Blue Shield Silver 70 PPO

Uniform Health Plan Benefits and Coverage Matrix

Blue Shield of California

Effective January 1, 2017

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

This health plan uses the Exclusive PPO Provider Network.

	Participating Providers [1]	**Non-Participating Providers [1]**
Calendar Year Medical Deductible [1] (Deductibles for Participating and Non-Participating Providers accrue separately.)	$2,500 per individual / $5,000 per family	$5,000 per individual / $10,000 per family
Calendar Year Out-of-Pocket Maximum [2] (Any calendar year medical deductible and any calendar year pharmacy deductible accrues to the calendar year out-of-pocket maximum. Copayments or coinsurance for covered services from participating providers accrues to both the participating and non-participating provider calendar year out-of-pocket maximum amounts.)	$6,800 per individual / $13,600 per family	$9,800 per individual / $19,600 per family
Calendar Year Pharmacy Deductible (Does not apply to contraceptive drugs and devices or oral anticancer medications. Otherwise applicable to covered drugs in Tiers 2, 3 and 4. Separate from the calendar year medical deductible. Accrues to the calendar year out-of-pocket maximum)	$250 per individual / $500 per family	Not Covered
Lifetime Benefit Maximum	None	None

Covered Services	**Member Copayment**	
	Participating Providers [1]	**Non-Participating Providers [1]**
PROFESSIONAL SERVICES		
Professional Benefits		
Primary care physician office visit	$35 per visit	50% (Subject to the calendar year medical deductible)
Other practitioner office visit	$35 per visit	50% (Subject to the calendar year medical deductible)
Specialist physician office visit	$70 per visit	50% (Subject to the calendar year medical deductible)
Teladoc consultation	$5 per consultation	Not Covered
Allergy Testing and Treatment Benefits		
Primary care physician office visits (includes visits for allergy serum injections)	$35 per visit	50% (Subject to the calendar year medical deductible)
Specialist physician office visits (includes visits for allergy serum injections)	$70 per visit	50% (Subject to the calendar year medical deductible)
Allergy serum purchased separately for treatment	20%	50% (Subject to the calendar year medical deductible)
Preventive Health Benefits [3]		
Preventive health services (as required by applicable Federal and California law)	$0	Not Covered

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Covered Services	Member Copayment	
	Participating Providers [1]	**Non-Participating Providers [1]**
OUTPATIENT SERVICES		
Hospital Benefits (Facility Services)		
Outpatient surgery performed at a freestanding ambulatory surgery center	20%	50% [4] (Subject to the calendar year medical deductible) The maximum allowed amount for non-participating providers is $300 per day. Members are responsible for 50% of this $300 per day, plus all charges in excess of $300
Outpatient surgery performed in a hospital or a hospital affiliated ambulatory surgery center	20%	50% [5] (Subject to the calendar year medical deductible) The maximum allowed amount for non-participating providers is $500 per day. Members are responsible for 50% of this $500 per day, plus all charges in excess of $500
Outpatient visit	20%	50% [5] (Subject to the calendar year medical deductible) The maximum allowed amount for non-participating providers is $500 per day. Members are responsible for 50% of this $500 per day, plus all charges in excess of $500
Outpatient services for treatment of illness or injury and necessary supplies (except as described under "Rehabilitation Benefits" and "Speech Therapy Benefits")	20%	50% [5] (Subject to the calendar year medical deductible) The maximum allowed amount for non-participating providers is $500 per day. Members are responsible for 50% of this $500 per day, plus all charges in excess of $500
CT scans, MRIs, MRAs, PET scans, and cardiac diagnostic procedures utilizing nuclear medicine performed in a hospital [6] (prior authorization is required)	$300 per visit	50% [5] (Subject to the calendar year medical deductible) The maximum allowed amount for non-participating providers is $500 per day. Members are responsible for 50% of this $500 per day, plus all charges in excess of $500
Outpatient diagnostic x-ray and imaging performed in a hospital [6]	$70 per visit	50% [5] (Subject to the calendar year medical deductible) The maximum allowed amount for non-participating providers is $500 per day. Members are responsible for 50% of this $500 per day, plus all charges in excess of $500
Outpatient diagnostic laboratory and pathology performed in a hospital [6]	$35 per visit	50% [5] (Subject to the calendar year medical deductible) The maximum allowed amount for non-participating providers is $500 per day. Members are responsible for 50% of this $500 per day, plus all charges in excess of $500
Bariatric surgery [7] (prior authorization is required; medically necessary surgery for weight loss, for morbid obesity only)	20%	Not Covered
HOSPITALIZATION SERVICES		
Hospital Benefits (Facility Services)		
Inpatient physician fee	20% (Subject to the calendar year medical deductible)	50% (Subject to the calendar year medical deductible)
Inpatient non-emergency facility fee (semi-private room and board, and medically necessary services and supplies, including sub-acute care)	20% (Subject to the calendar year medical deductible)	50% [5] (Subject to the calendar year medical deductible) The maximum allowed amount for non-participating providers is $2,000 per day. Members are responsible for 50% of this $2,000 per day, plus all charges in excess of $2,000
Bariatric surgery [7] (prior authorization is required; medically necessary surgery for weight loss, for morbid obesity only)	20% (Subject to the calendar year medical deductible)	Not Covered

