Effective: January 1, 2015

blue of california

Benefit Summary Guide

Health plan information for individuals & families

PPO

Healthcare coverage that fits your needs

We offer a range of health plans to choose from, with easy access to care from our quality provider network. When you choose a Blue Shield plan, you'll also have access to a variety of health and wellness resources and programs to help you maintain your health. Plus, Blue Shield offers dental, vision,* dental + vision,* and life insurance* products to complement your coverage.

This guide provides a summary of plan benefits and is not a contract. The actual, complete terms and conditions of a plan's benefits and coverage, limitations, and exclusions are located in the *Evidence of Coverage and Health Service Agreement* (EOC) or Policy. A copy of the EOC or Policy is available upon request prior to enrollment. We'll provide your EOC/Policy to you if your application for coverage is approved.

Please note: The *Important Legal Information* booklet, explaining general plan exclusions and limitations, is a companion to this guide. Please read both documents together.

For questions about plan information or to obtain a copy of the *Important Legal Information* booklet, contact your broker, call us at **(888) 256-3650**, or visit us online at **blueshieldca.com**.

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

In this guide, you'll find detailed benefit information for Blue Shield health, dental, and vision plans available directly from Blue Shield, as well as plans available for purchase through Covered California (www.CoveredCA.com).* Covered California is the state of California's health insurance marketplace, where you can compare and purchase health plans, and determine if you qualify for tax credits or cost-sharing subsidies from government assistance programs to lower your monthly health coverage costs.

Blue Shield medical plans available through Blue Shield or Covered California

Platinum 90 PPO	Bronze 60 PPO
Gold 80 PPO	Bronze 60 HSA PPO
Silver 70 PPO	Minimum Coverage PPO

Blue Shield dental, vision, dental + vision package, and individual term life insurance plans available only through Blue Shield

Enhanced Dental PPO 25/500	Dental PPO
Enhanced Dental PPO 50/1250	Ultimate Vision 15/25/150†
Dental HMO	Specialty Duo℠ dental + vision package†
Enhanced Dental HMO $0	Individual term life insurance† plans

Blue Shield medical plans available only through Covered California

Medical plans
Silver 94 PPO
Silver 87 PPO
Silver 73 PPO

Please note that Silver 94 PPO, Silver 87 PPO, and Silver 73 PPO plans are only available to individuals eligible for subsidies as determined by Covered California. The Minimum Coverage PPO plan is only available to people under age 30, or those age 30 and above who can provide a certification that they are without affordable coverage or are experiencing financial hardship.

We also offer American Indian - Alaska Native plans which are available to eligible American Indian - Alaska Natives‡ when purchased through Covered California. For more information, visit **blueshieldca.com**.

* Individual and Family Plans rates and benefits are pending regulatory approval.

† Underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life).

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

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Preferred Provider Organization (PPO) health plans

PPO plans at a glance

Blue Shield PPO plans vary by member out-of-pocket costs, but all offer members the flexibility and simplicity of having direct access to the physicians and specialists in Blue Shield's provider networks without the need for a referral. Additional highlights include:

- Comprehensive benefits
- Predictable copayments and out-of-pocket maximum
- Preventive care services without a copayment before meeting any annual deductible
- Access to a quality provider network in California

Blue Shield PPO plans are available in the following counties

Contra Costa	El Dorado	Fresno	Imperial
Inyo	Kern	Kings	Los Angeles
Madera	Mariposa	Merced	Mono
Orange County	Placer	Riverside	Sacramento
San Bernardino	San Diego	San Francisco	San Joaquin
San Luis Obispo	San Mateo	Santa Barbara	Santa Clara
Stanislaus	Tulare	Ventura	Yolo

Provider network

The PPO health plans offered by Blue Shield of California use the Exclusive PPO Network. This network consists of participating doctors and hospitals. Visit **blueshieldca.com/fap** to see if your provider is in our network.

Access to care and limitations

Plan features and copayments vary by plan. Members who receive care from a provider in their plan's provider network (participating provider) are responsible for meeting the plan's calendar-year deductible (if applicable) and copayments or coinsurance up to the calendar-year out-of-pocket maximum for covered services.

A PPO plan provides access to an Exclusive Network of participating doctors, specialists, and hospitals. Members have the freedom to see any doctor in our Exclusive PPO Network without a referral. Members have the option to receive care from non-participating providers, but are then responsible for meeting their plan's non-participating provider calendar-year deductible (if applicable), the copayment or coinsurance up to the non-participating provider calendar-year out-of-pocket maximum, and all charges that exceed Blue Shield's allowable amount. The Exclusive PPO Network includes fewer providers than Blue Shield's Full PPO Network.

Certain healthcare services may not be available in your area. You may be required to travel in excess of 30 minutes to access these services.

Platinum 90 PPO

Uniform Health Plan Benefits and Coverage Matrix

Blue Shield of California

Effective January 1, 2015

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 PPO plan uses the Exclusive PPO provider network.

	Participating Providers[1]	Non-Participating Providers[1]
Calendar Year Medical Deductible	$0	
Calendar Year Out-of-Pocket Maximum[2] (Copayments for participating providers apply to both participating and non-participating provider calendar year out-of-pocket maximum amounts.)	$4,000 per individual / $8,000 per family	$7,000 per individual / $14,000 per family
Calendar Year Brand Drug Deductible	$0	Not covered
Lifetime Benefit Maximum	None	

Covered Services	Member Copayments	
	Participating Providers[1]	Non-Participating Providers[1]
PROFESSIONAL SERVICES		
Professional (Physician) Benefits		
Physician office visits from internal medicine, family practice, pediatric, and OB/Gyn physicians	$20	50%
Specialist physician office visits	$40	50%
Outpatient diagnostic X-ray and imaging (non-hospital-based or -affiliated)	$40	50%
Outpatient diagnostic laboratory and pathology (non-hospital-based or -affiliated)	$20	50%
Preventive Health Benefits		
Preventive health services (as required by federal and California law)	$0	Not covered
OUTPATIENT SERVICES		
Outpatient surgery in a hospital	10%	50%[3] 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 surgery performed at an ambulatory surgery center	10%	50%[4] 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 services for treatment of illness or injury and necessary supplies	10%	50%[3] 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	$40	50%[3] The maximum allowed amount for non-participating providers is $500 per day. Members are responsible for 50% of this $500 per day, plus all charges in excess of $500

Covered Services	Member Copayments	
	Participating Providers[1]	**Non-Participating Providers**[1]
Outpatient diagnostic laboratory and pathology performed in a hospital	$20	50%[3] 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 (prior authorization is required)	10%	50%[5] 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
HOSPITALIZATION SERVICES		
Inpatient physician services	10%	50%
Inpatient non-emergency facility services (semi-private room and board, services and supplies, including subacute care)	10%	50%[3] 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 (prior authorization is required; medically necessary surgery for weight loss is for morbid obesity only)[6]	10%	Not covered
EMERGENCY HEALTH COVERAGE		
Emergency room services not resulting in admission	$150	$150
Emergency room services resulting in admission (when the member is admitted directly from the ER)	10%	10%
Emergency room physician services	10%	10%
Urgent care	$40	50%
AMBULANCE SERVICES		
Emergency or authorized transport (ground or air)	$150	$150
PRESCRIPTION DRUG COVERAGE[7,8,9]	**Participating Pharmacy**	**Non-Participating Pharmacy**
Retail Prescriptions (up to a 30-day supply)		
Contraceptive drugs and devices[8]	$0	Not covered
Generic drugs	$5 per prescription	Not covered
Preferred brand drugs	$15 per prescription	Not covered
Non-preferred brand drugs	$25 per prescription	Not covered
Mail Service Prescriptions (up to a 90-day supply)		
Contraceptive drugs and devices[8]	$0	Not covered
Generic drugs	$15 per prescription	Not covered
Preferred brand drugs	$45 per prescription	Not covered
Non-preferred brand drugs	$75 per prescription	Not covered
Specialty Pharmacies (up to a 30-day supply)		
Specialty drugs (May require prior authorization from Blue Shield. Specialty drugs are covered only when dispensed by Network Specialty Pharmacies. Drugs from non-participating pharmacies are not covered except in emergency and urgent situations.)	10%	Not covered
Oral Anti-cancer Medications	10% up to a maximum of $200 per prescription	Not covered
	Participating Providers[1]	**Non-Participating Providers**[1]
PROSTHETICS/ORTHOTICS		
Prosthetic equipment and devices (separate office visit copay may apply)	10%	50%
Orthotic equipment and devices (separate office visit copay may apply)	10%	50%
DURABLE MEDICAL EQUIPMENT		
Breast pump	$0	Not covered
Other durable medical equipment	10%	50%
MENTAL HEALTH SERVICES[10]		
Inpatient hospital services (prior authorization required)	10%	50%[3] The maximum allowed amount for

Covered Services	Member Copayments	
	Participating Providers[1]	Non-Participating Providers[1]
		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 mental health services (some services may require prior authorization and facility charges)	$20	50%
SUBSTANCE ABUSE SERVICES[10]		
Inpatient hospital (prior authorization required)	10%	50%[3] 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 substance abuse services (some services may require prior authorization and facility charges)	$20	50%
HOME HEALTH SERVICES		
Home health care agency services (up to 100 prior authorized visits per calendar year)	10%	Not covered (unless prior authorized)
OTHER		
Pregnancy and Maternity Care Benefits		
Prenatal physician office visits	$0	50%
Postnatal physician office visits	$20	50%
Inpatient hospital services for normal delivery and cesarean section	10%	50%[3] 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
Abortion services[11]	10%	50%
Family Planning Benefits		
Injectable and implantable contraceptives	$0	Not covered
Counseling and consulting	$0	Not covered
Tubal ligation	$0	Not covered
Vasectomy	10%	Not covered
Infertility services	Not covered	Not covered
Rehabilitation and Habilitation Benefits		
Office location	$20	50%
Outpatient department of a hospital	$20	50%[3] 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
Chiropractic Benefits		
Chiropractic services	Not covered	Not covered
Acupuncture Benefits		
Acupuncture services	$20	50%
Care Outside of California (benefits provided through the BlueCard® Program for out-of-state emergency and non-emergency care are provided at the preferred 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
Pediatric Dental Benefits – pediatric dental benefits are available for members through the end of the year in which the member turns 19		
Child Dental Diagnostic and Preventive		
Oral exam	No charge	20%
Preventive - cleaning	No charge	20%
Preventive - X-ray	No charge	20%
Sealants per tooth	No charge	20%
Topical fluoride application	No charge	20%
Caries risk management	No charge	20%
Space maintainers - fixed	No charge	20%

Covered Services	Member Copayments	
	Participating Providers[1]	**Non-Participating Providers**[1]
Child Dental Basic Services		
Amalgam fill - 1 surface	20%	30%
Child Dental Major Services[2]		
Root canal - molar	50%	50%
Gingivectomy per quad	50%	50%
Extraction - single tooth exposed root or	50%	50%
Extraction - complete bony	50%	50%
Porcelain with metal crown	50%	50%
Child Orthodontics[2]		
Medically necessary orthodontics	50%	50%
Pediatric Vision Benefits – for children up to age 19		
Comprehensive Eye Exam[12] 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 a maximum allowance of $30
Optometric - New patient exam (92002/92004) - Established patient exam (92012/92014)	$0	Covered up to a maximum allowance of $30
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. Polycarbonate lenses are covered in full for eligible members.	$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
Anti-reflective coating (standard only)	$35	Not covered
High-index lenses	$30	Not covered
Photochromic lenses (glass or plastic)	$25	Not covered
Polarized lenses	$45	Not covered
Standard progressives	$55	Not covered
Premium progressives	$95	Not covered
Frame (one frame per calendar year) Collection frame Non-collection frame[13] Note: "Collection" frames are available at no cost at participating independent providers. Retail chain providers typically do not display the "Collection," but are required to maintain a comparable selection of frames that are covered in full.	$0 Covered up to a maximum allowance of $150	Covered up to a maximum allowance $40
Contact Lenses[14]		
Elective – standard hard (V2500, V2510)	$0 (1 pair per year)	Covered up to a maximum allowance of $75
Elective – standard soft (V2520)	$0 (1 pair per month for up to 6 months)	Covered up to a maximum allowance of $75
Elective – non-standard hard (V2501, V2502, V2503, V2511, V2512, V2513, V2599)	$0 (1 pair per year)	Covered up to a maximum allowance of $75
Elective – non-standard soft (V2521, V2512, V2523)	$0 (1 pair per month for up to 3 months)	Covered up to a maximum allowance of $75
Medically necessary	$0 (1 pair per year)	Covered up to a maximum allowance of $225 for medically necessary contact lenses
Other Pediatric Vision Benefits		
Supplemental low-vision testing and equipment[15]	35%	Not covered
Diabetes management referral	$0	Not covered

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

Pediatric Dental Benefits Endnotes:

1 The Calendar Year Deductible and Copayments for Covered Services from Participating Dentists accrue to the Calendar Year Out-of-Pocket Maximum, including any Copayments for covered orthodontia services received from Participating Dentists. Costs for non-Covered Services, services from Non-Participating Dentists, charges in excess of benefit maximums, and Premiums, do not accrue to the Calendar Year Out-of-Pocket Maximum. The out-of-pocket maximum for the embedded pediatric dental benefit accumulates to the overall combined medical and dental out-of-pocket maximum amount. This maximum is calculated as follows: (Federal out-of-pocket maximum) minus (SADP or Family Dental Plan out-of-pocket maximum) equals (QHP out-of-pocket maximum); numerically this is $6,600 - $350 = $6,250.

