical deductible)
Delivery and all inpatient physician services	$0	20% (subject to the calendar year medical deductible)	50% (subject to the calendar year medical deductible)
Postnatal physician office visit (for inpatient hospital services, see "Hospitalization Services")	$0	$45	50% (subject to the calendar year medical deductible)
Abortion services (an additional facility copayment may apply when services are rendered in a hospital or outpatient surgery center)	$0	20%	50% (subject to the calendar year medical deductible)
FAMILY PLANNING BENEFITS			
Counseling and consulting (includes insertion of IUD, as well as injectable and implantable contraceptives for women)	$0	$0	Not Covered
Tubal ligation	$0	$0	Not Covered
Vasectomy (an additional facility copayment may apply when services are rendered in a hospital or outpatient surgery center)	$0	20%	Not Covered
Infertility services	Not covered	Not covered	Not Covered
DIABETES CARE BENEFITS			
Devices, equipment, and non-testing supplies (for testing supplies see Outpatient Prescription Drug Benefits)	$0	20%	50% (subject to the calendar year medical deductible)
Diabetes self-management training in an office setting	$0	$45	50% (subject to the calendar year medical deductible)
CARE OUTSIDE OF CALIFORNIA (Benefits provided through the BlueCard® Program for out-of-state emergency and non-emergency care are provided at the participating level of the local Blue Plan allowable amount when you use a Blue Cross/Blue Shield provider)			
Within US: BlueCard Program	See Applicable Benefit	See Applicable Benefit	See Applicable Benefit
Outside of US: BlueCard Worldwide	See Applicable Benefit	See Applicable Benefit	See Applicable Benefit
Pediatric Vision Benefits[27] – Pediatric vision benefits are available for members through the end of the month in which the member turns 19. All pediatric vision benefits are provided through MESVision, Blue Shield's Vision Plan Administrator.			
Comprehensive Eye Exam[13]: one per calendar year (includes dilation, if professionally indicated)			
Ophthalmologic - Routine ophthalmologic exam with refraction – new patient (S0620) - Routine ophthalmologic exam with refraction – established patient (S0621)	$0	$0	Up to a $30 Maximum Allowance
Optometric - New patient exam (92002/92004) - Established patient exam (92012/92014)	$0	$0	Up to a $30 Maximum Allowance
Eyeglasses			

Covered Services	Member Copayments		
	Native American Providers[1]	**Participating Providers[2]**	**Non-Participating Providers[2]**
Lenses: one pair per calendar year - Single vision (V2100-2199) - Conventional (lined) bifocal (V2200-2299) - Conventional (lined) trifocal (V2300-2399) - Lenticular (V2121, V2221, V2321) Lenses include choice of glass or plastic lenses, all lens powers (single vision, bifocal, trifocal, lenticular), fashion and gradient tinting, scratch coating, oversized and glass-grey #3 prescription sunglass lenses. Polycarbonate lenses are covered in full for eligible members.	$0	$0	Covered up to a maximum allowance of: $25 single vision $35 lined bifocal $45 lined trifocal $45 lenticular
Optional Lenses and Treatments			
UV coating (standard only)	$0	$0	Not Covered
Anti-reflective coating (standard only)	$0	$35	Not Covered
High-index lenses	$0	$30	Not Covered
Photochromic lenses (glass or plastic)	$0	$25	Not Covered
Polarized lenses	$0	$45	Not Covered
Standard progressives	$0	$55	Not Covered
Premium progressives	$0	$95	Not Covered
Frame[14] (one frame per calendar year)			
Collection frame	$0	$0	Up to a $40 Maximum Allowance
Non-collection frame (V2020)	$0	Up to a $150 Maximum Allowance	Up to a $40 Maximum Allowance
Contact Lenses[15]			
Elective (Cosmetic/Convenience) – standard hard (V2500, V2510) One pair per calendar year	$0	$0	Up to a $75 Maximum Allowance
Elective (Cosmetic/Convenience) – standard soft (V2520) One per month, up to 6 months, per calendar year	$0	$0 (	Up to a $75 Maximum Allowance
Elective (Cosmetic/Convenience)– non-standard hard (V2501, V2502, V2503, V2511, V2512, V2513, V2599) One pair per calendar year	$0	$0	Up to a $75 Maximum Allowance
Elective (Cosmetic/Convenience) – non-standard soft (V2521, V2512, V2523) One pair per month, up to 3 months, per calendar year	$0	$0	Up to a $75 Maximum Allowance
Non-Elective (Medically Necessary) – Hard or soft one pair per calendar year	$0	$0	Up to a $225 Maximum Allowance for medically necessary contact lenses
Other Pediatric Vision Benefits			
Supplemental low-vision testing and equipment[16]	$0	35%	Not Covered
Diabetes management referral	$0	$0	Not Covered
Pediatric Dental Benefits[22] – Pediatric dental benefits are available for members through the end of the month in which the member turns 19. All pediatric dental benefits are provided by Dental Benefits Providers, Blue Shield's Dental Plan Administrator.			
Child Dental Diagnostic and Preventive	**Native American Dentist**	**Participating Dentists**	**Non-Participating** Dentists[26]
Oral exam	No charge	No charge	20%
Preventive - cleaning	No charge	No charge	20%
Preventive - X-ray	No charge	No charge	20%
Sealants per tooth	No charge	No charge	20%
Topical fluoride application	No charge	No charge	20%
Caries risk management	No charge	No charge	20%
Space maintainers - fixed	No charge	No charge	20%
Child Dental Basic Services			
Amalgam fill - 1 surface[24]	No charge	20%	30%
Child Dental Major Services[23]			
Root canal - molar	No charge	50%	50%
Gingivectomy per quad	No charge	50%	50%
Extraction - single tooth exposed root or erupted	No charge	50%	50%
Extraction - complete bony	No charge	50%	50%
Porcelain with metal crown	No charge	50%	50%

