Effective: January 1, 2018

Important disclosures

for Blue Shield Individual and Family Plans

blue of california

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

Who to contact with questions

Which providers are available to you

What members pay

When coverage can terminate or change

Ways to file a grievance

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

Reproductive health service

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

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

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Enrollment and Renewal

For Coverage Purchased Through Covered California

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

For Coverage Purchased Directly From Blue Shield

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

Enrolling new dependents

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

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

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

Renewal provisions

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

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

What members pay

Prepayment fees

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

Other charges

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

Plan deductible

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

The full amount you pay – up to the allowable amount for that covered service – will count toward your deductible or integrated medical and pharmacy deductible. Once you meet the plan deductible or plan integrated medical and pharmacy deductible, Blue Shield will pay the allowable amount for covered services for the remainder of the calendar year, less the copayment or coinsurance that you pay for the covered service per your plan.

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

Calendar-year out-of-pocket maximum

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

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

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

Termination of benefits

When Coverage Is Purchased through Covered California

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

When Coverage is Purchased Directly from Blue Shield

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

Termination by the member

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

Termination by Blue Shield

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

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

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

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

Other coverage information

No pre-existing condition exclusions

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

Utilization review process

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

Continuity of care by a terminated provider

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

Continuity of Care for New Members by Non-Contracting Providers

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

Member financial responsibility for continuity of care services

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

Ratio of health care services

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

Payment of providers

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

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

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

Mental health, behavioral health, and substance use disorder benefits

Blue Shield has contracted with a specialized health care service plan to act as our mental health service administrator (MHSA). Except for emergency or urgent services, mental health services are delivered to our members through the MHSA's network of participating providers.

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

Reimbursement provisions

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

Prior authorization of selected drugs

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

Pediatric Dental

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

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

If you have any questions regarding the dental information in this booklet, need assistance, or have any problems, you may contact your dental Member Services Department at: **1-888-679-8928**.

GENERAL AND ELIGIBLITY INQUIRY:

In California	1-800-585-8111
Outside California	1-800-323-7201

PROBLEM RESOLUTION AND/OR GRIEVANCES:

In California	1-800-585-8111
Outside California	1-800-323-7201

Before Obtaining Dental Services

You are responsible for assuring that the Dentist you choose is a Participating Dentist. Note: A Participating Dentist's status may change. It is your obligation to verify whether the Dentist you choose is currently a Participating Dentist in case there have been any changes to the list of Participating Dentists. A list of Participating Dentists located in your area, can be obtained by contacting the DPA at 1-888-679-8928. You may also access a list of Participating Dentists through Blue Shield of California's internet site located at http://www.blueshieldca.com. You are also responsible for following the Pre-certification of Dental Benefits Program that includes obtaining or assuring that the Dentist obtains Pre-certification of Benefits.

NOTE: The DPA will respond to all requests for pre-certification and prior authorization within 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 you and the Dentist will know in advance which services are covered and the benefits that are payable.

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 first contact the DPA if possible to describe the emergency and receive referral instructions. If the DPA does not have a contracted Dentist in the area, or if the Member is unable to contact the DPA, 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.

Pediatric Vision

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

Blue Shield's vision plans are administered by the contracted Vision Plan Administrator (VPA). The contracted VPA is a vision care service plan licensed by the California Department of Managed Health Care, which contracts with Blue Shield to administer delivery of eyewear and eye exams covered under this Vision Plan through a network of VPA Participating Providers. The contracted VPA also contracts with Blue Shield to serve as a claims administrator for the processing of claims for services received from non-VPA Participating Providers.

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

A VPA Participating Provider will submit a claim for covered services on-line to the VPA or by claim form. VPA Participating Providers will accept Blue Shield of California's payment for covered services as payment in full except as noted in the Summary of Benefits.

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

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

Principal benefits and coverage

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

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

Blue Shield Trio HMO plan specifics

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

Choice of Physicians and Providers

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

An HMO offers Members a choice of providers within a contracted network of Physicians, Hospitals, and Non-Physician Health Care Practitioners. Each Member will select a Primary Care Physician from the Blue Shield Trio HMO Plan Directory of general practitioners, family practitioners, internists, obstetricians, gynecologists, and pediatricians. Members within the same family may select a different Primary Care Physician.

All Covered Services must be provided by or arranged through the Member's Primary Care Physician, except for the following:

1. Services received during an Trio+ Specialist visit,

2. OB/GYN Services provided by an obstetrician/gynecologist or a family practice Physician within the same Medical Group/IPA as the Primary Care Physician,

3. Emergency Services,

4. Urgent Services outside the Primary Care Physician's Service Area,

5. Mental Health Services, Behavioral Health Treatment, and Substance Use Disorder Services.*

* Mental Health Services, Behavioral Health Treatment, and Substance Use Disorder Services must be arranged and provided through the Mental Health Services Administrator (MHSA). See the Mental Health, Behavioral Health, and Substance Use Disorder Services paragraphs later in this section.

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

For Urgent Services, as soon as possible to accommodate the Member's condition not to exceed 72 hours from receipt of the request;

For other services, within 5 business days from receipt of the request. The treating provider will be notified of the decision within 24 hours followed by written notice to the provider and Member within 2 business days of the decision.

HMO Plans with ACO Network

Trio HMO plans offer a limited selection of IPAs and Medical Groups to Members from which to choose. The IPAs and Medical Groups in Trio participate in Accountable Care Organization (ACO) collaborations with Blue Shield.

It is important for Members to review the list of providers within the Trio HMO Physician and Hospital Directory before enrolling in this health plan. In many areas, there may only be one (1) IPA or Medical Group from which to select a Primary Care Physician or to receive Covered Services.

Referral to Specialty Services

When the Primary Care Physician determines that specialty services are Medically Necessary, he or she will initiate a referral to a designated Plan Provider and request necessary authorization. The Primary Care Physician will generally refer the Member to a Specialist or other health care provider within the same Medical Group/IPA. The Specialist or other health care provider will send a report to the Primary Care Physician.

In the event no Plan Provider is available to perform the needed services, the Primary Care Physician will refer the Member to a non-Plan Provider after obtaining authorization.

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

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

If the second opinion involves care provided by the Member's Primary Care Physician, the second opinion will be provided by a Physician within the same Medical Group/IPA. If the second opinion involves care received from a Specialist, the second opinion may be provided by any Blue Shield Specialist of the same or equivalent specialty. All second opinion consultations must be authorized by the Medical Group/IPA.

Trio+ Specialist

Through Trio+ Specialist, a Member may arrange an office visit with a Plan Specialist in the same Medical Group or IPA as the Primary Care Physician without a referral from the Primary Care Physician. This Benefit is subject to the limitations described in the EOC. The Applicable Copayment and Coinsurance amounts for Trio+ Specialist visits are indicated in the Summary of Benefits, which is included as part of this Disclosure Form.

Liability of Subscriber for Payment

For most Covered Services, a Member pays a Copayment at the time of service. Some Covered Services are covered at no cost-share to the Member.

The Member's Primary Care Physician will either provide or arrange for the provision of Covered Services, with the exception of Emergency Services or Urgent Care Services when the Member is out of the Service Area. The Member's Primary Care Physician will also manage obtaining prior authorization for services, when needed.

The Member is responsible for payment for any services that are not covered, or not authorized or rendered by Plan Providers (except for Emergency Services or Urgent Care Services) when the Member is out of the Service Area).