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

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

Those immediate qualifying conditions are:

- Cleft lip and or palate deformities
- Craniofacial Anomalies including the following: Crouzon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, Hemi-facial atrophy, Hem-facial hypertrophy and other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by our dental consultants.
- Deep impinging overbite, where the lower incisors are destroying the soft tissue of the palate and tissue laceration and/or clinical attachment loss are present. (Contact only does not constitute deep impinging overbite).
- Crossbite of individual anterior teeth when clinical attachment loss and recession of the gingival margin are present (e.g., stripping of the labial gingival tissue on the lower incisors). Treatment of bi-lateral posterior crossbite is not a benefit of the program.
- Severe traumatic deviation must be justified by attaching a description of the condition.
- Overjet greater than 9mm or mandibular protusion (reverse overjet) greater than 3.5mm.
- The remaining conditions must score 26 or more to qualify (based on the HDL Index).

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

Endnotes for Platinum 90 PPO

1 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 which the member is responsible for in addition to the applicable copayment or coinsurance when accessing these providers, which amount can be substantial. Charges in excess of the allowable amount do not count toward the calendar year out-of-pocket maximum.

2 Copayments or coinsurance for covered services apply toward the calendar year out-of-pocket maximum, except copayments or coinsurance for the following: (a) charges in excess of specified benefit maximums; (b) covered travel expenses for bariatric surgery; and (c) dialysis center services from a non-participating provider. Copayments, coinsurance, and charges for services not accruing to the calendar year out-of-pocket maximum continue to be the member's responsibility after the calendar year out-of-pocket maximum is reached.

3 The allowable amount for non-emergency services and supplies received from a non-participating hospital or facility is limited to $500 per day. Members are responsible for the coinsurance and all charges that exceed $500 per day.

4 The allowable amount for non-emergency services and supplies received from an ambulatory surgery center is limited to $300 per day. Members are responsible for the coinsurance and all charges that exceed $300 per day. Participating ambulatory surgery centers may not be available in all areas; however, the member can obtain outpatient surgery services from a hospital or an ambulatory surgery center affiliated with a hospital, with payment according to the hospital services benefit.

5 The allowable amount for non-emergency services and supplies received from a non-participating radiology center is limited to $300 per day. Members are responsible for all charges that exceed $300 per day. The allowable amount for non-emergency services and supplies received from a non-participating hospital is limited to $500 per day. Members are responsible for all charges that exceed $500 per day.

6 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 Evidence of Coverage and Summary of Benefits for details.

7 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.

8 Contraceptive drugs and devices covered under the outpatient prescription drug benefit do not require a copayment; however, if a brand contraceptive drug is requested when a generic drug equivalent is available, the member is responsible for paying the difference between the cost to Blue Shield for the brand contraceptive drug and its generic drug equivalent. If the brand contraceptive drug is medically necessary, it may be covered without a copayment with prior authorization. The difference in cost that the member must pay does not accrue to any calendar year out-of-pocket maximum responsibility.

9 If a member or physician requests a brand drug when a generic drug equivalent is available, the member is responsible for paying the difference between the cost to Blue Shield for the brand drug and its generic drug equivalent, as well as the applicable generic

drug copayment. The difference in cost that the member must pay does not accrue to any calendar year out-of-pocket maximum responsibility. Refer to the Evidence of Coverage and Summary of Benefits for details.

10 Blue Shield has contracted with a specialized health care service plan to act as our mental health services administrator (MHSA). The MHSA provides mental health and chemical dependency services, other than inpatient services for acute medical detoxification, through a separate network of MHSA participating providers. Inpatient acute medical detoxification is a medical benefit provided by Blue Shield participating or non-participating (not MHSA) providers.

11 Copayment shown is for physician's services. If the procedure is performed in a facility setting (hospital or outpatient surgery center), an additional facility copayment may apply.

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

13 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.

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

15 A report from the provider and prior authorization from the Vision Plan Administrator is required.

This plan is pending regulatory approval.

Gold 80 PPO

Uniform Health Plan Benefits and Coverage Matrix

Blue Shield of California

Effective January 1, 2015

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 PPO plan uses the Exclusive PPO provider network.

	Participating Providers[1]	Non-Participating Providers[1]
Calendar Year Medical Deductible	$0	
Calendar Year Out-of-Pocket Maximum[2] (Copayments for participating providers apply to both participating and non-participating provider calendar year out-of-pocket maximum amounts.)	$6,250 per individual / $12,500 per family	$9,250 per individual / $18,500 per family
Calendar Year Brand Drug Deductible	$0	Not covered
Lifetime Benefit Maximum	None	

Covered Services	Member Copayments	
	Participating Providers[1]	**Non-Participating Providers**[1]
PROFESSIONAL SERVICES		
Professional (Physician) Benefits		
Physician office visits from internal medicine, family practice, pediatric, and OB/Gyn physicians	$30	50%
Specialist physician office visits	$50	50%
Outpatient diagnostic X-ray and imaging (non-hospital-based or -affiliated)	$50	50%
Outpatient diagnostic laboratory and pathology (non-hospital-based or -affiliated)	$30	50%
Preventive Health Benefits		
Preventive health services (as required by federal and California law)	$0	Not covered
OUTPATIENT SERVICES		
Outpatient surgery in a hospital	20%	50%[3] 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 surgery performed at an ambulatory surgery center	20%	50%[4] 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 services for treatment of illness or injury and necessary supplies	20%	50%[3] 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	$50	50%[3] The maximum allowed amount for non-participating providers is $500 per day. Members are responsible for 50% of this $500 per day, plus all charges in excess of $500

Covered Services	Member Copayments	
	Participating Providers[1]	**Non-Participating Providers**[1]
Outpatient diagnostic laboratory and pathology performed in a hospital	$30	50%[3] 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 (prior authorization is required)	20%	50%[3] 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
HOSPITALIZATION SERVICES		
Inpatient physician services	20%	50%
Inpatient non-emergency facility services (semi-private room and board, services and supplies, including subacute care)	20%	50%[3] 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 (prior authorization is required; medically necessary surgery for weight loss is for morbid obesity only)[6]	20%	Not covered
EMERGENCY HEALTH COVERAGE		
Emergency room services not resulting in admission	$250	$250
Emergency room services resulting in admission (when the member is admitted directly from the ER)	20%	20%
Emergency room physician services	20%	20%
Urgent care	$60	50%
AMBULANCE SERVICES		
Emergency or authorized transport (ground or air)	$250	$250
PRESCRIPTION DRUG COVERAGE[7,8,9]	**Participating Pharmacy**	**Non-Participating Pharmacy**
Retail Prescriptions (up to a 30-day supply)		
Contraceptive drugs and devices[8]	$0	Not covered
Generic drugs	$15 per prescription	Not covered
Preferred brand drugs	$50 per prescription	Not covered
Non-preferred brand drugs	$70 per prescription	Not covered
Mail Service Prescriptions (up to a 90-day supply)		
Contraceptive drugs and devices[8]	$0	Not covered
Generic drugs	$45 per prescription	Not covered
Preferred brand drugs	$150 per prescription	Not covered
Non-preferred brand drugs	$210 per prescription	Not covered
Specialty Pharmacies (up to a 30-day supply)		
Specialty drugs (May require prior authorization from Blue Shield. Specialty drugs are covered only when dispensed by Network Specialty Pharmacies. Drugs from non-participating pharmacies are not covered except in emergency and urgent situations.)	20%	Not covered
Oral Anti-cancer Medications	20% up to a maximum of $200 per prescription	Not covered
	Participating Providers[1]	**Non-Participating Providers**[1]
PROSTHETICS/ORTHOTICS		
Prosthetic equipment and devices (separate office visit copay may apply)	20%	50%
Orthotic equipment and devices (separate office visit copay may apply)	20%	50%
DURABLE MEDICAL EQUIPMENT		
Breast pump	$0	Not covered
Other durable medical equipment	20%	50%
MENTAL HEALTH SERVICES[10]		

Covered Services	Member Copayments	
	Participating Providers[1]	**Non-Participating Providers**[1]
Inpatient hospital services (prior authorization required)	20%	50%[3] 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 mental health services (some services may require prior authorization and facility charges)	$30	50%
SUBSTANCE ABUSE SERVICES[10]		
Inpatient hospital services (prior authorization required)	20%	50%[3] 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 substance abuse services (some services may require prior authorization and facility charges)	$30	50%
HOME HEALTH SERVICES		
Home health care agency services (up to 100 prior authorized visits per calendar year)	20%	Not covered (unless prior authorized)
OTHER		
Pregnancy and Maternity Care Benefits		
Prenatal physician office visits	$0	50%
Postnatal physician office visits	$30	50%
Inpatient hospital services for normal delivery and cesarean section	20%	50%[3] 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
Abortion services[11]	20%	50%
Family Planning Benefits		
Injectable and implantable contraceptives	$0	Not covered
Counseling and consulting	$0	Not covered
Tubal ligation	$0	Not covered
Vasectomy	20%	Not covered
Infertility services	Not covered	Not covered
Rehabilitation and Habilitation Benefits		
Office location	$30	50%
Outpatient department of a hospital	$30	50%[3] 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
Chiropractic Benefits		
Chiropractic services	Not covered	Not covered
Acupuncture Benefits		
Acupuncture services	$30	50%
Care Outside of California (benefits provided through the BlueCard® Program for out-of-state emergency and non emergency care are provided at the preferred 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
Pediatric Dental Benefits – pediatric dental benefits are available for members through the end of the year in which the member turns 19		
Child Dental Diagnostic and Preventive		
Oral exam	No charge	20%
Preventive - cleaning	No charge	20%
Preventive - X-ray	No charge	20%
Sealants per tooth	No charge	20%
Topical fluoride application	No charge	20%

Covered Services	Member Copayments	
	Participating Providers[1]	**Non-Participating Providers**[1]
Caries risk management	No charge	
Space maintainers - fixed	No charge	20%
Child Dental Basic Services		
Amalgam fill - 1 surface	20%	30%
Child Dental Major Services[2]		
Root canal - molar	50%	50%
Gingivectomy per quad	50%	50%
Extraction - single tooth exposed root or	50%	50%
Extraction - complete bony	50%	50%
Porcelain with metal crown	50%	50%
Child Orthodontics[2]		
Medically necessary orthodontics	50%	50%
Pediatric Vision Benefits – for children up to age 19		
Comprehensive Eye Exam[12]: 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 a maximum allowance of $30
Optometric - New patient exam (92002/92004) - Established patient exam (92012/92014)	$0	Covered up to a maximum allowance of $30
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. Polycarbonate lenses are covered in full for eligible members.	$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
Anti-reflective coating (standard only)	$35	Not covered
High-index lenses	$30	Not covered
Photochromic lenses (glass or plastic)	$25	Not covered
Polarized lenses	$45	Not covered
Standard progressives	$55	Not covered
Premium progressives	$95	Not covered
Frame (one frame per calendar year) Collection frame Non-collection frame[13] Note: "Collection" frames are available at no cost at participating independent providers. Retail chain providers typically do not display the "Collection," but are required to maintain a comparable selection of frames that are covered in full.	$0 Covered up to a maximum allowance of $150	Covered up to a maximum allowance $40
Contact Lenses[14]		
Elective – standard hard (V2500, V2510)	$0 (1 pair per year)	Covered up to a maximum allowance of $75
Elective – standard soft (V2520)	$0 (1 pair per month for up to 6 months)	Covered up to a maximum allowance of $75
Elective – non-standard hard (V2501, V2502, V2503, V2511, V2512, V2513, V2599)	$0 (1 pair per year)	Covered up to a maximum allowance of $75
Elective – non-standard soft (V2521, V2512, V2523)	$0 (1 pair per month for up to 3 months)	Covered up to a maximum allowance of $75
Medically necessary	$0 (1 pair per year)	Covered up to a maximum allowance of $225 for medically necessary contact lenses

Covered Services	Member Copayments	
	Participating Providers[1]	Non-Participating Providers[1]
Other Pediatric Vision Benefits		
Supplemental low-vision testing and equipment[15]	35%	Not covered
Diabetes management referral	$0	Not covered

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

Pediatric Dental Benefits Endnotes:

1 The Calendar Year Deductible and Copayments for Covered Services from Participating Dentists accrue to the Calendar Year Out-of-Pocket Maximum, including any Copayments for covered orthodontia services received from Participating Dentists. Costs for non-Covered Services, services from Non-Participating Dentists, charges in excess of benefit maximums, and Premiums, do not accrue to the Calendar Year Out-of-Pocket Maximum. The out-of-pocket maximum for the embedded pediatric dental benefit accumulates to the overall combined medical and dental out-of-pocket maximum amount. This maximum is calculated as follows: (Federal out-of-pocket maximum) minus (SADP or Family Dental Plan out-of-pocket maximum) equals (QHP out-of-pocket maximum); numerically this is $6,600 - $350 = $6,250.