Child Orthodontics[23, 25]			
Medically necessary orthodontics	No charge	50%	50%

Please Note: Benefits are subject to modification for subsequently enacted state or federal legislation.

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Endnotes

* Native American means any individual as defined in section 4(d) of the Indian Self-Determination and Education Assistance Act (Pub. L. 93–638). Eligibility for coverage as a Native American is determined by Covered California..

1. Members enrolled in this plan can access benefits from any provider, including a Blue Shield participating provider, a non-participating provider, or a provider for Native Americans; however, there is no member cost-sharing for services received from a provider or pharmacy for Native Americans. “Benefits from a provider or pharmacy for Native Americans” refers to those essential health benefits furnished directly by the Indian Health Service (IHS), an Indian Tribe, a Tribal Organization, or an Urban Indian Organization or through referral under contracted health services (each as defined in 25 U.S.C. 1603)

2. For family coverage, there is an individual medical deductible and a separate individual pharmacy deductible within the family medical and pharmacy deductibles. This means that the medical and pharmacy deductibles will be met for an individual who meets the individual medical and pharmacy deductibles prior to meeting the family medical and pharmacy deductibles. After the calendar year medical deductible is met, the member is responsible for a copayment or coinsurance from participating providers. Participating providers accept Blue Shield’s allowable amounts as full payment for covered services.
   Non-participating providers can charge more than these amounts. When members use non-participating providers, they must pay the applicable deductibles, copayments or coinsurance plus any amount that exceeds Blue Shield’s allowable amount. Charges above the allowable amount do not count toward the calendar year medical deductible out-of-pocket maximum.

3. For family coverage, there is an individual out-of-pocket maximum within the family out-of-pocket maximum. This means that the out-of-pocket maximum will be met for an individual who meets the individual out-of-pocket maximum prior to the family meeting the family out-of-pocket maximum. Copayments or coinsurance for covered services accrue to the calendar year out-of-pocket maximum, except copayments or coinsurance for: (a) charges in excess of specified benefit maximums; (b) Bariatric surgery: covered travel expenses for bariatric surgery; and (c) Dialysis center benefits: dialysis services from a non-participating provider. Copayments, coinsurance and charges for services not accruing to the member's calendar year out-of-pocket maximum continue to be the member's responsibility after the calendar year out-of-pocket maximum is reached. Please refer to the Summary of Benefits and *Evidence of Coverage* for additional details.