Reimbursement Provisions

Except as identified, Members do not need to submit claim forms. Members pay a Copayment or Coinsurance at the time services are received. Coinsurance is calculated based on the negotiated rate with the Plan Provider. Some services are covered at no charge to the Member.

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

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

*BlueCard is a network of Blue Shield Participating Providers available to a Member while temporarily traveling outside of the Service Area. If a Member utilizes a BlueCard provider, they are responsible for applicable Copayment and Coinsurance amounts, as indicated on the Summary of Benefits, which is included as part of this Disclosure Form; no claim form is required. Complete information on the BlueCard program is contained in the EOC.

Facilities

The Blue Shield Trio HMO plan has a network of Physicians, Hospitals, Participating Hospice Agencies, and Non-Physician Health Care Practitioners in the Member's Primary Care Physician Service Area. The specific network associated with the Trio HMO plan is identified in the health plan Summary of Benefits and EOC.

Contact Customer Service for information on

non-Physician Health Care Practitioners in your Primary Care Physician Service Area.

The directory of Plan Providers for the Trio HMO plan can be located on Blue Shield's Web site http://www.blueshieldca.com/FAP or by calling the Customer Service Department.

Services for Emergency Care

Benefits will be provided for Emergency Services received anywhere in the world.

1. A Member who reasonably believes that he or she has an emergency medical condition or mental health condition that requires an emergency response is encouraged to appropriately use the "911" emergency response system (where available) or seek immediate care from the nearest Hospital.

2. A Member should notify their Primary Care Physician within 24 hours of receiving Emergency Services or as soon as reasonably possible following medical stabilization. The services will be reviewed retrospectively by Blue Shield to determine whether the services were for a medical condition for which a reasonable person would have believed that she or he had an emergency medical condition.

3. For Medically Necessary emergency care, the member is only responsible for the applicable Deductible, Copayment or coinsurance as shown in the Summary of Benefits, and is not responsible for any Allowed Charges Blue Shield is obligated to pay.

4. If the Member did not have a medical condition for which a reasonable person would have believed that he or she had an emergency, services will not be covered.

5. For Urgent care within the Primary Care Physician Service Area, a Member should call his or her Primary Care Physician.

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 health plan.

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

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

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

TRIO HMO SERVICE AREA CHART

The Trio HMO Service Area consists of only the counties, and Zip Codes listed within those counties, on the chart below. Note: the Trio HMO Service Area may change. To verify Service Area information, you can access Blue Shield's Internet site at http://www.blueshieldca.com or call Shield Concierge at the telephone number provided at the back of this booklet.

Alameda County (only those Zip Codes shown here)		
94501	94579	94622
94502	94580	94623
94505	94586	94624
94514	94587	94649
94536	94588	94659
94537	94601	94660
94538	94602	94661
94539	94603	94662
94540	94604	94666
94541	94605	94701
94542	94606	94702
94543	94607	94703
94544	94608	94704
94545	94609	94705
94546	94610	94706
94550	94611	94707
94551	94612	94708
94552	94613	94709
94555	94614	94710
94557	94615	94712
94560	94617	94720
94566	94618	95377
94568	94619	95391
94577	94620	---
94578	94621	---
Contra Costa County (only those Zip Codes shown here)		
94505	94514	94521
94506	94516	94522
94507	94517	94523
94509	94518	94524
94511	94519	94525
94513	94520	94526

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Contra Costa County (only those Zip Codes shown here) *continued*		
94527	94564	94707
94528	94565	94708
94529	94569	94801
94530	94570	94802
94531	94572	94803
94547	94575	94804
94548	94582	94805
94549	94583	94806
94551	94595	94807
94553	94596	94808
94556	94597	94820
94561	94598	94850
94563	94706	---
El Dorado County (only those Zip Codes shown here)		
95664	95682	---
95672	95762	---
Kern County (only those Zip Codes shown here)		
93203	93255	93307
93205	93263	93308
93206	93268	93309
93215	93276	93311
93216	93280	93312
93220	93283	93313
93224	93285	93314
93225	93287	93380
93226	93301	93383
93240	93302	93384
93241	93303	93385
93250	93304	93386
93251	93305	93387
93252	93306	93388

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Kern County (only those Zip Codes shown here) *continued*		
93389	93504	93531
93390	93505	93560
93501	93516	93561
93502	93518	93596
Los Angeles County (only those Zip Codes shown here)		
90001	90029	90057
90002	90030	90058
90003	90031	90059
90004	90032	90060
90005	90033	90061
90006	90034	90062
90007	90035	90063
90008	90036	90064
90009	90037	90065
90010	90038	90066
90011	90039	90067
90012	90040	90068
90013	90041	90069
90014	90042	90070
90015	90043	90071
90016	90044	90072
90017	90045	90073
90018	90046	90074
90019	90047	90075
90020	90048	90076
90021	90049	90077
90022	90050	90078
90023	90051	90079
90024	90052	90080
90025	90053	90081
90026	90054	90082
90027	90055	90083
90028	90056	90084

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Los Angeles County (only those Zip Codes shown here) *continued*		
90086	90248	90307
90087	90249	90308
90088	90250	90309
90089	90251	90310
90090	90254	90311
90091	90255	90312
90093	90260	90401
90094	90261	90402
90095	90262	90403
90096	90263	90404
90099	90264	90405
90189	90265	90406
90201	90266	90407
90202	90267	90408
90209	90270	90409
90210	90272	90410
90211	90274	90411
90212	90275	90501
90213	90277	90502
90220	90278	90503
90221	90280	90504
90222	90290	90505
90223	90291	90506
90224	90292	90507
90230	90293	90508
90231	90294	90509
90232	90295	90510
90233	90296	90601
90239	90301	90602
90240	90302	90603
90241	90303	90604
90242	90304	90605
90245	90305	90606
90247	90306	90607

TRIO HMO SERVICE AREA CHART

The Trio HMO Service Area consists of only the counties, and Zip Codes listed within those counties, on the chart below. Note: the Trio HMO Service Area may change. To verify Service Area information, you can access Blue Shield's Internet site at http://www.blueshieldca.com or call Shield Concierge at the telephone number provided at the back of this booklet.

Los Angeles County (only those Zip Codes shown here) *continued*		
90608	90745	91001
90609	90746	91003
90610	90747	91006
90637	90748	91007
90638	90749	91008
90639	90755	91009
90640	90801	91010
90650	90802	91011
90651	90803	91012
90652	90804	91016
90660	90805	91017
90661	90806	91020
90662	90807	91021
90670	90808	91023
90671	90809	91024
90701	90810	91025
90702	90813	91030
90703	90814	91031
90706	90815	91040
90707	90822	91041
90710	90831	91042
90711	90832	91043
90712	90833	91046
90713	90834	91066
90714	90835	91077
90715	90840	91101
90716	90842	91102
90717	90844	91103
90723	90846	91104
90731	90847	91105
90732	90848	91106
90733	90853	91107
90734	90895	91108
90744	90899	91109

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Los Angeles County (only those Zip Codes shown here) *continued*		
91110	91301	91350
91114	91302	91351
91115	91303	91352
91116	91304	91353
91117	91305	91354
91118	91306	91355
91121	91307	91356
91123	91308	91357
91124	91309	91364
91125	91310	91365
91126	91311	91367
91129	91313	91371
91182	91316	91372
91184	91321	91376
91185	91322	91380
91188	91324	91381
91189	91325	91382
91199	91326	91383
91201	91327	91384
91202	91328	91385
91203	91329	91386
91204	91330	91387
91205	91331	91390
91206	91333	91392
91207	91334	91393
91208	91335	91394
91209	91337	91395
91210	91340	91396
91214	91341	91401
91221	91342	91402
91222	91343	91403
91224	91344	91404
91225	91345	91405
91226	91346	91406