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

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

Those immediate qualifying conditions are:

- Cleft lip and or palate deformities
- Craniofacial Anomalies including the following: Crouzon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, Hemi-facial atrophy, Hem-facial hypertrophy and other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by our dental consultants.
- Deep impinging overbite, where the lower incisors are destroying the soft tissue of the palate and tissue laceration and/or clinical attachment loss are present. (Contact only does not constitute deep impinging overbite).
- Crossbite of individual anterior teeth when clinical attachment loss and recession of the gingival margin are present (e.g., stripping of the labial gingival tissue on the lower incisors). Treatment of bi-lateral posterior crossbite is not a benefit of the program.
- Severe traumatic deviation must be justified by attaching a description of the condition.
- Overjet greater than 9mm or mandibular protusion (reverse overjet) greater than 3.5mm.
- The remaining conditions must score 26 or more to qualify (based on the HDL Index).

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

Endnotes for Gold 80 PPO

1 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 which the member is responsible for in addition to the applicable copayment or coinsurance when accessing these providers, which amount can be substantial. Charges in excess of the allowable amount do not count toward the calendar year out-of-pocket maximum.

2 Copayments or coinsurance for covered services apply toward the calendar year out-of-pocket maximum, except copayments or coinsurance for the following: (a) charges in excess of specified benefit maximums; (b) covered travel expenses for bariatric surgery; and (c) dialysis center services from a non-participating provider. Copayments, coinsurance, and charges for services not accruing to the calendar year out-of-pocket maximum continue to be the member's responsibility after the calendar year out-of-pocket maximum is reached.

3 The allowable amount for non-emergency services and supplies received from a non-participating hospital or facility is limited to $500 per day. Members are responsible for the coinsurance and all charges that exceed $500 per day.

4 The allowable amount for non-emergency services and supplies received from an ambulatory surgery center is limited to $300 per day. Members are responsible for the coinsurance and all charges that exceed $300 per day. Participating ambulatory surgery centers may not be available in all areas; however, the member can obtain outpatient surgery services from a hospital or an ambulatory surgery center affiliated with a hospital, with payment according to the hospital services benefit.

5 The allowable amount for non-emergency services and supplies received from a non-participating radiology center is limited to $300 per day. Members are responsible for all charges that exceed $300 per day. The allowable amount for non-emergency services and supplies received from a non-participating hospital is limited to $500 per day. Members are responsible for all charges that exceed $500 per day.

6 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 Evidence of Coverage and Summary of Benefits for details.

7 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.

8 Contraceptive drugs and devices covered under the outpatient prescription drug benefit do not require a copayment; however, if a brand contraceptive drug is requested when a generic drug equivalent is available, the member is responsible for paying the difference between the cost to Blue Shield for the brand contraceptive drug and its generic drug equivalent. If the brand contraceptive drug is medically necessary, it may be covered without a copayment with prior authorization. The difference in cost that the member must pay does not accrue to any calendar year out-of-pocket maximum responsibility.

9 If a member or physician requests a brand drug when a generic drug equivalent is available, the member is responsible for paying the difference between the cost to Blue Shield for the brand drug and its generic drug equivalent, as well as the applicable generic drug copayment. The difference in cost that the member must pay does not accrue to any calendar year out-of-pocket maximum responsibility. Refer to the Evidence of Coverage and Summary of Benefits for details.

10 Blue Shield has contracted with a specialized health care service plan to act as our mental health services administrator (MHSA). The MHSA provides mental health and chemical dependency services, other than inpatient services for acute medical detoxification, through a separate network of MHSA participating providers. Inpatient acute medical detoxification is a medical benefit provided by Blue Shield participating or non-participating (not MHSA) providers.

11 Copayment shown is for physician's services. If the procedure is performed in a facility setting (hospital or outpatient surgery center), an additional facility copayment may apply.

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

13 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.

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

15 A report from the provider and prior authorization from the Vision Plan Administrator is required.

This plan is pending regulatory approval.

Silver 70 PPO

Uniform Health Plan Benefits and Coverage Matrix

Blue Shield of California

Effective January 1, 2015

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 PPO plan uses the Exclusive PPO provider network.

	Participating Providers[1]	Non-Participating Providers[1]
Calendar Year Medical Deductible[2] (For family coverage, an individual is responsible for satisfying their own individual deductible and that amount accumulates to the family deductible.)	$2,000 per individual / $4,000 per family (all providers combined)	
Calendar Year Out-of-Pocket Maximum[3] (Includes the calendar year medical deductible. Copayments for participating providers apply to both participating and non-participating provider calendar year out-of-pocket maximum amounts.)	$6,250 per individual / $12,500 per family	$9,250 per individual / $18,500 per family
Calendar Year Brand Drug Deductible (Separate from the calendar year medical deductible. Accrues to the calendar year out-of-pocket maximum. For family coverage, an individual is responsible for satisfying their own individual deductible and that amount accumulates to the family deductible.)	$250 per individual / $500 per family	Not covered
Lifetime Benefit Maximum	None	

Covered Services	Member Copayments	
	Participating Providers[1]	Non-Participating Providers[1]
PROFESSIONAL SERVICES		
Professional (Physician) Benefits		
Physician office visits from internal medicine, family practice, pediatric, and OB/Gyn physicians	$45	50%
Specialist physician office visits	$65	50%
Outpatient diagnostic X-ray and imaging (non-hospital-based or -affiliated)	$65	50%
Outpatient diagnostic laboratory and pathology (non-hospital-based or -affiliated)	$45	50%
Preventive Health Benefits		
Preventive health services (as required by federal and California law)	$0	Not covered
OUTPATIENT SERVICES		
Outpatient surgery in a hospital	20%	50%[4] 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 surgery performed at an ambulatory surgery center	20%	50%[5] 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 services for treatment of illness or injury and necessary supplies	20%	50%[4] The maximum allowed amount for non-participating providers is $500 per day. Members are responsible for 50% of this $500 per day, plus all charges in excess of $500

Covered Services	Member Copayments	
	Participating Providers[1]	**Non-Participating Providers**[1]
Outpatient diagnostic X-ray and imaging performed in a hospital	$65	50%[4] 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	$45	50%[4] 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[2] (prior authorization is required)	20%	50%[6] 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
HOSPITALIZATION SERVICES		
Inpatient physician services	20%	50%
Inpatient non-emergency facility services[2] (semi-private room and board, services and supplies, including subacute care)	20%	50%[4] 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 (prior authorization is required; medically necessary surgery for weight loss is for morbid obesity only) [2,7]	20%	Not covered
EMERGENCY HEALTH COVERAGE		
Emergency room services not resulting in admission[2]	$250	$250
Emergency room services resulting in admission[2] (when the member is admitted directly from the ER)	20%	20%
Emergency room physician services	20%	20%
Urgent care	$90	50%
AMBULANCE SERVICES		
Emergency or authorized transport[2] (ground or air)	$250	$250
PRESCRIPTION DRUG COVERAGE[8,9,10]	**Participating Pharmacy**	**Non-Participating Pharmacy**
Retail Prescriptions (up to a 30-day supply)		
Contraceptive drugs and devices[9]	$0	Not covered
Generic drugs	$15 per prescription	Not covered
Preferred brand drugs[2]	$50 per prescription	Not covered
Non-preferred brand drugs[2]	$70 per prescription	Not covered
Mail Service Prescriptions (up to a 90-day supply)		
Contraceptive drugs and devices[9]	$0	Not covered
Generic drugs	$45 per prescription	Not covered
Preferred brand drugs[2]	$150 per prescription	Not covered
Non-preferred brand drugs[2]	$210 per prescription	Not covered
Specialty Pharmacies (up to a 30-day supply)		
Specialty drugs[2] (May require prior authorization from Blue Shield. Specialty drugs are covered only when dispensed by Network Specialty Pharmacies. Drugs from non-participating pharmacies are not covered except in emergency and urgent situations.)	20%	Not covered
Oral Anti-cancer Medications	20% up to a maximum of $200 per prescription	Not covered
	Participating Providers[1]	**Non-Participating Providers**[1]
PROSTHETICS/ORTHOTICS		
Prosthetic equipment and devices (separate office visit copay may apply)	20%	50%
Orthotic equipment and devices (separate office visit copay may apply)	20%	50%

Covered Services	Member Copayments	
	Participating Providers[1]	Non-Participating Providers[1]
DURABLE MEDICAL EQUIPMENT		
Breast pump	$0	Not covered
Other durable medical equipment	20%	50%
MENTAL HEALTH SERVICES[11]		
Inpatient hospital services[2] (prior authorization required)	20%	50%[4] 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 mental health services (some services may require prior authorization and facility charges)	$45	50%
SUBSTANCE ABUSE SERVICES[11]		
Inpatient hospital services [2] (prior authorization required)	20%	50%[4] 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 substance abuse services (some services may require prior authorization and facility charges)	$45	50%
HOME HEALTH SERVICES		
Home health care agency services (up to 100 prior authorized visits per calendar year)	20%	Not covered (unless prior authorized)
OTHER		
Pregnancy and Maternity Care Benefits		
Prenatal physician office visits	$0	50%
Postnatal physician office visits	$45	50%
Inpatient hospital services for normal delivery and cesarean section	20%	50%[4] 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
Abortion services[12]	20%	50%
Family Planning Benefits		
Injectable and implantable contraceptives	$0	Not covered
Counseling and consulting	$0	Not covered
Tubal ligation	$0	Not covered
Vasectomy	20%	Not covered
Infertility services	Not covered	Not covered
Rehabilitation Benefits		
Office location	$45	50%
Outpatient department of a hospital	$45	50%[4] 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
Chiropractic Benefits		
Chiropractic services	Not covered	Not covered
Acupuncture Benefits		
Acupuncture services	$45	50%
Care Outside of California (benefits provided through the BlueCard® Program for out-of-state emergency and non-emergency care are provided at the preferred 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
Pediatric Dental Benefits – pediatric dental benefits are available for members through the end of the year in which the member turns 19		
Child Dental Diagnostic and Preventive		
Oral exam	No charge	20%