Covered Services	Member Copayment	
	Participating Providers [1]	**Non-Participating Providers [1]**
Inpatient Skilled Nursing Benefits [8, 9] (combined maximum of up to 100 days per benefit period; prior authorization is required; semi-private accommodations)		
Services by a freestanding skilled nursing facility	20% (Subject to the calendar year medical deductible)	20% [9] (Subject to the calendar year medical deductible)
Skilled nursing unit of a hospital	20% (Subject to the calendar year medical deductible)	50% [5] (Subject to the calendar year medical deductible) The maximum allowed amount for non-participating providers is $2,000 per day. Members are responsible for 50% of this $2,000 per day, plus all charges in excess of $2,000
EMERGENCY HEALTH COVERAGE		
Emergency room visit not resulting in admission - facility fee (copayment does not apply if the Member is directly admitted to the hospital for inpatient services)	$350 per visit	$350 per visit
Emergency room visit resulting in admission – facility fee (when the Member is admitted directly from the Emergency Room)	20% (Subject to the calendar year medical deductible)	20% (Subject to the calendar year medical deductible)
Emergency room visit not resulting in admission - physician fee (copayment does not apply if the Member is directly admitted to the hospital for inpatient services)	$0	$0
Emergency room visit resulting in admission - physician fee	$0	$0
Urgent care	$35 per visit	50% (Subject to the calendar year medical deductible)

Covered Services	Member Copayment	
	Participating Providers [1]	**Non-Participating Providers [1]**
AMBULANCE SERVICES		
Emergency or authorized transport (ground or air)	$250 (Subject to the calendar year medical deductible)	$250 (Subject to the calendar year medical deductible)
	Participating Pharmacy	**Non-Participating Pharmacy**
PRESCRIPTION DRUG (PHARMACY) COVERAGE [10, 11, 12, 13, 14, 15]		
Retail Pharmacies (up to a 30-day supply)		
Contraceptive drugs and devices [11]	$0	Not Covered
Tier 1 Drugs	$15 per prescription	Not Covered
Tier 2 Drugs	$55 per prescription (Subject to the calendar year pharmacy deductible)	Not Covered
Tier 3 Drugs	$80 per prescription (Subject to the calendar year pharmacy deductible)	Not Covered
Tier 4 Drugs (excluding Specialty Drugs)	20% up to $250 maximum per prescription (Subject to the calendar year pharmacy deductible)	Not Covered
Mail Service Pharmacies (up to a 90-day supply)		
Contraceptive drugs and devices [11]	$0	Not Covered
Tier 1 Drugs	$45 per prescription	Not Covered
Tier 2 Drugs	$165 per prescription (Subject to the calendar year pharmacy deductible)	Not Covered
Tier 3 Drugs	$240 per prescription (Subject to the calendar year pharmacy deductible)	Not Covered
Tier 4 Drugs (excluding Specialty Drugs)	20% up to $750 maximum per prescription (Subject to the calendar year pharmacy deductible)	Not Covered
Network Specialty Pharmacies [13, 14, 15] (up to a 30-day supply)		
Tier 4 Drugs	20% up to $250 maximum per prescription (Subject to the calendar year pharmacy deductible)	Not Covered
Oral anticancer medications	20% up to $200 maximum per prescription	Not Covered
	Participating Providers [1]	**Non-Participating Providers [1]**
PROSTHETICS/ORTHOTICS		
Prosthetic equipment and devices (separate office visit copayment may apply)	20%	50% (Subject to the calendar year medical deductible)
Orthotic equipment and devices (separate office visit copayment may apply)	20%	50% (Subject to the calendar year medical deductible)
DURABLE MEDICAL EQUIPMENT		
Breast pump	$0	Not Covered
Other durable medical equipment	20%	50% (Subject to the calendar year medical deductible)