TRIO HMO SERVICE AREA CHART

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Los Angeles County **(only those Zip Codes shown here)** *continued*		
91407	91605	91748
91408	91606	91749
91409	91607	91750
91410	91608	91754
91411	91609	91755
91412	91610	91756
91413	91611	91765
91416	91612	91766
91423	91614	91767
91426	91615	91768
91436	91616	91769
91470	91617	91770
91482	91618	91771
91495	91702	91772
91496	91706	91773
91499	91711	91775
91501	91714	91776
91502	91715	91778
91503	91716	91780
91504	91722	91788
91505	91723	91789
91506	91724	91790
91507	91731	91791
91508	91732	91792
91510	91733	91793
91521	91734	91801
91522	91735	91802
91523	91740	91803
91526	91741	91804
91601	91744	91896
91602	91745	91899
91603	91746	93510
91604	91747	93563

TRIO HMO SERVICE AREA CHART

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Marin County (only those Zip Codes shown here)		
94901	94939	94964
94903	94940	94965
94904	94941	94966
94912	94942	94970
94913	94945	94971
94914	94946	94973
94915	94947	94974
94920	94948	94976
94924	94949	94977
94925	94950	94978
94930	94956	94979
94933	94957	94998
94937	94960	---
94938	94963	---
Nevada County (only those Zip Codes shown here)		
95712	95946	95960
95924	95949	95975
95945	95959	95986
Orange County (only those Zip Codes shown here)		
90620	90742	92617
90621	90743	92618
90622	92602	92619
90623	92603	92620
90624	92604	92623
90630	92605	92624
90631	92606	92625
90632	92607	92626
90633	92609	92627
90638	92610	92628
90680	92612	92629
90720	92614	92630
90721	92615	92637
90740	92616	92646

TRIO HMO SERVICE AREA CHART

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Orange County **(only those Zip Codes shown here)** *continued*		
92647	92697	92822
92648	92698	92823
92649	92701	92825
92650	92702	92831
92651	92703	92832
92652	92704	92833
92653	92705	92834
92654	92706	92835
92655	92707	92836
92656	92708	92837
92657	92711	92838
92658	92712	92840
92659	92728	92841
92660	92735	92842
92661	92780	92843
92662	92781	92844
92663	92782	92845
92672	92799	92846
92673	92801	92850
92674	92802	92856
92675	92803	92857
92676	92804	92859
92677	92805	92861
92678	92806	92862
92679	92807	92863
92683	92808	92864
92684	92809	92865
92685	92811	92866
92688	92812	92867
92690	92814	92868
92691	92815	92869
92692	92816	92870
92693	92817	92871
92694	92821	92885

TRIO HMO SERVICE AREA CHART

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Orange County (only those Zip Codes shown here) *continued*		
92886	92887	92899
Placer County (only those Zip Codes shown here)		
95602	95658	95746
95603	95661	95747
95604	95663	95765
95648	95677	---
95650	95678	---
Riverside County (only those Zip Codes shown here)		
91752	92530	92582
92220	92531	92583
92223	92532	92584
92230	92543	92585
92320	92544	92586
92501	92545	92587
92502	92546	92589
92503	92548	92590
92504	92551	92591
92505	92552	92592
92506	92553	92593
92507	92554	92595
92508	92555	92596
92509	92556	92599
92513	92557	92860
92514	92562	92877
92515	92563	92878
92516	92564	92879
92517	92567	92880
92518	92570	92881
92519	92571	92882
92521	92572	92883
92522	92581	---

TRIO HMO SERVICE AREA CHART

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Sacramento County (only those Zip Codes shown here)		
94203	94271	95638
94204	94273	95639
94205	94274	95652
94206	94277	95655
94207	94278	95660
94208	94279	95662
94209	94280	95670
94211	94282	95671
94229	94283	95673
94230	94284	95683
94232	94285	95693
94234	94286	95741
94235	94287	95742
94236	94288	95757
94237	94289	95758
94239	94290	95759
94240	94291	95763
94244	94293	95811
94245	94294	95812
94247	94295	95813
94248	94296	95814
94249	94297	95815
94250	94298	95816
94252	94299	95817
94254	95608	95818
94256	95609	95819
94257	95610	95820
94258	95611	95821
94259	95615	95822
94261	95621	95823
94262	95624	95824
94263	95626	95825
94267	95628	95826
94268	95630	95827
94269	95632	95828

TRIO HMO SERVICE AREA CHART

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Sacramento County (only those Zip Codes shown here) *continued*		
95829	95837	95853
95830	95838	95860
95831	95840	95864
95832	95841	95865
95833	95842	95866
95834	95843	95867
95835	95851	95894
95836	95852	95899
San Bernardino County (only those Zip Codes shown here)		
91701	92315	92354
91708	92316	92356
91709	92317	92357
91710	92318	92358
91729	92321	92359
91730	92322	92368
91737	92324	92369
91739	92325	92371
91743	92329	92372
91758	92331	92373
91759	92333	92374
91761	92334	92375
91762	92335	92376
91763	92336	92377
91764	92337	92378
91784	92339	92382
91785	92340	92385
91786	92341	92386
92301	92342	92391
92305	92344	92392
92307	92345	92393
92308	92346	92394
92313	92350	92395
92314	92352	92397

TRIO HMO SERVICE AREA CHART

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San Bernardino County (only those Zip Codes shown here) *continued*		
92399	92406	92415
92401	92407	92418
92402	92408	92423
92403	92410	92427
92404	92411	---
92405	92413	---
San Diego County (only those Zip Codes shown here)		
91901	91948	92025
91902	91950	92026
91903	91951	92027
91905	91962	92028
91906	91963	92029
91908	91976	92030
91909	91977	92033
91910	91978	92036
91911	91979	92037
91912	91980	92038
91913	91987	92039
91914	92003	92040
91915	92007	92046
91916	92008	92049
91917	92009	92051
91921	92010	92052
91931	92011	92054
91932	92013	92055
91933	92014	92056
91935	92018	92057
91941	92019	92058
91942	92020	92059
91943	92021	92060
91944	92022	92061
91945	92023	92064
91946	92024	92065

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San Diego County (only those Zip Codes shown here) *continued*		
92067	92115	92155
92068	92116	92158
92069	92117	92159
92071	92118	92160
92072	92119	92161
92074	92120	92163
92075	92121	92165
92078	92122	92166
92079	92123	92167
92081	92124	92168
92082	92126	92169
92083	92127	92170
92084	92128	92171
92085	92129	92172
92088	92130	92173
92091	92131	92174
92092	92132	92175
92093	92134	92176
92096	92135	92177
92101	92136	92178
92102	92137	92179
92103	92138	92182
92104	92139	92186
92105	92140	92187
92106	92142	92190
92107	92143	92191
92108	92145	92192
92109	92147	92193
92110	92149	92195
92111	92150	92196
92112	92152	92197
92113	92153	92198
92114	92154	92199