Covered Services	Member Copayments	
	Participating Providers[1]	**Non-Participating Providers**[1]
Preventive - cleaning	No charge	20%
Preventive - X-ray	No charge	20%
Sealants per tooth	No charge	20%
Topical fluoride application	No charge	20%
Caries risk management	No charge	20%
Space maintainers - fixed	No charge	20%
Child Dental Basic Services		
Amalgam fill - 1 surface	20%	30%
Child Dental Major Services[2]		
Root canal - molar	50%	50%
Gingivectomy per quad	50%	50%
Extraction - single tooth exposed root or	50%	50%
Extraction - complete bony	50%	50%
Porcelain with metal crown	50%	50%
Child Orthodontics[2]		
Medically necessary orthodontics	50%	50%
Pediatric Vision Benefits – for children up to age 19		
Comprehensive Eye Exam[13] one per calendar year (includes dilation, if professionally indicated)		
Ophthalmologic - Routine ophthalmologic exam with refraction – new patient (S0620) - Routine ophthalmologic exam with refraction – established patient (S0621)	$0	Covered up to a maximum allowance of $30
Optometric - New patient exam (92002/92004) - Established patient exam (92012/92014)	$0	Covered up to a maximum allowance of $30
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. Polycarbonate lenses are covered in full for eligible members.	$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
Anti-reflective coating (standard only)	$35	Not covered
High-index lenses	$30	Not covered
Photochromic lenses (glass or plastic)	$25	Not covered
Polarized lenses	$45	Not covered
Standard progressives	$55	Not covered
Premium progressives	$95	Not covered
Frame (one frame per calendar year)		Covered up to a maximum allowance $40
Collection frame	$0	
Non-collection frame[14] Note: "Collection" frames are available at no cost at participating independent providers. Retail chain providers typically do not display the "Collection," but are required to maintain a comparable selection of frames that are covered in full.	Covered up to a maximum allowance of $150	
Contact Lenses[15]		
Elective – standard hard (V2500, V2510)	$0 (1 pair per year)	Covered up to a maximum allowance of $75
Elective – standard soft (V2520)	$0 (1 pair per month for up to 6 months)	Covered up to a maximum allowance of $75
Elective – non-standard hard (V2501, V2502, V2503, V2511, V2512, V2513, V2599)	$0 (1 pair per year)	Covered up to a maximum allowance of $75
Elective – non-standard soft (V2521, V2512, V2523)	$0 (1 pair per month for up to 3 months)	Covered up to a maximum allowance of $75

Covered Services	Member Copayments	
	Participating Providers[1]	Non-Participating Providers[1]
Medically necessary	$0 (1 pair per year)	Covered up to a maximum allowance of $225
Other Pediatric Vision Benefits		
Supplemental low-vision testing and equipment[16]	35%	Not covered
Diabetes management referral	$0	Not covered

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

Pediatric Dental Benefits Endnotes:

1 The Calendar Year Deductible and Copayments for Covered Services from Participating Dentists accrue to the Calendar Year Out-of-Pocket Maximum, including any Copayments for covered orthodontia services received from Participating Dentists. Costs for non-Covered Services, services from Non-Participating Dentists, charges in excess of benefit maximums, and Premiums, do not accrue to the Calendar Year Out-of-Pocket Maximum. The out-of-pocket maximum for the embedded pediatric dental benefit accumulates to the overall combined medical and dental out-of-pocket maximum amount. This maximum is calculated as follows: (Federal out-of-pocket maximum) minus (SADP or Family Dental Plan out-of-pocket maximum) equals (QHP out-of-pocket maximum); numerically this is $6,600 - $350 = $6,250.

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

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

Those immediate qualifying conditions are:

- Cleft lip and or palate deformities
- Craniofacial Anomalies including the following: Crouzon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, Hemi-facial atrophy, Hem-facial hypertrophy and other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by our dental consultants.
- Deep impinging overbite, where the lower incisors are destroying the soft tissue of the palate and tissue laceration and/or clinical attachment loss are present. (Contact only does not constitute deep impinging overbite).
- Crossbite of individual anterior teeth when clinical attachment loss and recession of the gingival margin are present (e.g., stripping of the labial gingival tissue on the lower incisors). Treatment of bi-lateral posterior crossbite is not a benefit of the program.
- Severe traumatic deviation must be justified by attaching a description of the condition.
- Overjet greater than 9mm or mandibular protusion (reverse overjet) greater than 3.5mm.
- The remaining conditions must score 26 or more to qualify (based on the HDL Index).

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

Endnotes for Silver 70 PPO

1 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. The member is responsible for these charges in addition to the applicable copayment or coinsurance when accessing these providers, which amount can be substantial. Amounts applied to the calendar year deductible accrue towards the applicable out-of-pocket maximum. Charges in excess of the allowable amount do not count toward the calendar year medical deductible or out-of-pocket maximum.

2 The covered services listed below are subject to, and will accrue to the calendar year medical or brand drug deductibles.

- Ambulance benefits
- Bariatric surgery benefits: hospital inpatient services
- Emergency room benefits: emergency room services (facility)
- Hospital benefits (facility services): inpatient facility services, inpatient skilled nursing services including subacute care, and inpatient services to treat acute medical complications of detoxification
- Medical treatment for the teeth, gums, jaw joints, or jaw bones benefits: inpatient hospital services
- Mental health and substance abuse benefits: inpatient hospital services, and residential care
- Outpatient X-Ray, imaging, pathology, and laboratory benefits: radiological and nuclear imaging services
- Pregnancy and maternity care benefits: inpatient hospital services
- Reconstructive surgery benefits: inpatient hospital services
- Skilled nursing facility benefits
- Transplant benefits: inpatient hospital or facility services
- Preferred brand drugs, non-preferred brand drugs, and specialty drugs (subject to and accrues to the brand drug deductible)

3 Copayments or coinsurance for covered services apply toward the calendar year out-of-pocket maximum, except copayments or coinsurance for the following: (a) charges in excess of specified benefit maximums; (b) covered travel expenses for bariatric surgery; and (c) dialysis center services from a non-participating provider. Copayments, coinsurance, and charges for services not accruing to the calendar year out-of-pocket maximum continue to be the member's responsibility after the calendar year out-of-pocket maximum is reached.

4 The allowable amount for non-emergency services and supplies received from a non-participating hospital or facility is limited to $500 per day. Members are responsible for the coinsurance and all charges that exceed $500 per day.

5 The allowable amount for non-emergency services and supplies received from an ambulatory surgery center is limited to $300 per day. Members are responsible for the coinsurance and all charges that exceed $300 per day. Participating ambulatory surgery centers may not be available in all areas; however, the member can obtain outpatient surgery services from a hospital or an ambulatory surgery center affiliated with a hospital, with payment according to the hospital services benefit.

6 The allowable amount for non-emergency services and supplies received from a non-participating radiology center is limited to $300 per day. Members are responsible for all charges that exceed $300 per day. The allowable amount for non-emergency services and supplies received from a non-participating hospital is limited to $500 per day. Members are responsible for all charges that exceed $500 per day.

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 Evidence of Coverage and Summary of Benefits for details.

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

9 Contraceptive drugs and devices covered under the outpatient prescription drug benefit do not require a copayment and will not be subject to any calendar year brand drug deductible; however, if a brand contraceptive drug is requested when a generic drug equivalent is available, the member is responsible for paying the difference between the cost to Blue Shield for the brand contraceptive drug and its generic drug equivalent. If the brand contraceptive drug is medically necessary, it may be covered without a copayment with prior authorization. The difference in cost that the member must pay does not accrue to any calendar year brand drug deductible, medical deductible, or the calendar year out-of-pocket maximum responsibility.

10 If a member or physician requests a brand drug when a generic drug equivalent is available, and the calendar year brand drug deductible has been satisfied, the member is responsible for paying the difference between the cost to Blue Shield for the brand drug and its generic drug equivalent, as well as the applicable generic drug copayment. The difference in cost that the member must pay does not accrue to any calendar year brand drug deductible, medical deductible, or the calendar year out-of-pocket maximum responsibility. Refer to the Evidence of Coverage and Summary of Benefits for details.

11 Blue Shield has contracted with a specialized health care service plan to act as our mental health services administrator (MHSA). The MHSA provides mental health and chemical dependency services, other than inpatient services for acute medical detoxification, through a separate network of MHSA participating providers. Inpatient acute medical detoxification is a medical benefit provided by Blue Shield participating or non-participating (not MHSA) providers.

12 Copayment shown is for physician's services. If the procedure is performed in a facility setting (hospital or outpatient surgery center), an additional facility copayment may apply.

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

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

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

16 A report from the provider and prior authorization from the Vision Plan Administrator is required.

This plan is pending regulatory approval.

Silver 94 PPO

This federally subsidized plan is only available to those whose income is 150% above federal poverty level.

Uniform Health Plan Benefits and Coverage Matrix

Blue Shield of California

Effective January 1, 2015

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 PPO plan uses the Exclusive PPO provider network.

	Participating Providers[1]	Non-Participating Providers[1]
Calendar Year Medical Deductible	$0	
Calendar Year Out-of-Pocket Maximum[2] (Copayments for participating providers apply to both participating and non-participating provider calendar year out-of-pocket maximum amounts.)	$2,250 per individual / $4,500 per family	$5,250 per individual / $10,500 per family
Calendar Year Brand Drug Deductible	$0	Not covered
Lifetime Benefit Maximum	None	

Covered Services	Member Copayments	
	Participating Providers[1]	**Non-Participating Providers**[1]
PROFESSIONAL SERVICES		
Professional (Physician) Benefits		
Physician office visits from internal medicine, family practice, pediatric, and OB/Gyn physicians	$3	50%
Specialist physician office visits	$5	50%
Outpatient diagnostic X-ray and imaging (non-hospital-based or -affiliated)	$5	50%
Outpatient diagnostic laboratory and pathology (non-hospital-based or -affiliated)	$3	50%
Preventive Health Benefits		
Preventive health services (as required by federal and California law)	$0	Not covered
OUTPATIENT SERVICES		
Outpatient surgery in a hospital	10%	50%[3] 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 surgery performed at an ambulatory surgery center	10%	50%[4] 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 services for treatment of illness or injury and necessary supplies	10%	50%[3] 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	$5	50%[3] The maximum allowed amount for non-participating providers is $500 per day. Members are responsible for 50% of this $500 per day, plus all charges in excess of $500

Covered Services	Member Copayments	
	Participating Providers[1]	**Non-Participating Providers**[1]
Outpatient diagnostic laboratory and pathology performed in a hospital	$3	50%[3] 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 (prior authorization is required)	10%	50%[5] 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
HOSPITALIZATION SERVICES		
Inpatient physician services	10%	50%
Inpatient non-emergency facility services (semi-private room and board, services and supplies, including subacute care)	10%	50%[3] 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 (prior authorization is required; medically necessary surgery for weight loss is for morbid obesity only)[6]	10%	Not covered
EMERGENCY HEALTH COVERAGE		
Emergency room services not resulting in admission	$25	$25
Emergency room services resulting in admission (when the member is admitted directly from the ER)	10%	10%
Emergency room physician services	10%	10%
Urgent care	$6	50%
AMBULANCE SERVICES		
Emergency or authorized transport (ground or air)	$25	$25
PRESCRIPTION DRUG COVERAGE[7,8,9]	**Participating Pharmacy**	**Non-Participating Pharmacy**
Retail Prescriptions (up to a 30-day supply)		
Contraceptive drugs and devices[8]	$0	Not covered
Generic drugs	$3 per prescription	Not covered
Preferred brand drugs	$5 per prescription	Not covered
Non-preferred brand drugs	$10 per prescription	Not covered
Mail Service Prescriptions (up to a 90-day supply)		
Contraceptive drugs and devices[8]	$0	Not covered
Generic drugs	$9 per prescription	Not covered
Preferred brand drugs	$15 per prescription	Not covered
Non-preferred brand drugs	$30 per prescription	Not covered
Specialty Pharmacies (up to a 30-day supply)		
Specialty drugs (May require prior authorization from Blue Shield. Specialty drugs are covered only when dispensed by Network Specialty Pharmacies. Drugs from non-participating pharmacies are not covered except in emergency and urgent situations.)	10%	Not covered
Oral Anti-cancer Medications	10% up to a maximum of $200 per prescription	Not covered
	Participating Providers[1]	**Non-Participating Providers**[1]
PROSTHETICS/ORTHOTICS		
Prosthetic equipment and devices (separate office visit copay may apply)	10%	50%
Orthotic equipment and devices (separate office visit copay may apply)	10%	50%
DURABLE MEDICAL EQUIPMENT		
Breast pump	$0	Not covered
Other durable medical equipment	10%	50%
MENTAL HEALTH SERVICES[10]		
Inpatient hospital services (prior authorization required)	10%	50%[3] The maximum allowed amount for