Covered Services	Member Copayment	
	Participating Providers [1]	**Non-Participating Providers [1]**
MENTAL HEALTH AND BEHAVIORAL HEALTH SERVICES [16]		
Inpatient hospital services (prior authorization required)	20% (Subject to the calendar year medical deductible)	50% [5] (Subject to the calendar year medical deductible) The maximum allowed amount for non-participating providers is $2,000 per day. Members are responsible for 50% of this $2,000 per day, plus all charges in excess of $2,000
Residential care (prior authorization required)	20% (Subject to the calendar year medical deductible)	50% [5] (Subject to the calendar year medical deductible) The maximum allowed amount for non-participating providers is $2,000 per day. Members are responsible for 50% of this $2,000 per day, plus all charges in excess of $2,000
Inpatient professional (physician) services (prior authorization required)	20% (Subject to the calendar year medical deductible)	50% (Subject to the calendar year medical deductible)
Routine outpatient mental health and behavioral health services (includes professional/physician visits; some services may require prior authorization and facility charges)	$35 per visit	50% (Subject to the calendar year medical deductible)
Non-routine outpatient mental health and behavioral health services (includes behavioral health treatment, electroconvulsive therapy, intensive outpatient programs, partial hospitalization programs, transcranial magnetic stimulation, and psychological testing. For partial hospitalization programs, a higher copayment and facility charges may apply per episode of care. Some services may require prior authorization and facility charges)	$0	50% (Subject to the calendar year medical deductible)
SUBSTANCE USE DISORDER SERVICES [16]		
Inpatient hospital services (prior authorization required)	20% (Subject to the calendar year medical deductible)	50% [5] (Subject to the calendar year medical deductible) The maximum allowed amount for non-participating providers is $2,000 per day. Members are responsible for 50% of this $2,000 per day, plus all charges in excess of $2,000
Residential care (prior authorization required)	20% (Subject to the calendar year medical deductible)	50% [5] (Subject to the calendar year medical deductible) The maximum allowed amount for non-participating providers is $2,000 per day. Members are responsible for 50% of this $2,000 per day, plus all charges in excess of $2,000
Inpatient professional (physician) services (prior authorization required)	20% (Subject to the calendar year medical deductible)	50% (Subject to the calendar year medical deductible)
Routine outpatient substance use disorder services (includes professional/physician visits; some services may require prior authorization and facility charges)	$35 per visit	50% (Subject to the calendar year medical deductible)
Non-routine outpatient substance use disorder services (services may require prior authorization; includes partial hospitalization program, intensive outpatient program, and office-based opioid detoxification and/or maintenance therapy. Higher copayment and facility charges per episode of care may apply for partial hospitalization programs.)	$0	50% (Subject to the calendar year medical deductible)
HOME HEALTH SERVICES		
Home health care agency visits [8] (up to 100 prior authorized visits per calendar year)	$45 per visit	Not Covered
Home infusion/home intravenous injectable therapy	$45 per visit	Not Covered
Home infusion nursing visits provided by a home infusion agency	$45 per visit	Not Covered

Covered Services	Member Copayment	
	Participating Providers [1]	**Non-Participating Providers [1]**
HOSPICE PROGRAM BENEFITS		
Routine home care	$0	Not Covered
Inpatient respite care	$0	Not Covered
24-hour continuous home care	$0	Not Covered
Short-term inpatient care for pain and symptom management	$0	Not Covered
CHIROPRACTIC BENEFITS		
Chiropractic services	Not Covered	Not Covered
ACUPUNCTURE BENEFITS		
Acupuncture services (benefits provided are for the treatment of nausea or as part of a comprehensive pain management program for the treatment of chronic pain only)	$35 per visit	50% (Subject to the calendar year medical deductible)
REHABILITATION AND HABILITATIVE BENEFITS (Physical, Occupational, and Respiratory Therapy)		
Office location	$35 per visit	50% (Subject to the calendar year medical deductible)
SPEECH THERAPY BENEFITS		
Office location	$35 per visit	50% (Subject to the calendar year medical deductible)
PREGNANCY AND MATERNITY CARE BENEFITS		
Prenatal and preconception physician office visit (for inpatient hospital services, see "Hospitalization Services")	$0	50% (Subject to the calendar year medical deductible)
Delivery and all inpatient physician services	20% (Subject to the calendar year medical deductible)	50% (Subject to the calendar year medical deductible)
Postnatal physician office visit: initial visit (for inpatient hospital services, see "Hospitalization Services")	$0	50% (Subject to the calendar year medical deductible)
Abortion services (an additional facility copayment may apply when services are rendered in a hospital or outpatient surgery center)	20%	50% (Subject to the calendar year medical deductible)
FAMILY PLANNING BENEFITS		
Counseling, consulting, and education (includes insertion of IUD, as well as injectable and implantable contraceptives for women)	$0	Not Covered
Tubal ligation	$0	Not Covered
Vasectomy (an additional facility copayment may apply when services are rendered in a hospital or outpatient surgery center)	20%	Not Covered
Infertility services	Not Covered	Not Covered
DIABETES CARE BENEFITS		
Devices, equipment, and non-testing supplies (Member share is based upon allowed charges; for testing supplies see "Prescription Drug Coverage")	20%	50% (Subject to the calendar year medical deductible)
Diabetes self-management training in an office setting	$0	50% (Subject to the calendar year medical deductible)
CARE OUTSIDE OF CALIFORNIA (Benefits provided through the BlueCard® Program for out-of-state emergency and non-emergency care are provided at the participating level of the local Blue Plan allowable amount when you use a Blue Cross/Blue Shield provider)		
Within US: BlueCard Program	See Applicable Benefit	See Applicable Benefit
Outside of US: BlueCard Worldwide	See Applicable Benefit	See Applicable Benefit