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San Francisco County (only those Zip Codes shown here)		
94102	94121	94141
94103	94122	94142
94104	94123	94143
94105	94124	94144
94107	94125	94145
94108	94126	94146
94109	94127	94147
94110	94128	94151
94111	94129	94158
94112	94130	94159
94114	94131	94160
94115	94132	94161
94116	94133	94163
94117	94134	94164
94118	94137	94172
94119	94139	94177
94120	94140	94188
San Joaquin County (only those Zip Codes shown here)		
94514	95219	95297
95201	95220	95304
95202	95227	95320
95203	95230	95330
95204	95231	95336
95205	95234	95337
95206	95236	95361
95207	95237	95366
95208	95240	95376
95209	95241	95377
95210	95242	95378
95211	95253	95385
95212	95258	95391
95213	95267	95632
95214	95269	95686
95215	95296	95690

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San Luis Obispo County (only those Zip Codes shown here)		
93401	93422	93445
93402	93423	93446
93403	93424	93447
93405	93426	93448
93406	93428	93449
93407	93430	93451
93408	93432	93453
93409	93433	93461
93410	93435	93465
93412	93442	93475
93420	93443	93483
93421	93444	---
San Mateo County (only those Zip Codes shown here)		
94002	94026	94066
94005	94027	94070
94010	94028	94074
94011	94030	94080
94014	94037	94083
94015	94038	94128
94016	94044	94303
94017	94060	94401
94018	94061	94402
94019	94062	94403
94020	94063	94404
94021	94064	94497
94025	94065	---
Santa Clara County (only those Zip Codes shown here)		
94022	94041	94088
94023	94042	94089
94024	94043	94301
94035	94085	94302
94039	94086	94303
94040	94087	94304

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Santa Clara County (only those Zip Codes shown here) *continued*		
94305	95056	95134
94306	95070	95135
94309	95071	95136
94550	95076	95138
95002	95101	95139
95008	95103	95140
95009	95106	95141
95011	95108	95148
95013	95109	95150
95014	95110	95151
95015	95111	95152
95020	95112	95153
95021	95113	95154
95023	95115	95155
95026	95116	95156
95030	95117	95157
95031	95118	95158
95032	95119	95159
95033	95120	95160
95035	95121	95161
95036	95122	95164
95037	95123	95170
95038	95124	95172
95042	95125	95173
95044	95126	95190
95046	95127	95191
95050	95128	95192
95051	95129	95193
95052	95130	95194
95053	95131	95196
95054	95132	---
95055	95133	---

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Santa Cruz County (only those Zip Codes shown here)		
95001	95019	95065
95003	95033	95066
95005	95041	95067
95006	95060	95073
95007	95061	95076
95010	95062	95077
95017	95063	---
95018	95064	---
Solano County (only those Zip Codes shown here)		
94503	94589	95620
94510	94592	---
Stanislaus County (only those Zip Codes shown here)		
95307	95351	95363
95313	95352	95367
95316	95353	95368
95319	95354	95380
95323	95355	95381
95326	95356	95382
95328	95357	95386
95329	95358	95387
95350	95361	95397
Tulare County (only those Zip Codes shown here)		
93219	93256	93260
Ventura County (only those Zip Codes shown here)		
91319	91377	93007
91320	93001	93009
91358	93002	93010
91359	93003	93011
91360	93004	93012
91361	93005	93015
91362	93006	93016

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Ventura County (only those Zip Codes shown here) *continued*		
93020	93034	93061
93021	93035	93062
93022	93036	93063
93023	93040	93064
93024	93041	93065
93030	93042	93066
93031	93043	93094
93032	93044	93099
93033	93060	---
Yolo County (only those Zip Codes shown here)		
95605	95627	95697
95606	95637	95698
95607	95645	95776
95612	95653	95798
95616	95691	95799
95617	95694	95937
95618	95695	---

- Subscribers must reside in the Plan Service Area to enroll in this Plan and to maintain eligibility for coverage in this Plan.

Blue Shield PPO plans

This information applies only to Blue Shield PPO plans.

Choice of Physicians and Providers

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

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

Blue Shield provider network, including facilities

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

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

Participating providers

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

Reimbursement provisions

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

Non-participating providers

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

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

Reimbursement® provisions

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

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

Obtaining emergency services worldwide

With all Blue Shield plans, emergency services are covered anywhere in the world. An emergency is defined as an unexpected medical condition, including a psychiatric emergency medical condition, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

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

For Emergency Services from either a Participating or Non-Participating Provider, the Member is only responsible for the applicable Deductible or integrated medical and pharmacy deductible, Copayment or Coinsurance as shown in the Summary of Benefits, and is not responsible for any Allowable Amount Blue Shield is obligated to pay.

Obtaining urgent care away from home – the BlueCard Program

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

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

General exclusions and limitations on benefits

For all Blue Shield health plans for individuals and families No Benefits are provided for the following:

1. Routine physical examinations, 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. For hospitalization primarily for X-ray, laboratory or any other outpatient diagnostic studies or for medical observation;
3. Routine foot care items and services that are not Medically Necessary, including callus, corn paring or excision and toenail trimming except as may be provided through a Participating Hospice Agency; treatment (other than surgery) of chronic conditions of the foot, e.g., weak or fallen arches; flat or pronated foot; pain or cramp of the foot; for special footwear required for foot disfigurement (e.g., non-custom made or over-the-counter shoe inserts or arch supports), except as specifically listed under Orthotics Benefits and Diabetes Care Benefits; bunions; or muscle trauma due to exertion; or any type of massage procedure on the foot;
4. Services for or incident to hospitalization or confinement in a pain management center to treat or cure chronic pain, except as may be provided through a Participating Hospice Agency or through a palliative care program offered by Blue Shield;
5. Home services, hospitalization or confinement in a health facility primarily for rest, Custodial, Maintenance, or Domiciliary Care, except as provided under Hospice Program Benefits (see Hospice Program Benefits for exception);
6. Services in connection with private duty nursing, except as provided under Home Health Care Benefits, Home Infusion/Home Injectable Therapy Benefits, and except as provided through a Participating Hospice Agency;
7. Prescription and non-prescription food and nutritional supplements, except as provided under Home Infusion/Home Injectable Therapy Benefits, PKU-Related Formulas and Special Food Products Benefits, or as provided through a Participating Hospice Agency;

8. Hearing aids;

9. Eye exams and refractions, lenses and frames for eyeglasses, lens options and treatments and contact lenses for Members 19 years of age and over, and video-assisted visual aids or video magnification equipment for any purpose;

10. Surgery to correct refractive error (such as but not limited to radial keratotomy, refractive keratoplasty);

11. Any type of communicator, voice enhancer, voice prosthesis, electronic voice producing machine, or any other language assistive devices, except as specifically listed under Prosthetic Appliances Benefits;

12. For dental care or services incident to the treatment, prevention, or relief of pain or dysfunction of the Temporomandibular Joint and/or muscles of mastication, except as specifically provided under the Medical Treatment of the Teeth, Gums, Jaw Joints or Jaw Bones Benefits and Hospital Benefits (Facility Services);

13. For or incident to services and supplies for treatment of the teeth and gums of Members 19 years and older (except for tumors, preparation of the Member's jaw for radiation therapy to treat cancer in the head or neck, and dental and orthodontic services that are an integral part of Reconstructive Surgery for cleft palate procedures) and associated periodontal structures, including but not limited to diagnostic, preventive, orthodontic and other services such as dental cleaning, tooth whitening, X-rays, imaging, laboratory services, topical fluoride treatment except when used with radiation therapy to the oral cavity, fillings, and root canal treatment; treatment of periodontal disease or periodontal surgery for inflammatory conditions; tooth extraction; dental implants, braces, crowns, dental orthoses and prostheses; except as specifically provided under Medical Treatment of the Teeth, Gums, Jaw Joints or Jaw Bones Benefits, Pediatric Dental Benefits, and Hospital Benefits (Facility Services);

14. For Cosmetic Surgery except for Medically Necessary treatment of resulting complications (e.g., infections or hemorrhages).