Covered Services	Member Copayments	
	Participating Providers[1]	**Non-Participating Providers**[1]
		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 mental health services (some services may require prior authorization and facility charges)	$3	50%
SUBSTANCE ABUSE SERVICES[10]		
Inpatient hospital services (prior authorization required)	10%	50%[3] 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 substance abuse services (some services may require prior authorization and facility charges)	$3	50%
HOME HEALTH SERVICES		
Home health care agency services (up to 100 prior authorized visits per calendar year)	10%	Not covered (unless prior authorized)
OTHER		
Pregnancy and Maternity Care Benefits		
Prenatal physician office visits	$0	50%
Postnatal physician office visits	$3	50%
Inpatient hospital services for normal delivery and cesarean section	10%	50%[3] 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
Abortion services[11]	10%	50%
Family Planning Benefits		
Injectable and implantable contraceptives	$0	Not covered
Counseling and consulting	$0	Not covered
Tubal ligation	$0	Not covered
Vasectomy	10%	Not covered
Infertility services	Not covered	Not covered
Rehabilitation and Habilitation Benefits		
Office location	$3	50%
Outpatient department of a hospital	$3	50%[3] 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
Chiropractic Benefits		
Chiropractic services	Not covered	Not covered
Acupuncture Benefits		
Acupuncture services	$3	50%
Care Outside of California (benefits provided through the BlueCard® Program for out-of-state emergency and non-emergency care are provided at the preferred 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
Pediatric Dental Benefits – pediatric dental benefits are available for members through the end of the year in which the member turns 19		
Child Dental Diagnostic and Preventive		
Oral exam	No charge	20%
Preventive - cleaning	No charge	20%
Preventive - X-ray	No charge	20%
Sealants per tooth	No charge	20%
Topical fluoride application	No charge	20%
Caries risk management	No charge	20%
Space maintainers - fixed	No charge	20%

Covered Services	Member Copayments	
	Participating Providers[1]	**Non-Participating Providers**[1]
Child Dental Basic Services		
Amalgam fill - 1 surface	20%	30%
Child Dental Major Services[2]		
Root canal - molar	50%	50%
Gingivectomy per quad	50%	50%
Extraction - single tooth exposed root or	50%	50%
Extraction - complete bony	50%	50%
Porcelain with metal crown	50%	50%
Child Orthodontics[2]		
Medically necessary orthodontics	50%	50%
Pediatric Vision Benefits – for children up to age 19		
Comprehensive Eye Exam[12]: 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 a maximum allowance of $30
Optometric - New patient exam (92002/92004) - Established patient exam (92012/92014)	$0	Covered up to a maximum allowance of $30
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. Polycarbonate lenses are covered in full for eligible members.	$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
Anti-reflective coating (standard only)	$35	Not covered
High-index lenses	$30	Not covered
Photochromic lenses (glass or plastic)	$25	Not covered
Polarized lenses	$45	Not covered
Standard progressives	$55	Not covered
Premium progressives	$95	Not covered
Frame (one frame per calendar year) Collection frame Non-collection frame[13] Note: "Collection" frames are available at no cost at participating independent providers. Retail chain providers typically do not display the "Collection," but are required to maintain a comparable selection of frames that are covered in full.	$0 Covered up to a maximum allowance of $150	Covered up to a maximum allowance $40
Contact Lenses[14]		
Elective – standard hard (V2500, V2510)	$0 (1 pair per year)	Covered up to a maximum allowance of $75
Elective – standard soft (V2520)	$0 (1 pair per month for up to 6 months)	Covered up to a maximum allowance of $75
Elective – non-standard hard (V2501, V2502, V2503, V2511, V2512, V2513, V2599)	$0 (1 pair per year)	Covered up to a maximum allowance of $75
Elective – non-standard soft (V2521, V2512, V2523)	$0 (1 pair per month for up to 3 months)	Covered up to a maximum allowance of $75
Medically necessary	$0 (1 pair per year)	Covered up to a maximum allowance of $225 for medically necessary contact lenses
Other Pediatric Vision Benefits		
Supplemental low-vision testing and equipment[15]	35%	Not covered

Covered Services	Member Copayments	
	Participating Providers[1]	Non-Participating Providers[1]
Diabetes management referral	$0	Not covered

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

Pediatric Dental Benefits Endnotes:

1 The Calendar Year Deductible and Copayments for Covered Services from Participating Dentists accrue to the Calendar Year Out-of-Pocket Maximum, including any Copayments for covered orthodontia services received from Participating Dentists. Costs for non-Covered Services, services from Non-Participating Dentists, charges in excess of benefit maximums, and Premiums, do not accrue to the Calendar Year Out-of-Pocket Maximum. The out-of-pocket maximum for the embedded pediatric dental benefit accumulates to the overall combined medical and dental out-of-pocket maximum amount. This maximum is calculated as follows: (Federal out-of-pocket maximum) minus (SADP or Family Dental Plan out-of-pocket maximum) equals (QHP out-of-pocket maximum); numerically this is $6,600 - $350 = $6,250.

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

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

Those immediate qualifying conditions are:

- Cleft lip and or palate deformities
- Craniofacial Anomalies including the following: Crouzon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, Hemi-facial atrophy, Hem-facial hypertrophy and other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by our dental consultants.
- Deep impinging overbite, where the lower incisors are destroying the soft tissue of the palate and tissue laceration and/or clinical attachment loss are present. (Contact only does not constitute deep impinging overbite).
- Crossbite of individual anterior teeth when clinical attachment loss and recession of the gingival margin are present (e.g., stripping of the labial gingival tissue on the lower incisors). Treatment of bi-lateral posterior crossbite is not a benefit of the program.
- Severe traumatic deviation must be justified by attaching a description of the condition.
- Overjet greater than 9mm or mandibular protusion (reverse overjet) greater than 3.5mm.
- The remaining conditions must score 26 or more to qualify (based on the HDL Index).

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

Endnotes for Silver 94 PPO

1 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 which the member is responsible for in addition to the applicable copayment or coinsurance when accessing these providers, which amount can be substantial. Charges in excess of the allowable amount do not count toward the calendar year out-of-pocket maximum.

2 Copayments or coinsurance for covered services apply toward the calendar year out-of-pocket maximum, except copayments or coinsurance for the following: (a) charges in excess of specified benefit maximums; (b) covered travel expenses for bariatric surgery; and (d) dialysis center services from a non-participating provider. Copayments, coinsurance, and charges for services not accruing to the calendar year out-of-pocket maximum continue to be the member's responsibility after the calendar year out-of-pocket maximum is reached.

3 The allowable amount for non-emergency services and supplies received from a non-participating hospital or facility is limited to $500 per day. Members are responsible for the coinsurance and all charges that exceed $500 per day.

4 The allowable amount for non-emergency services and supplies received from an ambulatory surgery center is limited to $300 per day. Members are responsible for the coinsurance and all charges that exceed $300 per day. Participating ambulatory surgery centers may not be available in all areas; however, the member can obtain outpatient surgery services from a hospital or an ambulatory surgery center affiliated with a hospital, with payment according to the hospital services benefit.

5 The allowable amount for non-emergency services and supplies received from a non-participating radiology center is limited to $300 per day. Members are responsible for all charges that exceed $300 per day. The allowable amount for non-emergency services and supplies received from a non-participating hospital is limited to $500 per day. Members are responsible for all charges that exceed $500 per day.

6 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 Evidence of Coverage and Summary of Benefits for details.

7 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.

8 Contraceptive drugs and devices covered under the outpatient prescription drug benefit do not require a copayment; however, if a brand contraceptive drug is requested when a generic drug equivalent is available, the member is responsible for paying the difference between the cost to Blue Shield for the brand contraceptive drug and its generic drug equivalent. If the brand contraceptive drug is medically necessary, it may be covered without a copayment with prior authorization. The difference in cost that the member must pay does not accrue to any calendar year out-of-pocket maximum responsibility.

9 If a member or physician requests a brand drug when a generic drug equivalent is available, the member is responsible for paying the difference between the cost to Blue Shield for the brand drug and its generic drug equivalent, as well as the applicable generic drug copayment. The difference in cost that the member must pay does not accrue to any calendar year out-of-pocket maximum responsibility. Refer to the Policy and Summary of Benefits for details.

10 Blue Shield has contracted with a specialized health care service plan to act as our mental health services administrator (MHSA). The MHSA provides mental health and chemical dependency services, other than inpatient services for acute medical detoxification, through a separate network of MHSA participating providers. Inpatient acute medical detoxification is a medical benefit provided by Blue Shield participating or non-participating (not MHSA) providers.

11 Copayment shown is for physician's services. If the procedure is performed in a facility setting (hospital or outpatient surgery center), an additional facility copayment may apply.

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

13 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.

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

15 A report from the provider and prior authorization from the Vision Plan Administrator is required.

This plan is pending regulatory approval.

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This PPO plan uses the Exclusive PPO provider network.

	Participating Providers[1]	Non-Participating Providers[1]
Calendar Year Medical Deductible[2] (For family coverage, an individual is responsible for satisfying their own individual deductible and that amount accumulates to the family deductible.)	$500 per individual / $1,000 per family (all providers combined)	
Calendar Year Out-of-Pocket Maximum[3] (Includes the calendar year medical deductible. Copayments for participating providers apply to both participating and non-participating provider calendar year out-of-pocket maximum amounts.)	$2,250 per individual / $4,500 per family	$5,250 per individual / $10,500 per family
Calendar Year Brand Drug Deductible (Separate from the calendar year medical deductible. Accrues to the calendar year out-of-pocket maximum. For family coverage, an individual is responsible for satisfying their own individual deductible and that amount accumulates to the family deductible.)	$50 per individual / $100 per family	Not covered
Lifetime Benefit Maximum	None	

Covered Services	**Member Copayments**	
	Participating Providers[1]	**Non-Participating Providers**[1]
PROFESSIONAL SERVICES		
Professional (Physician) Benefits		
Physician office visits from internal medicine, family practice, pediatric, and OB/Gyn physicians	$15	50%
Specialist physician office visits	$20	50%
Outpatient diagnostic X-ray and imaging (non-hospital-based or -affiliated)	$20	50%
Outpatient diagnostic laboratory and pathology (non-hospital-based or -affiliated)	$15	50%
Preventive Health Benefits		
Preventive health services (as required by federal and California law)	$0	Not covered
OUTPATIENT SERVICES		
Outpatient surgery in a hospital	15%	50%[4] 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 surgery performed at an ambulatory surgery center	15%	50%[5] 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 services for treatment of illness or injury and necessary supplies	15%	50%[4] The maximum allowed amount for non-participating providers is $500 per day. Members are responsible for 50% of this $500 per day, plus all charges in excess of $500

Covered Services	Member Copayments	
	Participating Providers[1]	**Non-Participating Providers**[1]
Outpatient diagnostic X-ray and imaging performed in a hospital	$20	50%[4] 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	$15	50%[4] 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[2] (prior authorization is required)	15%	50%[6] 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
HOSPITALIZATION SERVICES		
Inpatient physician services	15%	50%
Inpatient non-emergency facility services[2] (semi-private room and board, services and supplies, including subacute care)	15%	50%[4] 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 (prior authorization is required; medically necessary surgery for weight loss is for morbid obesity only)[2,7]	15%	Not covered
EMERGENCY HEALTH COVERAGE		
Emergency room services not resulting in admission[2]	$75	$75
Emergency room services resulting in admission[2] (when the member is admitted directly from the ER)	15%	15%
Emergency room physician services	15%	15%
Urgent care	$30	50%
AMBULANCE SERVICES		
Emergency or authorized transport[2] (ground or air)	$75	$75
PRESCRIPTION DRUG COVERAGE[8,9,10]	**Participating Pharmacy**	**Non-Participating Pharmacy**
Retail Prescriptions (up to a 30-day supply)		
Contraceptive drugs and devices[9]	$0	Not covered
Generic drugs	$5 per prescription	Not covered
Preferred brand drugs[2]	$15 per prescription	Not covered
Non-preferred brand drugs[2]	$25 per prescription	Not covered
Mail Service Prescriptions (up to a 90-day supply)		
Contraceptive drugs and devices[9]	$0	Not covered
Generic drugs	$15 per prescription	Not covered
Preferred brand drugs[2]	$45 per prescription	Not covered
Non-preferred brand drugs[2]	$75 per prescription	Not covered
Specialty Pharmacies (up to a 30-day supply)		
Specialty drugs (May require prior authorization from Blue Shield. Specialty drugs are covered only when dispensed by Network Specialty Pharmacies. Drugs from non-participating pharmacies are not covered except in emergency and urgent situations.)	15%	No covered
Oral Anti-cancer Medications	15% up to a maximum of $200 per prescription	Not covered
	Participating Providers[1]	**Non-Participating Providers**[1]
PROSTHETICS/ORTHOTICS		
Prosthetic equipment and devices (separate office visit copay may apply)	15%	50%
Orthotic equipment and devices (separate office visit copay may apply)	15%	50%