4. The allowable amount for non-emergency services and supplies received from a non-participating hospital or facility is limited to $500 (outpatient) or to $2000 (inpatient) per day. Members are responsible for the coinsurance and all charges that exceed $500 (outpatient) or $2000 (inpatient) per day. Charges that exceed the allowable amount do not count toward the calendar year out-of-pocket maximum and continue to be owed after the maximum is reached.

5. Services may require prior authorization by the plan. When services are prior authorized, members pay the participating provider amount.

6. The allowable amount for non-emergency surgery and services performed in a non-participating ambulatory surgery center is $300 per day. Members are responsible for the coinsurance and all charges in excess of $300 per day. Charges that exceed the allowable amount do not count toward the calendar year out-of-pocket maximum and continue to be owed after the maximum is reached.

7. Bariatric surgery is covered when prior authorized by Blue Shield; however, for members residing in Imperial, Kern, Los Angeles, Orange, Riverside, San Bernardino, San Diego, Santa Barbara and Ventura counties (“Designated Counties”), bariatric surgery services are covered only when performed at designated contracting bariatric surgery facilities and by designated contracting surgeons. Coverage is not available for bariatric services from any other participating provider and there is no coverage for bariatric services from non-participating providers. In addition, if prior authorized by Blue Shield, a member in a Designated County who is required to travel more than 50 miles to a designated bariatric surgery facility will be eligible for limited reimbursement for specified travel expenses for the member and one companion. Refer to the Summary of Benefits and Evidence of Coverage for further details.

8. This plan’s prescription drug coverage is on average equivalent to or better than the standard benefit set by the federal government for Medicare Part D (also called creditable coverage). Because this plan’s prescription drug coverage is creditable, you do not have to enroll in a Medicare prescription drug plan while you maintain this coverage. However, you should be aware that if you have a subsequent break in this coverage of 63 days or more anytime after you were first eligible to enroll in a Medicare prescription drug plan, you could be subject to a late enrollment penalty in addition to your Medicare Part D premium.

9. Contraceptive drugs and devices covered under the outpatient prescription drug benefit do not require a copayment and are not subject to the calendar year medical deductible. However, if a brand contraceptive is selected when a Tier 1 drug equivalent is available, the member is responsible for paying the difference between the cost to Blue Shield for the brand contraceptive and its Tier 1 drug equivalent. The difference in cost that the member must pay does not accrue to any calendar year medical or pharmacy deductible and is not included in the calendar year out-of-pocket maximum responsibility calculation. The member or physician may request a medical necessity exception to the difference in cost as further described in the *Evidence of Coverage*. In addition, select brand. In addition, select contraceptives may need prior authorization to be covered without a copayment.

10. If a member or physician selects a brand drug when a Tier 1 drug equivalent is available, the member is responsible for paying the difference between the cost to Blue Shield for the brand drug and its Tier 1 drug equivalent, as well as the applicable generic copayment. The difference in cost that the member must pay does not accrue to any calendar year out-of-pocket maximum responsibility. The member or physician may request a medical necessity exception to the difference in cost as further described in the Evidence of Coverage. Refer to the *Evidence of Coverage* and Summary of Benefits for details.

11. Mental Health and Substance Use Disorder services are accessed through Blue Shield's Mental Health Service Administrator (MHSA) using Blue Shield's MHSA participating and non-participating providers. Only Mental Health and Substance Use Disorder services rendered by Blue Shield MHSA participating providers are administered by the Blue Shield MHSA. Mental Health and Substance Use Disorder services rendered by non-participating providers are administered by Blue Shield. Inpatient services for acute detoxification are covered under the medical benefit; see the Hospital Benefits (Facility Services) section of the *Evidence of Coverage* for benefit details. Services for acute medical detoxification are accessed through Blue Shield using Blue Shield's participating providers or non-participating providers.

12. Network Specialty Pharmacies dispense Specialty Drugs which require coordination of care, close monitoring, or extensive patient training that generally cannot be met by a retail pharmacy. Network Specialty Pharmacy also dispense Specialty Drugs requiring 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.