15. For Reconstructive Surgery where there is another more appropriate covered surgical procedure or when the proposed reconstructive surgery offers only a minimal improvement in the appearance of the Member. This exclusion shall not apply to breast reconstruction when performed subsequent to a mastectomy, including surgery on either breast to achieve or restore symmetry;

16. For sexual dysfunctions and sexual inadequacies, except as provided for treatment of organically based conditions;

17. For or incident to the treatment of Infertility, including the cause of Infertility, or any form of assisted reproductive technology, including but not limited to reversal of surgical sterilization, or any resulting complications, except for Medically Necessary treatment of medical complications;

18. Any services related to assisted reproductive technology, including but not limited to the harvesting or stimulation of the human ovum, in vitro fertilization, Gamete Intrafallopian Transfer (GIFT) procedure, artificial insemination (including related medications, laboratory, and radiology services), services or medications to treat low sperm count, or services incident to or resulting from procedures for a surrogate mother who is otherwise not eligible for covered Pregnancy and Maternity Care under a Blue Shield health plan;

19. Services incident to bariatric surgery services, except as specifically provided under Bariatric Surgery Benefits;

20. Home testing devices and monitoring equipment except as specifically provided in the Durable Medical Equipment Benefits;

21. Genetic testing except as described in the sections on Outpatient X-ray, Imaging, Pathology and Laboratory Benefits and the Pregnancy and Maternity Care Benefits;

22. Preventive Health benefits by Non-Participating Providers;

23. Services performed in a Hospital by house officers, residents, interns, and 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 Member who ordinarily resides in the Member's home;

25. Services provided by an individual or entity that is not appropriately licensed or certified by the state to provide 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; or 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. For non-prescription (over-the-counter) medical equipment or supplies such as oxygen saturation monitors, prophylactic knee braces and bath chairs that can be purchased without a licensed provider's prescription order, even if a licensed provider writes a prescription order for a non-prescription item, except as specifically provided under Preventive Health Benefits, Home Health Care Benefits, Home Infusion/Home Injectable Therapy Benefits, Hospice Program Benefits, Diabetes Care Benefits, Durable Medical Equipment Benefits, and Prosthetic Appliances Benefits;

32. Patient convenience items such as telephone, television, guest trays, and personal hygiene items;

33. For disposable supplies for home use, such as bandages, gauze, tape, antiseptics, dressings, Ace-type bandages, and diapers, underpads and other incontinence supplies, except as specifically provided under the Durable Medical Equipment Benefits, Home HealthCare, 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 (Physician) Benefits (other than for Mental Health, Behavioral Health, and Substance Use Disorder Benefits) in the Plan Benefits section;

37. for transportation services other than provided under Ambulance Benefits in the Plan Benefits section;

38. for inpatient and Other Outpatient Mental Health Services and Behavioral Health Treatment, and Outpatient Substance Use Disorder Services unless authorized by the MHSA;

39. Drugs dispensed by a Physician or Physician's office for outpatient use; and

40. Services not specifically listed as a benefit. 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.

Also excluded from Trio HMO plans

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

1. for services, including Hospice services rendered by a Participating Hospice Agency, not provided, prescribed, referred, or authorized as described herein except for Trio+ Specialist visits, OB/GYN services provided by an obstetrician/gynecologist or family practice Physician within the same Medical Group/IPA as the Primary Care Physician, Emergency Services or Urgent Services as provided under Emergency Room Benefits and Urgent Services Benefits in the Plan Benefits section; and

General exclusions and limitations for outpatient prescription drug coverage

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

1. Any drug the Member receives while an Inpatient, in a Physician's office, Skilled Nursing Facility or Outpatient Facility. See the Professional (Physician) Benefits and Hospital Benefits (Facility Services) sections of the EOC/Policy;

2. Take home drugs received from a Hospital, Skilled Nursing Facility, or similar facilities See the Hospital Benefits and Skilled Nursing Facility Benefits sections of the EOC/Policy;

3. Unless listed as covered under this Outpatient Prescription Drug Benefit, Drugs that are available without a prescription (OTC), including Drugs for which there is an OTC drug that has the same active ingredient and dosage as the prescription drug;

4. Drugs not listed on the Formulary. These Drugs may be covered if Medically Necessary and prior authorization is obtained from Blue Shield. See the Prior Authorization/Exception Request Process section of this Evidence of Coverage.

5. Drugs for which the Member is not legally obligated to pay, or for which no charge is made;

6. Drugs that are considered to be experimental or investigational;

7. Medical devices or supplies except as listed as covered herein. See the Prosthetic Appliances Benefits, Durable Medical Equipment Benefits, and the Orthotics Benefits sections of your EOC/Policy. This exclusion also applies to prescription

preparations applied to the skin that are approved by the FDA as medical devices;

8. Blood or blood products See the Hospital Benefits (Facility Services) section of the EOC/Policy;

9. Drugs when prescribed for cosmetic purposes. This includes but is not limited to drugs used to slow or reverse the effects of skin aging or to treat hair loss;

10. Medical food, dietary or nutritional products. See the Home Health Care section, Home Infusion/Home Injectable Therapy section and PKU Related Formulas and Special Food Product section of the EOC/Policy;

11. Any Drugs which are not considered to be safe for self-administration. These medications may be covered under the Home Health Care Benefits, Home Infusion/Home Injectable Therapy Benefits, the Hospice Program Benefits and Family Planning Benefits sections of the EOC/Policy;

12. All Drugs for the treatment of infertility;

13. Appetite suppressants or drugs for body weight reduction. These drugs may be covered if Medically Necessary for the treatment of morbid obesity. In these cases prior authorization by Blue Shield is required;

14. Contraceptive drugs or devices which do not meet all of the following requirements: (1) are FDA-approved, (2) are ordered by a Physician or Health Care Provider, (3) are generally purchased at an outpatient pharmacy and, (4) are self-administered;

15. Compounded medications which do not meet all the following requirements (1) the compounded medications(s) includes at least one Drug, (2) there are no FDA-approved, commercially available medically appropriate alternative(s), (3) the compounded medication(s) is self-administered, and (4) medical literature supports its use for the requested diagnosis;

16. Replacement of lost, stolen or destroyed Drugs;

17. If the Member is enrolled in a Hospice Program through a Participating Hospice Agency, Drugs that are Medically Necessary for the palliation and management of terminal illness and related conditions. These Drugs are excluded from coverage under Outpatient Prescription Drug Benefits and are covered under the Hospice Program Benefits section of the Evidence of Coverage;

18. Drugs prescribed for treatment of dental conditions. This exclusion shall not apply to (1) antibiotics prescribed to treat infection, (2) Drugs prescribed to treat pain, or (3) Drug treatment related to surgical procedures for conditions affecting the upper/lower jawbone or associated bone joints;

19. Except for a covered emergency, Drugs obtained from a Pharmacy not licensed by the State Board of Pharmacy or included on a government exclusion list;

20. Immunizations and vaccinations solely for the purpose of travel;

21. Drugs packaged in convenience kits that include non-prescription convenience items, unless the Drug is not otherwise available without the non-prescription convenience items. This exclusion shall not apply to items used for the administration of diabetes or asthma Drugs; and

22. Repackaged prescription drugs (drugs that are repackaged by an entity other than the original manufacturer).

Also excluded from Trio HMO Outpatient Prescription Drug coverage

Blue Shield does not provide coverage in the HMO Outpatient Prescription Drug Benefit for the following item. The Member may receive coverage for certain services excluded below under other Benefits. Refer to the General Exclusions and Limitations for Outpatient Prescription Drug Coverage above and to the applicable section(s) of this Evidence of Coverage and Health Service Agreement to determine if the Plan covers Drugs under that Benefit.