Covered Services	Member Copayments	
	Participating Providers[1]	Non-Participating Providers[1]
DURABLE MEDICAL EQUIPMENT		
Breast pump	$0	Not covered
Other durable medical equipment	15%	50%
MENTAL HEALTH SERVICES[11]		
Inpatient hospital services[2] (prior authorization required)	15%	50%[4] 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 mental health services (some services may require prior authorization and facility charges)	$15	50%
SUBSTANCE ABUSE SERVICES[11]		
Inpatient hospital [2] (prior authorization required)	15%	50%[4] 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 substance abuse services (some services may require prior authorization and facility charges)	$15	50%
HOME HEALTH SERVICES		
Home health care agency services (up to 100 prior authorized visits per calendar year)	15%	Not covered (unless prior authorized)
OTHER		
Pregnancy and Maternity Care Benefits		
Prenatal physician office visits	$0	50%
Postnatal physician office visits	$15	50%
Inpatient hospital services for normal delivery and cesarean section[2]	15%	50%[4] 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
Abortion services[12]	15%	50%
Family Planning Benefits		
Injectable and implantable contraceptives	$0	Not covered
Counseling and consulting	$0	Not covered
Tubal ligation	$0	Not covered
Vasectomy	15%	Not covered
Infertility services	Not covered	Not covered
Rehabilitation and Habilitation Benefits		
Office location	$15	50%
Outpatient department of a hospital	$15	50%[4] 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
Chiropractic Benefits		
Chiropractic services	Not covered	Not covered
Acupuncture Benefits		
Acupuncture services	$15	50%
Care Outside of California (benefits provided through the BlueCard® Program for out-of-state emergency and non-emergency care are provided at the preferred 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
Pediatric Dental Benefits – pediatric dental benefits are available for members through the end of the year in which the member turns 19		
Child Dental Diagnostic and Preventive		
Oral exam	No charge	20%

Covered Services	Member Copayments	
	Participating Providers[1]	**Non-Participating Providers**[1]
Preventive - cleaning	No charge	20%
Preventive - X-ray	No charge	20%
Sealants per tooth	No charge	20%
Topical fluoride application	No charge	20%
Caries risk management	No charge	20%
Space maintainers - fixed	No charge	20%
Child Dental Basic Services		
Amalgam fill - 1 surface	20%	30%
Child Dental Major Services[2]		
Root canal - molar	50%	50%
Gingivectomy per quad	50%	50%
Extraction - single tooth exposed root or	50%	50%
Extraction - complete bony	50%	50%
Porcelain with metal crown	50%	50%
Child Orthodontics[2]		
Medically necessary orthodontics	50%	50%
Pediatric Vision Benefits – for children up to age 19		
Comprehensive Eye Exam[13]: one per calendar year (includes dilation, if professionally indicated)		
Ophthalmologic - Routine ophthalmologic exam with refraction – new patient (S0620) - Routine ophthalmologic exam with refraction – established patient (S0621)	$0	Covered up to a maximum allowance of $30
Optometric - New patient exam (92002/92004) - Established patient exam (92012/92014)	$0	Covered up to a maximum allowance of $30
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. Polycarbonate lenses are covered in full for eligible members.	$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
Anti-reflective coating (standard only)	$35	Not covered
High-index lenses	$30	Not covered
Photochromic lenses (glass or plastic)	$25	Not covered
Polarized lenses	$45	Not covered
Standard progressives	$55	Not covered
Premium progressives	$95	Not covered
Frame (one frame per calendar year) Collection frame Non-collection frame[14] Note: "Collection" frames are available at no cost at participating independent providers. Retail chain providers typically do not display the "Collection," but are required to maintain a comparable selection of frames that are covered in full.	$0 Covered up to a maximum allowance of $150	Covered up to a maximum allowance $40
Contact Lenses[15]		
Elective – standard hard (V2500, V2510)	$0 (1 pair per year)	Covered up to a maximum allowance of $75
Elective – standard soft (V2520)	$0 (1 pair per month for up to 6 months)	Covered up to a maximum allowance of $75
Elective – non-standard hard (V2501, V2502, V2503, V2511, V2512, V2513, V2599)	$0 (1 pair per year)	Covered up to a maximum allowance of $75
Elective – non-standard soft (V2521, V2512, V2523)	$0 (1 pair per month for up to 3 months)	Covered up to a maximum allowance of $75

Covered Services	Member Copayments	
	Participating Providers[1]	Non-Participating Providers[1]
Medically necessary	$0 (1 pair per year)	Covered up to a maximum allowance of $225 for medically necessary contact lenses
Other Pediatric Vision Benefits		
Supplemental low-vision testing and equipment[16]	35%	Not covered
Diabetes management referral	$0	Not covered

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

Pediatric Dental Benefits Endnotes:

1 The Calendar Year Deductible and Copayments for Covered Services from Participating Dentists accrue to the Calendar Year Out-of-Pocket Maximum, including any Copayments for covered orthodontia services received from Participating Dentists. Costs for non-Covered Services, services from Non-Participating Dentists, charges in excess of benefit maximums, and Premiums, do not accrue to the Calendar Year Out-of-Pocket Maximum. The out-of-pocket maximum for the embedded pediatric dental benefit accumulates to the overall combined medical and dental out-of-pocket maximum amount. This maximum is calculated as follows: (Federal out-of-pocket maximum) minus (SADP or Family Dental Plan out-of-pocket maximum) equals (QHP out-of-pocket maximum); numerically this is $6,600 - $350 = $6,250.

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

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

Those immediate qualifying conditions are:

- Cleft lip and or palate deformities
- Craniofacial Anomalies including the following: Crouzon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, Hemi-facial atrophy, Hem-facial hypertrophy and other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by our dental consultants.
- Deep impinging overbite, where the lower incisors are destroying the soft tissue of the palate and tissue laceration and/or clinical attachment loss are present. (Contact only does not constitute deep impinging overbite).
- Crossbite of individual anterior teeth when clinical attachment loss and recession of the gingival margin are present (e.g., stripping of the labial gingival tissue on the lower incisors). Treatment of bi-lateral posterior crossbite is not a benefit of the program.
- Severe traumatic deviation must be justified by attaching a description of the condition.
- Overjet greater than 9mm or mandibular protusion (reverse overjet) greater than 3.5mm.
- The remaining conditions must score 26 or more to qualify (based on the HDL Index).

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

Endnotes for Silver 87 PPO

1 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. The member is responsible for these charges in addition to the applicable copayment or coinsurance when accessing these providers, which amount can be substantial. Amounts applied to the calendar year deductible accrue towards the applicable out-of-pocket maximum. Charges in excess of the allowable amount do not count toward the calendar year medical deductible or out-of-pocket maximum.

2 The covered services listed below are subject to, and will accrue to the calendar year medical or brand drug deductibles.

- Ambulance benefits
- Bariatric surgery benefits: hospital inpatient services
- Emergency room benefits: emergency room services (facility)
- Hospital benefits (facility services): inpatient facility services, inpatient skilled nursing services including subacute care, and inpatient services to treat acute medical complications of detoxification
- Medical treatment for the teeth, gums, jaw joints, or jaw bones benefits: inpatient hospital services
- Mental health and substance abuse benefits: inpatient hospital services, and residential care
- Outpatient X-Ray, imaging, pathology, and laboratory benefits: radiological and nuclear imaging services
- Pregnancy and maternity care benefits: inpatient hospital services
- Reconstructive surgery benefits: inpatient hospital services

- Skilled nursing facility benefits
- Transplant benefits: inpatient hospital or facility services
- Preferred brand drugs, non-preferred brand drugs, and specialty drugs (subject to and accrues to the brand drug deductible)

3 Copayments or coinsurance for covered services apply toward the calendar year out-of-pocket maximum, except copayments or coinsurance for the following: (a) charges in excess of specified benefit maximums; (b) covered travel expenses for bariatric surgery; and (c) dialysis center services from a non-participating provider. Copayments, coinsurance, and charges for services not accruing to the calendar year out-of-pocket maximum continue to be the member's responsibility after the calendar year out-of-pocket maximum is reached.

4 The allowable amount for non-emergency services and supplies received from a non-participating hospital or facility is limited to $500 per day. Members are responsible for the coinsurance and all charges that exceed $500 per day.

5 The allowable amount for non-emergency services and supplies received from an ambulatory surgery center is limited to $300 per day. Members are responsible for the coinsurance and all charges that exceed $300 per day. Participating ambulatory surgery centers may not be available in all areas; however, the member can obtain outpatient surgery services from a hospital or an ambulatory surgery center affiliated with a hospital, with payment according to the hospital services benefit.

6 The allowable amount for non-emergency services and supplies received from a non-participating radiology center is limited to $300 per day. Members are responsible for all charges that exceed $300 per day. The allowable amount for non-emergency services and supplies received from a non-participating hospital is limited to $500 per day. Members are responsible for all charges that exceed $500 per day.

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 Evidence of Coverage and Summary of Benefits for details.

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

9 Contraceptive drugs and devices covered under the outpatient prescription drug benefit do not require a copayment and will not be subject to any calendar year brand drug deductible; however, if a brand contraceptive drug is requested when a generic drug equivalent is available, the member is responsible for paying the difference between the cost to Blue Shield for the brand contraceptive drug and its generic drug equivalent. If the brand contraceptive drug is medically necessary, it may be covered without a copayment with prior authorization. The difference in cost that the member must pay does not accrue to any calendar year brand drug deductible, medical deductible, or the calendar year out-of-pocket maximum responsibility.

10 If a member or physician requests a brand drug when a generic drug equivalent is available, and the calendar year brand drug deductible has been satisfied, the member is responsible for paying the difference between the cost to Blue Shield for the brand drug and its generic drug equivalent, as well as the applicable generic drug copayment. The difference in cost that the member must pay does not accrue to any calendar year brand drug deductible, medical deductible, or the calendar year out-of-pocket maximum responsibility. Refer to the Policy and Summary of Benefits for details.

11 Blue Shield has contracted with a specialized health care service plan to act as our mental health services administrator (MHSA). The MHSA provides mental health and chemical dependency services, other than inpatient services for acute medical detoxification, through a separate network of MHSA participating providers. Inpatient acute medical detoxification is a medical benefit provided by Blue Shield participating or non-participating (not MHSA) providers.

12 Copayment shown is for physician's services. If the procedure is performed in a facility setting (hospital or outpatient surgery center), and additional facility copayment may apply.

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

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

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

16 A report from the provider and prior authorization from the Vision Plan Administrator is required.

This plan is pending regulatory approval.

Silver 73 PPO

This federally subsidized plan is only available to those whose income is 250% above federal poverty level.

Uniform Health Plan Benefits and Coverage Matrix

Blue Shield of California

Effective January 1, 2015

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 PPO plan uses the Exclusive PPO provider network.