Covered Services	Member Copayment	
	Participating Providers [1]	**Non-Participating Providers [1]**
Pediatric Vision Benefits [17] – Pediatric vision benefits are available for Members through the end of the month in which the Member turns 19. All pediatric vision benefits are provided through MESVision, Blue Shield's Vision Plan Administrator.		
Comprehensive Eye Exam [18] one per calendar year (includes dilation, if professionally indicated)		
Ophthalmologic - Routine ophthalmologic exam with refraction – new patient (S0620) - Routine ophthalmologic exam with refraction – established patient (S0621)	$0	Covered up to $30 maximum Allowance
Optometric - New patient exam (92002/92004) - Established patient exam (92012/92014)	$0	Covered up to $30 maximum Allowance
Eyeglasses		
Lenses: one pair per calendar year - Single vision (V2100-2199) - Conventional (lined) bifocal (V2200-2299) - Conventional (lined) trifocal (V2300-2399) - Lenticular (V2121, V2221, V2321) Lenses include choice of glass or plastic lenses, all lens powers (single vision, bifocal, trifocal, lenticular), fashion and gradient tinting, scratch coating, oversized and glass-grey #3 prescription sunglass lenses.	$0	Covered up to a maximum Allowance of: $25 single vision $35 lined bifocal $45 lined trifocal $45 lenticular
Optional Lenses and Treatments		
UV coating (standard only)	$0	Not Covered
Polycarbonate lenses	$0	Not Covered
Anti-reflective coating (standard only)	$35	Not Covered
Hi-index lenses	$30	Not Covered
Photochromic lenses - plastic	$0	Not Covered
Photochromic lenses - glass	$25	Not Covered
Polarized lenses	$45	Not Covered
Standard progressives	$0	Not Covered
Premium progressives	$95	Not Covered
Frame [19] (one frame per calendar year)		
Collection frame	$0	Covered up to $40 maximum Allowance
Non-collection frame (V2020)	Covered up to $150 maximum Allowance	Covered up to $40 maximum Allowance
Contact Lenses [20]		
Elective (Cosmetic/Convenience) – standard hard (V2500, V2510)	$0	Covered up to $75 maximum Allowance
Elective (Cosmetic/Convenience) – standard soft (V2520) (One pair per month, up to 6 months, per Calendar Year)	$0	Covered up to $75 maximum Allowance
Elective (Cosmetic/Convenience) – non-standard hard (V2501-V2503, V2511-V2513, V2530-V2531)	$0	Covered up to $75 maximum Allowance
Elective (Cosmetic/Convenience) – non-standard soft (V2521-V2523) (One pair per month, up to 3 months, per Calendar Year)	$0	Covered up to $75 maximum Allowance
Non-Elective (Medically Necessary) - hard or soft [21]	$0	Covered up to $225 maximum Allowance

Covered Services	Member Copayment	
	Participating Providers [1]	**Non-Participating Providers [1]**
Other Pediatric Vision Benefits		
Comprehensive low vision exam [21] (Once every 5 Calendar Years)	$0	Not Covered
Low vision devices [21] (One aid per Calendar Year)	$0	Not Covered
Diabetes management referral	$0	Not Covered
Pediatric Dental Benefits [22] – Pediatric dental benefits are available for Members through the end of the month in which the Member turns 19. All pediatric dental benefits are provided by Dental Benefits Providers, Blue Shield's Dental Plan Administrator.		
Diagnostic and Preventive	**Participating Dentists**	**Non-Participating Dentists [23]**
Oral exam	$0	10%
Preventive - cleaning	$0	10%
Preventive - x-ray	$0	10%
Sealants per tooth	$0	10%
Topical fluoride application	$0	10%
Space maintainers - fixed	$0	10%
Basic Services [24]		
Restorative procedures	20%	30%
Periodontal maintenance services	20%	30%
Major Services [24]		
Crowns and casts	50%	50%
Endodontics	50%	50%
Periodontics (other than maintenance)	50%	50%
Prosthodontics	50%	50%
Oral surgery	50%	50%
Orthodontics [24, 25]		
Medically necessary orthodontics	50%	50%