1. Drugs obtained from a Non-Participating Pharmacy. This exclusion does not apply to Drugs obtained for a covered emergency. Nor does it apply to Drugs obtained for an

urgently needed service for which a Participating Pharmacy was not reasonably accessible.

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

Specific Exclusions & Limitations to the Pediatric Dental Plan

1. Dental services in excess of the limits specified in the Limitations section of the EOC;
2. Dental services that are received in an emergency care setting for conditions that are not emergencies if the Member reasonably should have known that an emergency care situation did not exist;
3. Hospital charges of any kind;
4. Loss of theft of dentures or bridgework;
5. Surgical removal of implants;
6. Services of a pedodontist/pediatric Dentist for a Member except when a Member child is unable to be treated by his or her Dental Provider or treatment is Dentally Necessary or his or her Dental Provider is a pedodontist/pediatric Dentist;
7. Non-medically necessary orthodontia is not a covered benefit;
8. Treatment for a malocclusion that is not causing difficulty in chewing, speech, or overall dental functioning;
9. Treatment in progress (after banding) at inception of eligibility;
10. Surgical orthodontics (including extraction of teeth) incidental to orthodontic treatment;
11. Myofunctional therapy;
12. Changes in treatment necessitated by an accident;
13. Treatment for TMJ (temporomandibular joint) disorder or dysfunction;
14. Special orthodontic appliances, including, but not limited to, Invisalign, lingual, or invisible braces, sapphire or clear braces, or ceramic braces which are considered to be cosmetic;
15. Replacement of lost or stolen appliance or repair of same if broken through no fault of orthodontist;
16. Reimbursement for any services after the 24 months of treatment for which a claim has not been submitted; and
17. In the event of a member's loss of coverage for any reason, if at the time of loss of coverage the member is still receiving orthodontic treatment during the 24-month treatment period, the member and not the dental plan administrator will be responsible for the remainder of the cost for that treatment, at the participating orthodontist's billed charges, prorated for the number of months remaining.

Specific Limitations:

1. Restorations are limited as follows:
   a) Amalgam, composite resin, acrylic, synthetic or plastic restorations for treatment of caries. If the tooth can be restored with such materials, any other restoration such as a crown or jacket is considered optional;
   b) Composite resin or acrylic restorations in posterior teeth are optional services and if rendered, will be paid at the equivalent amalgam restoration fee;
   c) Micro filled resin restorations which are non-cosmetic; and

d) Replacement of a restoration is covered only when it is defective, as evidenced by conditions such as recurrent caries or fracture, and replacement is Dentally Necessary.

2. Oral Surgery is limited as follows:

   a) Surgical removal of impacted teeth is a Covered Service only when evidence of pathology exists.

3. Endodontics: Retreatment of root canals is a Covered Service only if clinical or radiographic signs of abscess formation are present, and/or the patient is experiencing symptoms. Removal or retreatment of silver points, overfills, underfills, incomplete fills, or broken instruments lodged in a canal, in the absence of pathology is not a Covered Service;

4. Periodontics: Periodontal scaling and root planing and subgingival curettage is limited to five quadrant treatments in any 12 consecutive months;

5. Crowns and Fixed Bridges. Five units of crown or bridgework per arch. Upon the sixth unit, the treatment is considered full mouth reconstruction.

   a) Crowns, including those made of acrylic, acrylic with metal, porcelain, porcelain with metal, full metal, gold onlay or three-quarter crown, and stainless steel. Related dowel pins and pin build-up are also included. Crowns are limited as follows:

      i. Replacement of each unit is limited to once every 36 consecutive months, except when the crown is no longer functional as determined by the Dental Plan Administrator;

      ii. Only acrylic crowns and stainless steel crowns are a benefit for children under 12 years of age. If other types of crowns are chosen as an optional benefit for children under 12 years of age, the covered dental benefit level will be that of an acrylic crown;

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

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

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

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

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

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

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

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

6. Removable Prosthetics.

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

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

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

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

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

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

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

c. Tissue conditioning is limited to two per denture;

d. Implants are considered an optional service; and

e. Stayplates are a Covered Service only when used as anterior space maintainers for children.

Orthodontic Limitations & Exclusions for the Pediatric Dental Plan

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

Those immediate qualifying conditions are:

1. Cleft lip and/or palate deformities.
2. Craniofacial Anomalies including the following: Crouzon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, Hemi-facial atrophy, Hem-facial hypertrophy and other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by our dental consultants.
3. Deep impinging overbite, where the lower incisors are destroying the soft tissue of the palate and tissue laceration and/or clinical attachment loss are present. (Contact only does not constitute deep impinging overbite).
4. Crossbite of individual anterior teeth when clinical attachment loss and recession of the gingival margin are present (e.g., stripping of the labial gingival tissue on the lower incisors). Treatment of 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

General exclusions and limitations for Blue Shield pediatric vision plans

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

Blue Shield dental plans

Dental Plan Information

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

- Dental PPO, Dental HMO, and Specialty Duo Dental Plan benefits are not subject to the deductible or integrated medical and pharmacy deductible requirements of the health plan and do not accumulate toward the maximum calendar-year copayment/coinsurance maximum of the health plan.
- Dental benefits for the Dental PPO and Dental HMO will be administered by Blue Shield's DPA.
- If your dental coverage is cancelled for any reason by you or by Blue Shield, you may apply for reinstatement.
- You may access a Directory of Participating Dentists by going to Blue Shield's Internet site located at **blueshieldca.com** and clicking on the Find A Provider section. The names of Participating Dentists in your area may also be obtained by contacting the DPA at **(888)679-8928**.
- For the dental PPO and Specialty Duo Plans:
    - The Blue Shield of California Dental PPO Plan is specifically designed for you to use Participating Dentists. Participating Dentists agree to accept the DPA's payment, plus your payment of any applicable deductible and copayment, as payment in full for covered services. This is not true of Non-Participating Dentists
    - If you go to a Non-Participating Dentist, you will be reimbursed up to a pre-determined

maximum amount, for covered services. Your reimbursement may be substantially less than the billed amount. The Subscriber is responsible for all differences between the amount you are reimbursed and the amount billed by Non-Participating Dentists. It is therefore to your advantage to obtain dental services from Participating Dentists.

- Participating Providers submit claims for payment after their services have been rendered. These payments go directly to the Participating Provider. You or your Non-Participating Providers submit claims for reimbursement after services have been rendered. If you receive services from Non-Participating Providers, you have the option of having payments sent directly to the Non-Participating Provider or sent directly to you. The DPA will notify you of its determination within 30 days after receipt of the claim.