	Participating Providers[1]	Non-Participating Providers[1]
Calendar Year Medical Deductible[2] (For family coverage, an individual is responsible for satisfying their own individual deductible and that amount accumulates to the family deductible.)	$1,600 per individual / $3,200 per family (all providers combined)	
Calendar Year Out-of-Pocket Maximum[3] (Includes the calendar year medical deductible. Copayments for participating providers apply to both participating and non-participating provider calendar year out-of-pocket maximum amounts.)	$5,200 per individual / $10,400 per family	$8,250 per individual / $16,500 per family
Calendar Year Brand Drug Deductible (Separate from the calendar year medical deductible. Accrues to the calendar year out-of-pocket maximum. For family coverage, an individual is responsible for satisfying their own individual deductible and that amount accumulates to the family deductible.)	$250 per individual / $500 per family	Not covered
Lifetime Benefit Maximum	None	

Covered Services	**Member Copayments**	
	Participating Providers[1]	**Non-Participating Providers**[1]
PROFESSIONAL SERVICES		
Professional (Physician) Benefits		
Physician office visits from internal medicine, family practice, pediatric, and OB/Gyn physicians	$40	50%
Specialist physician office visits	$50	50%
Outpatient diagnostic X-ray and imaging (non-hospital-based or -affiliated)	$50	50%
Outpatient diagnostic laboratory and pathology (non-hospital-based or -affiliated)	$40	50%
Preventive Health Benefits		
Preventive health services (as required by federal and California law)	$0	Not covered
OUTPATIENT SERVICES		
Outpatient surgery in a hospital	20%	50%[4] 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 surgery performed at an ambulatory surgery center	20%	50%[5] 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 services for treatment of illness or injury and necessary supplies	20%	50%[4] The maximum allowed amount for non-participating providers is $500 per day. Members are responsible for 50% of this $500 per day, plus all charges in excess of $500

Covered Services	Member Copayments	
	Participating Providers[1]	**Non-Participating Providers**[1]
Outpatient diagnostic X-ray and imaging performed in a hospital	$50	50%[4] 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	$40	50%[4] 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 (prior authorization is required)	20%	50%[6] 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
HOSPITALIZATION SERVICES		
Inpatient physician services	20%	50%
Inpatient non-emergency facility services[2] (semi-private room and board, services and supplies, including subacute care)	20%	50%[4] 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 (prior authorization is required; medically necessary surgery for weight loss is for morbid obesity only)[2,7]	20%	Not covered
EMERGENCY HEALTH COVERAGE		
Emergency room services not resulting in admission[2]	$250	$250
Emergency room services resulting in admission[2] (when the member is admitted directly from the ER)	20%	20%
Emergency room physician services	20%	20%
Urgent care	$80	50%
AMBULANCE SERVICES		
Emergency or authorized transport (ground or air)	$250	$250
PRESCRIPTION DRUG COVERAGE[8,9,10]	**Participating Pharmacy**	**Non-Participating Pharmacy**
Retail Prescriptions (up to a 30-day supply)		
Contraceptive drugs and devices[9]	$0	Not covered
Generic drugs	$15 per prescription	Not covered
Preferred brand drugs[2]	$35 per prescription	Not covered
Non-preferred brand drugs[2]	$60per prescription	Not covered
Mail Service Prescriptions (up to a 90-day supply)		
Contraceptive drugs and devices[9]	$0	Not covered
Generic drugs	$45 per prescription	Not covered
Preferred brand drugs[2]	$105 per prescription	Not covered
Non-preferred brand drugs[2]	$180 per prescription	Not covered
Specialty Pharmacies (up to a 30-day supply)		
Specialty drugs[2] (May require prior authorization from Blue Shield. Specialty drugs are covered only when dispensed by Network Specialty Pharmacies. Drugs from non-participating pharmacies are not covered except in emergency and urgent situations.)	20%	Not covered
Oral Anti-cancer Medications	20% up to a maximum of $200 per prescription	Not covered
	Participating Providers[1]	**Non-Participating Providers**[1]
PROSTHETICS/ORTHOTICS		
Prosthetic equipment and devices (separate office visit copay may apply)	20%	50%
Orthotic equipment and devices (separate office visit copay may apply)	20%	50%

Covered Services	Member Copayments	
	Participating Providers[1]	Non-Participating Providers[1]
DURABLE MEDICAL EQUIPMENT		
Breast pump	$0	Not covered
Other durable medical equipment	20%	50%
MENTAL HEALTH SERVICES[11]		
Inpatient hospital services[2] (prior authorization required)	20%	50%[4] 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 mental health services (some services may require prior authorization and facility charges)	$40	50%
SUBSTANCE ABUSE SERVICES[11]		
Inpatient hospital services [2] (prior authorization required)	20%	50%[4] 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 substance abuse services (some services may require prior authorization and facility charges)	$40	50%
HOME HEALTH SERVICES		
Home health care agency services (up to 100 prior authorized visits per calendar year)	20%	Not covered (unless prior authorized)
OTHER		
Pregnancy and Maternity Care Benefits		
Prenatal physician office visits	$0	50%
Postnatal physician office visits	$40	50%
Inpatient hospital services for normal delivery and cesarean section[2]	20%	50%[4] 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
Abortion services[12]	20%	50%
Family Planning Benefits		
Injectable and implantable contraceptives	$0	Not covered
Counseling and consulting	$0	Not covered
Tubal ligation	$0	Not covered
Vasectomy	20%	Not covered
Infertility services	Not covered	Not covered
Rehabilitation and Habilitation Benefits		
Office location	$40	50%
Outpatient department of a hospital	$40	50%[4] 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
Chiropractic Benefits		
Chiropractic services	Not covered	Not covered
Acupuncture Benefits		
Acupuncture services	$40	50%
Care Outside of California (benefits provided through the BlueCard® Program for out-of-state emergency and non-emergency care are provided at the preferred 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
Pediatric Dental Benefits – pediatric dental benefits are available for members through the end of the year in which the member turns 19		
Child Dental Diagnostic and Preventive		
Oral exam	No charge	20%

Covered Services	Member Copayments	
	Participating Providers[1]	**Non-Participating Providers**[1]
Preventive - cleaning	No charge	20%
Preventive - X-ray	No charge	20%
Sealants per tooth	No charge	20%
Topical fluoride application	No charge	20%
Caries risk management	No charge	20%
Space maintainers - fixed	No charge	20%
Child Dental Basic Services		
Amalgam fill - 1 surface	20%	30%
Child Dental Major Services[2]		
Root canal - molar	50%	50%
Gingivectomy per quad	50%	50%
Extraction - single tooth exposed root or	50%	50%
Extraction - complete bony	50%	50%
Porcelain with metal crown	50%	50%
Child Orthodontics[2]		
Medically necessary orthodontics	50%	50%
Pediatric Vision Benefits – for children up to age 19		
Comprehensive Eye Exam[13]: one per calendar year (includes dilation, if professionally indicated)		
Ophthalmologic - Routine ophthalmologic exam with refraction – new patient (S0620) - Routine ophthalmologic exam with refraction – established patient (S0621)	$0	Covered up to a maximum allowance of $30
Optometric - New patient exam (92002/92004) - Established patient exam (92012/92014)	$0	Covered up to a maximum allowance of $30
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. Polycarbonate lenses are covered in full for eligible members.	$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
Anti-reflective coating (standard only)	$35	Not covered
High-index lenses	$30	Not covered
Photochromic lenses (glass or plastic)	$25	Not covered
Polarized lenses	$45	Not covered
Standard progressives	$55	Not covered
Premium progressives	$95	Not covered
Frame (one frame per calendar year) Collection frame Non-collection frame[14] Note: "Collection" frames are available at no cost at participating independent providers. Retail chain providers typically do not display the "Collection," but are required to maintain a comparable selection of frames that are covered in full.	$0 Covered up to a maximum allowance of $150	Covered up to a maximum allowance $40
Contact Lenses[15]		
Elective – standard hard (V2500, V2510)	$0 (1 pair per year)	Covered up to a maximum allowance of $75
Elective – standard soft (V2520)	$0 (1 pair per month for up to 6 months)	Covered up to a maximum allowance of $75
Elective – non-standard hard (V2501, V2502, V2503, V2511, V2512, V2513, V2599)	$0 (1 pair per year)	Covered up to a maximum allowance of $75
Elective – non-standard soft (V2521, V2512, V2523)	$0 (1 pair per month for up to 3 months)	Covered up to a maximum allowance of $75

Covered Services	Member Copayments	
	Participating Providers[1]	Non-Participating Providers[1]
Medically necessary	$0 (1 pair per year)	Covered up to a maximum allowance of $225 for medically necessary contact lenses
Other Pediatric Vision Benefits		
Supplemental low-vision testing and equipment[15]	35%	Not covered
Diabetes management referral	$0	Not covered

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

Pediatric Dental Benefits Endnotes:

1 The Calendar Year Deductible and Copayments for Covered Services from Participating Dentists accrue to the Calendar Year Out-of-Pocket Maximum, including any Copayments for covered orthodontia services received from Participating Dentists. Costs for non-Covered Services, services from Non-Participating Dentists, charges in excess of benefit maximums, and Premiums, do not accrue to the Calendar Year Out-of-Pocket Maximum. The out-of-pocket maximum for the embedded pediatric dental benefit accumulates to the overall combined medical and dental out-of-pocket maximum amount. This maximum is calculated as follows: (Federal out-of-pocket maximum) minus (SADP or Family Dental Plan out-of-pocket maximum) equals (QHP out-of-pocket maximum); numerically this is $6,600 - $350 = $6,250.

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

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

Those immediate qualifying conditions are:

- Cleft lip and or palate deformities
- Craniofacial Anomalies including the following: Crouzon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, Hemi-facial atrophy, Hem-facial hypertrophy and other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by our dental consultants.
- Deep impinging overbite, where the lower incisors are destroying the soft tissue of the palate and tissue laceration and/or clinical attachment loss are present. (Contact only does not constitute deep impinging overbite).
- Crossbite of individual anterior teeth when clinical attachment loss and recession of the gingival margin are present (e.g., stripping of the labial gingival tissue on the lower incisors). Treatment of bi-lateral posterior crossbite is not a benefit of the program.
- Severe traumatic deviation must be justified by attaching a description of the condition.
- Overjet greater than 9mm or mandibular protusion (reverse overjet) greater than 3.5mm.
- The remaining conditions must score 26 or more to qualify (based on the HDL Index).

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

Endnotes for Silver 73 PPO

1 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. The member is responsible for these charges in addition to the applicable copayment or coinsurance when accessing these providers, which amount can be substantial. Amounts applied to the calendar year deductible accrue towards the applicable out-of-pocket maximum. Charges in excess of the allowable amount do not count toward the calendar year medical deductible or out-of-pocket maximum.

2 The covered services listed below are subject to, and will accrue to the calendar year medical or brand drug deductibles.

- Ambulance benefits
- Bariatric surgery benefits: hospital inpatient services
- Emergency room benefits: emergency room services (facility)
- Hospital benefits (facility services): inpatient facility services, inpatient skilled nursing services including subacute care, and inpatient services to treat acute medical complications of detoxification
- Medical treatment for the teeth, gums, jaw joints, or jaw bones benefits: inpatient hospital services
- Mental health and substance abuse benefits: inpatient hospital services, and residential care
- Outpatient X-Ray, imaging, pathology, and laboratory benefits: radiological and nuclear imaging services
- Pregnancy and maternity care benefits: inpatient hospital services
- Reconstructive surgery benefits: inpatient hospital services
- Skilled nursing facility benefits
- Transplant benefits: inpatient hospital or facility services
- Preferred brand drugs, non-preferred brand drugs, and specialty drugs (subject to and accrues to the brand drug deductible)

3 Copayments or coinsurance for covered services apply toward the calendar year out-of-pocket maximum, except copayments or coinsurance for the following: ((a) charges in excess of specified benefit maximums; (b) covered travel expenses for bariatric surgery; and (c) dialysis center services from a non-participating provider. Copayments, coinsurance, and charges for services not

accruing to the calendar year out-of-pocket maximum continue to be the member's responsibility after the calendar year out-of-pocket maximum is reached.

4 The allowable amount for non-emergency services and supplies received from a non-participating hospital or facility is limited to $500 per day. Members are responsible for the coinsurance and all charges that exceed $500 per day.

5 The allowable amount for non-emergency services and supplies received from an ambulatory surgery center is limited to $300 per day. Members are responsible for the coinsurance and all charges that exceed $300 per day. Participating ambulatory surgery centers may not be available in all areas; however, the member can obtain outpatient surgery services from a hospital or an ambulatory surgery center affiliated with a hospital, with payment according to the hospital services benefit.

6 The allowable amount for non-emergency services and supplies received from a non-participating radiology center is limited to $300 per day. Members are responsible for all charges that exceed $300 per day. The allowable amount for non-emergency services and supplies received from a non-participating hospital is limited to $500 per day. Members are responsible for all charges that exceed $500 per day.

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 Evidence of Coverage and Summary of Benefits for details.

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

9 Contraceptive drugs and devices covered under the outpatient prescription drug benefit do not require a copayment and will not be subject to any calendar year brand drug deductible; however, if a brand contraceptive drug is requested when a generic drug equivalent is available, the member is responsible for paying the difference between the cost to Blue Shield for the brand contraceptive drug and its generic drug equivalent. If the brand contraceptive drug is medically necessary, it may be covered without a copayment with prior authorization. The difference in cost that the member must pay does not accrue to any calendar year brand drug deductible, medical deductible, or the calendar year out-of-pocket maximum responsibility.