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

Endnotes

1 For family coverage, there is an individual medical deductible and a separate individual pharmacy deductible within the family medical and pharmacy deductibles. This means that the medical and pharmacy deductibles will be met for an individual who meets the individual medical and pharmacy deductibles prior to meeting the family medical and pharmacy deductibles. After the calendar year medical deductible is met, the Member is responsible for a copayment or coinsurance from participating providers. Participating providers accept Blue Shield's allowable amounts as full payment for covered services.

Non-participating providers can charge more than these amounts. When Members use non-participating providers, they must pay the applicable deductibles, copayments or coinsurance plus any amount that exceeds Blue Shield's allowable amount. Charges above the allowable amount do not count toward the calendar year medical deductible or out-of-pocket maximum. Covered Services by Non-Preferred and Non-Participating Providers that are prior authorized as Preferred or Participating will be covered as a Preferred or Participating Provider Benefit. Note: All covered services received from non-participating providers are subject to the deductible except for covered pediatric vision and pediatric dental services.

2 For family coverage, there is an individual out-of-pocket maximum within the family out-of-pocket maximum. This means that the out-of-pocket maximum will be met for an individual who meets the individual out-of-pocket maximum prior to the family meeting the family out-of-pocket maximum.

Copayments or coinsurance for covered services accrue to the calendar year out-of-pocket maximum, except copayments or coinsurance for (a) charges in excess of specified benefit maximums; (b) Bariatric surgery: covered travel expenses for bariatric surgery; and (c) Dialysis center services dialysis services from a non-participating provider. Copayments, coinsurance, and charges for services not accruing to the Member's calendar year out-of-pocket maximum continue to be the Member's responsibility after the calendar year out-of-pocket maximum is reached. Please refer to the Summary of Benefits and *Evidence of Coverage* for additional details. Copayments may never exceed the plan's actual cost of the service.

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

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

5 The allowable amount for non-emergency surgery and services and supplies received from a non-participating hospital or facility is limited to $500 (outpatient) or $2,000 (inpatient) per day. Members are responsible for the coinsurance and all charges that exceed $500 (outpatient) or $2,000 (inpatient) per day. Charges that exceed the allowable amount do not count toward the calendar year out-of-pocket maximum and continue to be owed after the maximum is reached.

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

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

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

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

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

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

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

13 Network Specialty Pharmacies dispense Specialty Drugs, which require coordination of care, close monitoring, or extensive patient training that generally cannot be met by a retail pharmacy. Network Specialty Pharmacies also dispense Specialty Drugs which may also require special handling or manufacturing processes, restriction to certain Physicians or pharmacies, or reporting of certain clinical events to the FDA. Specialty Drugs are generally high cost.

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

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

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

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

18 The comprehensive examination benefit allowance includes fitting, evaluation and follow-up care fees for Non-Elective (Medically Necessary) Contact Lenses (hard or soft) or Elective Contact Lenses (standard hard or soft) in lieu of eyeglasses by Participating or Preferred Providers.

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

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

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

22 Pediatric dental benefits are available through a network of participating dentists. With the exception of emergency dental services, all dental services must be provided through a participating dentist in this network. For a list of participating dentists, Members can search in the “Find a Provider” section of blueshieldca.com. All pediatric dental benefits are provided by Dental Benefits Providers, Blue Shield’s Dental Plan Administrator.

Copayments and coinsurance for covered dental services accrue to the calendar year out-of-pocket maximum, including any copayments for covered orthodontia services. Costs for non-covered services, charges in excess of benefit maximums, and premiums, do not accrue to the calendar year out-of-pocket maximum.

23 For Covered Services rendered by Non-Participating Dentists, the Member is responsible for all charges above the Allowable Amount.

24 There are no waiting periods for pediatric dental services.

25 The Member’s Copayment or Coinsurance for covered Medically Necessary Orthodontia services applies to a course of treatment even if it extends beyond a Calendar Year. This applies as long as the Member remains enrolled in the Plan.

Benefit plans may be modified to ensure compliance with state and federal requirements

Pending Regulatory Approval