- For the Dental HMO plans:
  - Blue Shield of California Dental HMO Plan contracts with the DPA to provide Services to our Members. A monthly fee is paid to the DPA for each Member. This payment system includes incentives to the DPA to manage all Covered Services provided to Members in an appropriate manner consistent with this Contract. If you want to know more about this payment system, contact dental Member Services at **(888)679-8928** or talk to your Plan Provider.
  - The DPA is responsible for providing Covered Services and/or referring the Member to Plan Specialists and Providers. Your Dental Provider must obtain authorization from the DPA before referring you to providers outside of the Dental Center.
  - You or a Dependent may change Dental Providers without cause at the following times:
    1. When your change in residence or work address prevents you or a dependent from continuing with the same Dental Provider;
    2. One (1) other time during the Calendar Year.

    If you want to change Dental Providers at any of the above times, you may call Dental Member Services at **(888)679-8928**. Before changing Dental Providers you must pay any outstanding copayment balance owed to your existing Dental Provider. The change will be effective the first day of the month following notice of approval by the Plan.
  - All specialty Dental Care Services must be provided by or arranged for by the Dental Provider. Referral by a Dental Provider does not guarantee coverage for the services for which the Member is being referred. The Benefit and eligibility provisions, exclusions, and limitations will apply. Members may be referred to a Plan Specialist within the Dental Center. However, you may also be referred to a Plan Specialist outside of the Dental Center if the type of Specialty Service needed is not available within your Dental Center.
  - If the Dental Provider determines specialty Dental Care Services are necessary, they will complete a referral form and you will then be able to schedule an appointment with the Specialist. When no Plan Provider is available to perform the needed service, the Dental Provider will refer you to a non-Plan provider after obtaining Authorization from the DPA. This Authorization procedure is handled for you by your Dental Provider.

Dental plans general exclusions and limitations

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

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

General exclusions

1. Services not listed as covered in the member's EOC/Policy/Summary of Benefits;
2. Services to be paid by the member's Blue Shield health plan;

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

3. Services begun prior to the patient's effective date of coverage;

4. Services performed or supplies provided in a hospital or any place other than a dental office;

5. Unnecessary, investigational, experimental, cosmetic, or elective services; services for which the prognosis is not favorable, as determined by the dental plan administrator;

6. Services performed by a close relative or someone who lives in the member's home; services for which the member is not obligated to pay or services performed at no charge;

7. Services paid for by any governmental agency;

8. Implants, except when covered in specific plans;

9. Vestibuloplasy, orthognathic surgery, treatment of jaw fractures or TMJ (temporomandibular joint) syndrome;

10. Treatment of congenital anomalies or developmental malformation;

11. Treatment to correct malignancies, cysts, tumors, and neoplasm;

12. Myofunctional therapy, biofeedback procedures, athletic mouth guards, precision or semi-precision attachments, denture duplication;

13. Treatment of accidental or self-inflicted injuries, including setting of fractures and dislocation; accidental injury means a condition or injury caused by external, violent or accidental means, rather than by dental illness (e.g. injury caused by a fall or car accident);

14. General anesthesia or intravenous or inhalation sedation, unless medically necessary;

15. Prescription or non-prescription drugs;

16. Replacement of appliances (dentures, space maintainers, crowns, etc.) lost or stolen within five years of installation;
17. Removal of wisdom teeth unless of dental necessity;

18. Any services Blue Shield or the dental plan administrator determines not to be of dental necessity as defined in the EOC/Policy/Summary of Benefits;

19. Temporary dental services. Charges for temporary dental services are considered an integral part of the final dental service and will not be separately payable;

20. Periodontal splinting of teeth by any method including, but not limited to, crowns, fillings, appliances, or any other method that splints or connects teeth together;

21. Services provided by an individual or entity that is not licensed or certified by the state to provide health care services, or is not operating within the scope of such license or certification, except as specifically stated herein;

22. Any service, procedure, or supply for which the prognosis for long term success is not reasonably favorable as determined by a contracted Dental Plan Administrator and its dental consultants;

23. Services and/or appliances that alter the vertical dimension, including, not limited to, full mouth rehabilitation, splinting, fillings to restore tooth structure lost from attrition, erosion, or abrasion, appliances or any other method;

24. Procedures that are principally cosmetic in nature, including, but not limited to, bleaching, veneer facings, crowns, porcelain on molar crowns, personalization or characterization of crowns, bridges and/or dentures; and

25. Charges for saliva and bacterial testing when caries management procedures D0601, D0602, and D0603 are performed.

General Limitations

1. Periodic oral exam, Routine prophylaxis, Fluoride treatment, bitewing X-rays (maximum of four per occurrence), and Recementations (if the crown was provided by other than the original dentist; not eligible if the dentist is doing the recementation of service he/she provided within 12 months) are covered services every 6-month period;

2. Denture (complete and partial) relines and oral cancer screenings (this benefit only applies to the Dental PPO and Specialty Duo Dental Plan*) are covered services every 12-month period;

3. Gingival flap surgery per quad, diagnostic casts, sealants, and occlusal guards are covered services every 24-month period;

4. Full-mouth debridement, mucogingival surgery per area, Osseous surgery per quad, Gingivectomy per quad, Gingivectomy per tooth, Bone replacement grafts for periodontal purposes, Guided tissue regeneration for periodontal purposes, Full-mouth series and panoramic X-rays are covered services every 36-month period.

5. Single crowns and onlays, Single post and core buildups, Crown buildup including pins, Prefabricated post and core, Cast post and core in addition to crown, Complete dentures, Partial dentures, Fixed partial denture (bridge) pontics, Fixed partial denture (bridge) abutments, Abutment post and core buildups are covered services every five-year period.

6. Space maintainers are only eligible for members through age 15 (for Dental PPO and Specialty Duo plans) or through age 11 (for the Dental HMO and Enhanced Dental HMO $0 plans) when used to maintain space as a result of prematurely lost deciduous first and second molars, or permanent first molars that have not developed, or will never develop.

7. Sealants are only eligible for members one per tooth per two-year period through age 15 (for the Dental HMO plan) or through age 11 (for the Dental PPO and Specialty Duo plans) on permanent first and second molars.

8. Oral surgery services are limited to removal of teeth, preparation of the mouth for dentures, frenectomy, and crown lengthening.

9. An Alternate Benefit Provision (ABP) may be applied if a dental condition can be treated by means of a professionally acceptable procedure, which is less costly than the treatment recommended by the dentist. For example, an alternate benefit of a partial denture will be applied when there are bilaterally missing teeth or more than three teeth missing in one quadrant or in the anterior region. The ABP does not commit the member to the less costly treatment. However, if the member and the dentist choose the more expensive treatment, the member is responsible for the additional charges beyond those allowed for the ABP.

10. General IV or inhalation sedation is covered for the following:

    A. Three or more surgical extractions;

    B. One or more impactions;

    C. Full-mouth or arch alveoloplasty;

    D. Surgical root recovery from sinus;

    E. Medical problem contraindicates local anesthesia; and

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

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

11. Restorations, crowns, inlays, and onlays are covered only if necessary to treat diseased or accidentally fractured teeth;

12. Root canal treatment is covered one per tooth per lifetime;

13. Root canal retreatment is covered one per tooth per lifetime;

14. Pulpal therapy is covered through age 5 on primary anterior teeth and through age 11 on primary posterior teeth;

15. For mucogingival surgeries, one site is equal to two consecutive teeth or bonded spaces;

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16. Scaling and root planing are covered once for each of the four quadrants of the mouth in a 24-month period. Scaling and root planing is limited to two quadrants of the mouth per visit;

17. Cone Beam CT (D0367) is a benefit only when placing an implant. This procedure cannot be used for orthodontics or periodontics. This is a once in a lifetime benefit and is limited to projection of upper and lower jaws only; and

18. You must be 21 or older to be eligible for dental implant benefits due to continued growth and development of the mid face and jaws. If there are bilaterally missing teeth or more than three (3) teeth missing in a quadrant, or more than three (3) teeth missing in the anterior region, the Member will be given an alternate Benefit of a partial denture. If the Member elects a different procedure, payment will be based on the partial denture Benefit.