13. The comprehensive examination benefit and allowance does not include fitting and evaluation fees for contact lenses.

14. This benefit covers collection frames at no cost at participating independent and retail chain providers. Participating retail chain providers typically do not display the frames as “Collection” but are required to maintain a comparable selection of frames that are covered in full. For non-collection frames, the allowable amount is up to $150; however, if (a) the participating provider uses wholesale pricing, then the wholesale allowable amount will be up to $99.06, or if (b) the participating provider uses warehouse pricing, then the warehouse allowable amount will be up to $103.64. Participating providers using wholesale pricing are identified in the provider directory. If frames are selected that are more expensive than the allowable amount established for this benefit, the member is responsible for the difference between the allowable amount and the provider’s charge.

15. Contact lenses are covered in lieu of eyeglasses once per calendar year. See the Definitions section in the Evidence of Coverage for the definitions of Elective Contact Lenses and Non-Elective (Medically Necessary) Contact Lenses. A report from the provider and prior authorization from the Vision Plan Administrator (VPA) is required.

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

17. Preventive Health Services, including an annual preventive care or well-baby care office visit, are not subject to the calendar year medical deductible. Other covered non-preventive services received during, or in connection with, the preventive care or well-baby care office visit are subject to the calendar year medical deductible and applicable member copayment/coinsurance.

18. Specialty Drugs are available from a Network Specialty Pharmacy. A Network Specialty Pharmacy provides Specialty Drugs by mail or upon member request, at an associated retail store for pickup.

19. Participating non-hospital based ("freestanding") outpatient X-ray, laboratory and pathology or radiology center may not be available in all areas. Outpatient x-ray, pathology and laboratory and radiology services may also be obtained from a hospital, an ambulatory surgery center or radiology center that is affiliated with a hospital, and paid according to the hospital services benefits.

20. For plans with a calendar year medical deductible amount, services with a day or visit limit accrue to the calendar year day or visit limit maximum regardless of whether the plan calendar year medical deductible has been met.

21. Blue Shield’s Short-Cycle Specialty Drug Program allows initial prescriptions for select Specialty Drugs to be dispensed for a 15-day trial supply, as further described in the *Evidence of Coverage*. In such circumstances, the applicable Specialty Drugs copayment or coinsurance will be pro-rated.

22. Members can search for dental network providers in the “Find a Provider” section of blueshieldca.com. All pediatric dental benefits are provided by Dental Benefits Providers, Blue Shield’s Dental Plan Administrator. Any calendar year pediatric dental services deductible, copayments and coinsurance for covered dental services accrue to the calendar year out-of-pocket maximum, including any copayments for covered orthodontia services. Charges in excess of benefit maximums and premiums do not accrue to the calendar year out-of-pocket maximum.

23. There are no waiting periods for major & orthodontic services.

24. Posterior composite resin, or acrylic restorations are optional services, and Blue Shield will only pay the amalgam filling rate while the member will be responsible for the difference in cost between the Posterior composite resin and amalgam filling.

25. Medically necessary orthodontia services include an oral evaluation and diagnostic casts. An initial orthodontic examination (a Limited Oral Evaluation) must be conducted which includes completion of the Handicapping Labio-Lingual Deviation (HLD) Score sheet. The HLD Score Sheet is the preliminary measurement tool used in determining if the Member qualifies for medically necessary orthodontic services (see list of qualifying conditions below). Diagnostic casts may be covered only if qualifying conditions are present. Pre-certification for all orthodontia evaluation and services is required.

    Those immediate qualifying conditions are:

    - Cleft lip and or palate deformities
    - Craniofacial Anomalies including the following: Crouzon’s syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, Hemi-facial atrophy, Hemi-facial hypertrophy and other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by our dental consultants.
    - Deep impinging overbite, where the lower incisors are destroying the soft tissue of the palate and tissue laceration and/or clinical attachment loss are present. (Contact only does not constitute deep impinging overbite).
    - Crossbite of individual anterior teeth when clinical attachment loss and recession of the gingival margin are present (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.
    - Severe traumatic deviation must be justified by attaching a description of the condition.
    - 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 HLD Index).

26. For covered Services rendered by non-participating dentists, the member is responsible for all charges above the allowable amount.

27. Members can search for vision care providers in the “Find a Provider” section of blueshieldca.com. All pediatric vision benefits are provided through MESVision, Blue Shield’s Vision Plan Administrator. Any vision services deductibles, copayments and coinsurance for covered vision services accrue to the calendar year out-of-pocket maximum. Charges in excess of benefit maximums and premiums do not accrue to the calendar year out-of-pocket maximum.

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