Specific Exclusions & Limitations to Dental HMO plans

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

1. Services not performed, prescribed, or authorized by the member's dental provider, unless authorized by the plan or when required in an emergency, as stated in the contract;

2. Precious metals;

3. Services of prosthodontists, and procedures requiring fixed prosthodontic restoration for complete oral rehabilitation or reconstruction;

4. Unauthorized second opinions;

5. House calls for dental services;

6. Dental implants (Enhanced Dental HMO $0 only) – surgical insertion and/or removal, transplants, ridge augmentations, or socket preservation and appliance and/or crown attached to implants;

7. Duplicate dentures, prosthetic devices, or any other duplicate appliance;

8. Treatment for a malocclusion that is not causing difficulty in chewing, speech, or overall dental functioning;

9. Treatment in progress (after banding) at inception of eligibility;

10. Surgical orthodontics (including extraction of teeth) incidental to orthodontic treatment;

11. Myofunctional therapy;

12. Changes in treatment necessitated by an accident;

13. Treatment for TMJ (temporomandibular joint) disorder or dysfunction;

14. Special orthodontic appliances, including, but not limited to, Invisalign, lingual, or invisible braces, sapphire or clear braces, or ceramic braces which are considered to be cosmetic;

15. Replacement of lost or stolen appliance or repair of same if broken through no fault of orthodontist;

16. Reimbursement for any services after the 24 months of treatment for which a claim has not been submitted;

17. In the event of a member's loss of coverage for any reason, if at the time of loss of coverage the member is still receiving orthodontic treatment during the 24-month treatment period, the member and not the dental plan administrator will be responsible for the remainder of the cost for that treatment, at the participating orthodontist's billed charges, prorated for the number of months remaining; and

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

Specific Limitations:

1. Referral to a specialty care dentist is limited to orthodontics, oral surgery, periodontics, endondontics, and pediatrics;

2. Coverage for referral to a pediatric specialty care dentist is covered up to the age of six (6) and is contingent on dental necessity. However, exceptions for physical or mental handicaps or medically compromised children over the age of six (6), when confirmed by a physician, may be considered on an individual basis with prior approval;

3. Payment for orthodontic treatment is made in installments. If for any reason orthodontic services are terminated or coverage is terminated before competition of the approved orthodontics treatment, the responsibility of the contracted Dental Plan Administrator will cease with payment through the month of termination; and

4. In the case of a dental emergency involving pain or a condition requiring immediate treatment occurring more than 50 miles from the Member's home, the Plan covers necessary diagnostic and therapeutic dental procedures administered by an out-of-network dentist up to the difference between the out-of-network dentist's charge and the Member's Copayment up to a maximum of $50 for each emergency visit.

Specific Exclusions & Limitations to Dental PPO plans

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

1. Any inlay restorations;

2. Crowns or onlays installed as multiple abutments;

3. Prosthetic appliance related to periodontics;

4. Charges for missed appointments;

5. Alloplastic bone grafting materials;

6. Bone grafting done for socket preservation after tooth extraction or in preparation for implants; (unless your plan provides special implant benefits. Please see the Summary of Benefits to determine if you have implant benefits.);

7. Charges for services in connection with orthodontia when rendered by a Non-Participating Provider;

8. Treatment for a malocclusion that is not causing difficulty in chewing, speech, or overall dental functioning;

9. Treatment in progress (after banding) at inception of eligibility;

10. Surgical orthodontics (including extraction of teeth) incidental to orthodontic treatment;

11. Treatment for TML (Temporomandibular Joint) disorder or dysfunction;

12. Special orthodontic appliance, including but not limited to lingual or invisible braces, sapphire or clear braces, or ceramic braces which are considered to be cosmetic;

13. Replacement of lost or stolen appliance or repair of same if broken through no fault of orthodontist;

14. Treatment exceeding 24 months except for treatment prior approved by Blue Shield as Dentally Necessary;

15. In the event of a Member's loss of coverage for any reason, if at the time of loss of coverage the Member is still receiving Orthodontic treatment during the 24 month treatment period, the Member and not a contracted Dental Plan Administrator will be responsible for the remainder of the cost for that treatment at the participating Orthodontist's Billed Charges, prorated for the number of months remaining;

16. If the insured is reinstated after Cancellation, there are no Orthodontic benefits for treatment begun prior to his or her reinstatement effective date;

17. There is a 12 month waiting period before beginning orthodontic treatment;

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

19. Benefits for the initial placement will not exceed 20% of the Lifetime Maximum Benefit Amount for Orthodontia. Periodic follow-up visits will be payable on a monthly basis during the scheduled course of the orthodontic treatment. Allowable expenses for the initial placement, periodic follow-up visits, and procedures performed in connection with the orthodontic treatment are all subject to the Orthodontia coinsurance level and Lifetime Maximum Benefit Amount; and

20. Orthodontic benefits end at cancellation of coverage.

Specific exclusions to Specialty Duo Dental Plan*

1. Any inlay restorations.

2. Alloplastic bone grafting materials.

3. Bone grafting done for socket preservation after tooth extraction or in preparation for implants.

Blue Shield vision plans

Vision Plan Information

All Vision plans, including Specialty Duo Vision*

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

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

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

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

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

Blue Shield of California

P.O. Box 25208

Santa Ana, CA

92799-5208

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

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

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

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

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

Grievance process

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

External independent medical review

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

Department of Managed Health Care review

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

The California Department of Managed Health Care is responsible for regulating healthcare service plans. If you have a grievance against your health plan, you should first telephone your health plan at the telephone number on your Blue Shield member ID card, or call **(888) 256-3650** if you purchased your coverage directly from Blue Shield or **(855) 836-9705** if you purchased your coverage from Covered California and use your health plan's grievance process before contacting the 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 an IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature, and payment disputes for

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emergency or urgent medical services. The department also has a toll-free number, **(888) HMO-2219**, and a TTY line, **(877) 688-9891**, for the hearing and speech impaired. The department's Internet website, www.hmohelp.ca.gov, has complaint forms, IMR application forms, and instructions online.

Department of Insurance review

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

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

Confidentiality and privacy

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

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

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

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

Correspondence Address:

Blue Shield of California Privacy Office

P.O. Box 272540

Chico, CA 95927-2540

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Notice of privacy policy

Blue Shield of California Life & Health Insurance Company

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

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

Our privacy standards

Blue Shield Life:

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

Our privacy safeguards

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

- Administrative safeguards
- Physical safeguards
- Technical safeguards

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

Personal information that we collect

We collect information that we need to:

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

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

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

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How we use your information

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

Why and with whom we share your personal information

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

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

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

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

Your rights to access and amend information about you

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

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

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

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

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

or

(888) 266-8080

Consumer reporting and fraud detection agencies

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

blue of california

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

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Important disclosures