10 If a member or physician requests a brand drug when a generic drug equivalent is available, and the calendar year brand drug deductible has been satisfied, the member is responsible for paying the difference between the cost to Blue Shield for the brand drug and its generic drug equivalent, as well as the applicable generic drug copayment. The difference in cost that the member must pay does not accrue to any calendar year brand drug deductible, medical deductible, or the calendar year out-of-pocket maximum responsibility. Refer to the Policy and Summary of Benefits for details.

11 Blue Shield has contracted with a specialized health care service plan to act as our mental health services administrator (MHSA). The MHSA provides mental health and chemical dependency services, other than inpatient services for acute medical detoxification, through a separate network of MHSA participating providers. Inpatient acute medical detoxification is a medical benefit provided by Blue Shield participating or non-participating (not MHSA) providers.

12 Copayment shown is for physician's services. If the procedure is performed in a facility setting (hospital or outpatient surgery center), and additional facility copayment may apply.

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

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

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

16 A report from the provider and prior authorization from the Vision Plan Administrator is required.

This plan is pending regulatory approval.

Bronze 60 PPO

Uniform Health Plan Benefits and Coverage Matrix

Blue Shield of California

Effective January 1, 2015

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 PPO plan uses the Exclusive PPO provider network.

	Participating Providers[1]	Non-Participating Providers[1]
Calendar Year Medical Deductible[2] (For family coverage, an individual is responsible for satisfying their own individual deductible and that amount accumulates to the family deductible.) Medical deductible applies to all benefits except those in endnote 2.	$5,000 per individual / $10,000 per family (all providers combined)	
Calendar Year Out-of-Pocket Maximum[3] (Includes the calendar year medical deductible. Copayments for participating providers apply to both participating and non-participating provider calendar year out-of-pocket maximum amounts.)	$6,250 per individual / $12,500 per family	$9,250 per individual / $18,500 per family
Calendar Year Brand Drug Deductible (Brand drugs are subject to the calendar year medical deductible)	$0	Not covered
Lifetime Benefit Maximum	None	

Covered Services	Member Copayments	
	Participating Providers[1]	Non-Participating Providers[1]
PROFESSIONAL SERVICES		
Professional (Physician) Benefits		
Physician office visits from internal medicine, family practice, pediatric, and OB/Gyn physicians (visit limit is a combination of any physician office visits, urgent care, outpatient mental health, behavioral health, outpatient substance abuse, and postnatal visits)	$60 for first 3 visits per calendar year prior to deductible[2], then $60 after deductible	50%
Specialist physician office visits	$70	50%
Outpatient diagnostic X-ray and imaging (non-hospital-based or -affiliated)	30%	50%
Outpatient diagnostic laboratory and pathology (non-hospital-based or -affiliated)	30%	50%
Preventive Health Benefits		
Preventive health services (as required by federal and California law)	$0[2]	Not covered
OUTPATIENT SERVICES		
Outpatient surgery in a hospital	30%	50%[4] 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 surgery performed at an ambulatory surgery center	30%	50%[5] 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 services for treatment of illness or injury and necessary supplies	30%	50%[4] The maximum allowed amount for non-participating providers is $500 per day. Members are responsible for 50% of this $500 per day, plus all charges in excess of $500

Covered Services	Member Copayments	
	Participating Providers[1]	**Non-Participating Providers**[1]
Outpatient diagnostic X-ray and imaging performed in a hospital	30%	50%[4] 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	30%	50%[4] 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 (prior authorization is required)	30%	50%[6] 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
HOSPITALIZATION SERVICES		
Inpatient physician services	30%	50%
Inpatient non-emergency facility services (semi-private room and board, services and supplies, including subacute care)	30%	50%[4] 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 (prior authorization is required; medically necessary surgery for weight loss is for morbid obesity only)[7]	30%	Not covered
EMERGENCY HEALTH COVERAGE		
Emergency room services not resulting in admission	$300	$300
Emergency room services resulting in admission (when the member is admitted directly from the ER)	30%	30%
Emergency room physician services	30%	30%
Urgent care (visit limit is a combination of any physician office visits, urgent care, outpatient mental health, behavioral health, outpatient substance abuse, and postnatal visits)	$120 for first 3 visits per calendar year prior to deductible[2], then $120 after deductible	50%
AMBULANCE SERVICES		
Emergency or authorized transport (ground or air)	$300	$300
PRESCRIPTION DRUG COVERAGE[8,9,10]	**Participating Pharmacy**	**Non-Participating Pharmacy**
Retail Prescriptions (up to a 30-day supply)		
Contraceptive drugs and devices[9]	$0[2]	Not covered
Generic drugs	$15 per prescription	Not covered
Preferred brand drugs	$50 per prescription	Not covered
Non-preferred brand drugs	$75 per prescription	Not covered
Mail Service Prescriptions (up to a 90-day supply)		
Contraceptive drugs and devices[9]	$0[2]	Not covered
Generic drugs	$45 per prescription	Not covered
Preferred brand drugs	$150 per prescription	Not covered
Non-preferred brand drugs	$225 per prescription	Not covered
Specialty Pharmacies (up to a 30-day supply)		
Specialty drugs (May require prior authorization from Blue Shield. Specialty drugs are covered only when dispensed by Network Specialty Pharmacies. Drugs from non-participating pharmacies are not covered except in emergency and urgent situations.)	30%	Not covered
Oral Anti-cancer Medications	30% up to a maximum of $200 per prescription	Not covered
	Participating Providers[1]	**Non-Participating Providers**[1]
PROSTHETICS/ORTHOTICS		
Prosthetic equipment and devices	30%	50%

Covered Services	Member Copayments	
	Participating Providers[1]	Non-Participating Providers[1]
(separate office visit copay may apply)		
Orthotic equipment and devices (separate office visit copay may apply)	30%	50%
DURABLE MEDICAL EQUIPMENT		
Breast pump	$0[2]	Not covered
Other durable medical equipment	30%	50%
MENTAL HEALTH SERVICES[11]		
Inpatient hospital services (prior authorization required)	30%	50%[4] 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 mental health services (visit limit is a combination of any physician office visits, urgent care, outpatient mental health, behavioral health, outpatient substance abuse, and postnatal visits; some services may require prior authorization and facility charges)	$60 for first 3 visits per calendar year prior to deductible[2], then $60 after deductible	50%
SUBSTANCE ABUSE SERVICES[11]		
Inpatient hospital (prior authorization required)	30%	50%[4] 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 substance abuse services (visit limit is a combination of any physician office visits, urgent care, outpatient mental health, behavioral health, outpatient substance abuse, and postnatal visits; some services may require prior authorization and facility charges)	$60 for first 3 visits per calendar year prior to deductible[2], then $60 after deductible	50%
HOME HEALTH SERVICES		
Home health care agency services (up to 100 prior authorized visits per calendar year)	30%	Not covered (unless prior authorized)
OTHER		
Pregnancy and Maternity Care Benefits		
Prenatal physician office visits	$0[2]	50%
Postnatal physician office visits (visit limit is a combination of any physician office visits, urgent care, outpatient mental health, behavioral health, outpatient substance abuse, and postnatal visits)	$60 for first 3 visits per calendar year prior to deductible[2], then $60 after deductible	50%
Inpatient hospital services for normal delivery and cesarean section	30%	50%[4] 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
Abortion services[12]	30%	50%
Family Planning Benefits		
Injectable and implantable contraceptives	$0[2]	Not covered
Counseling and consulting	$0[2]	Not covered
Tubal ligation	$0[2]	Not covered
Vasectomy	30%	Not covered
Infertility services	Not covered	Not covered
Rehabilitation and Habilitation Benefits		
Office location	$60	50%
Outpatient department of a hospital	$60	50%[4] 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
Chiropractic Benefits		
Chiropractic services	Not covered	Not covered
Acupuncture Benefits		
Acupuncture services	$60	50%

Covered Services	Member Copayments	
	Participating Providers[1]	Non-Participating Providers[1]
Care Outside California (benefits provided through the BlueCard® Program for out-of-state emergency and non emergency care are provided at the preferred 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
Pediatric Dental Benefits – pediatric dental benefits are available for members through the end of the year in which the member turns 19		
Child Dental Diagnostic and Preventive		
Oral exam	No charge	20%
Preventive - cleaning	No charge	20%
Preventive - X-ray	No charge	20%
Sealants per tooth	No charge	20%
Topical fluoride application	No charge	20%
Caries risk management	No charge	20%
Space maintainers - fixed	No charge	20%
Child Dental Basic Services		
Amalgam fill - 1 surface	20%	30%
Child Dental Major Services[2]		
Root canal - molar	50%	50%
Gingivectomy per quad	50%	50%
Extraction - single tooth exposed root or	50%	50%
Extraction - complete bony	50%	50%
Porcelain with metal crown	50%	50%
Child Orthodontics[2]		
Medically necessary orthodontics	50%	50%
Pediatric Vision Benefits – for children up to age 19		
Comprehensive Eye Exam[13]: one per calendar year (includes dilation, if professionally indicated)		
Ophthalmologic - Routine ophthalmologic exam with refraction – new patient (S0620) - Routine ophthalmologic exam with refraction – established patient (S0621)	$0[2]	Covered up to a maximum allowance of $30[2]
Optometric - New patient exam (92002/92004) - Established patient exam (92012/92014)	$0[2]	Covered up to a maximum allowance of $30[2]
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. Polycarbonate lenses are covered in full for eligible members.	$0[2]	Covered up to a maximum allowance of: $25 single vision[2] $35 lined bifocal[2] $45 lined trifocal[2] $45 lenticular[2]
Optional Lenses and Treatments		
UV coating (standard only)	$0[2]	Not covered
Anti-reflective coating (standard only)	$35[2]	Not covered
High-index lenses	$30[2]	Not covered
Photochromic lenses (glass or plastic)	$25[2]	Not covered
Polarized lenses	$45[2]	Not covered
Standard progressives	$55[2]	Not covered
Premium progressives	$95[2]	Not covered

Covered Services	Member Copayments	
	Participating Providers[1]	Non-Participating Providers[1]
Frame (one frame per calendar year) Collection frame Non-collection frame[14] Note: "Collection" frames are available at no cost at participating independent providers. Retail chain providers typically do not display the "Collection," but are required to maintain a comparable selection of frames that are covered in full.	$0[2] Covered up to a maximum allowance of $150[2]	Covered up to a maximum allowance $40[2]
Contact Lenses[15]		
Elective – standard hard (V2500, V2510)	$0[2] (1 pair per year)	Covered up to a maximum allowance of $75[2]
Elective – standard soft (V2520)	$0[2] (1 pair per month for up to 6 months)	Covered up to a maximum allowance of $75[2]
Elective – non-standard hard (V2501, V2502, V2503, V2511, V2512, V2513, V2599)	$0[2] (1 pair per year)	Covered up to a maximum allowance of $75[2]
Elective – non-standard soft (V2521, V2512, V2523)	$0[2] (1 pair per month for up to 3 months)	Covered up to a maximum allowance of $75[2]
Medically necessary	$0[2] (1 pair per year)	Covered up to a maximum allowance of $225 for medically necessary contact lenses[2]
Other Pediatric Vision Benefits		
Supplemental low-vision testing and equipment[16]	35%[2]	Not covered
Diabetes management referral	$0[2]	Not covered

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

Pediatric Dental Benefits Endnotes:

1 The Calendar Year Deductible and Copayments for Covered Services from Participating Dentists accrue to the Calendar Year Out-of-Pocket Maximum, including any Copayments for covered orthodontia services received from Participating Dentists. Costs for non-Covered Services, services from Non-Participating Dentists, charges in excess of benefit maximums, and Premiums, do not accrue to the Calendar Year Out-of-Pocket Maximum. The out-of-pocket maximum for the embedded pediatric dental benefit accumulates to the overall combined medical and dental out-of-pocket maximum amount. This maximum is calculated as follows: (Federal out-of-pocket maximum) minus (SADP or Family Dental Plan out-of-pocket maximum) equals (QHP out-of-pocket maximum); numerically this is $6,600 - $350 = $6,250.

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

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

Those immediate qualifying conditions are:

- Cleft lip and or palate deformities
- Craniofacial Anomalies including the following: Crouzon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, Hemi-facial atrophy, Hem-facial hypertrophy and other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by our dental consultants.
- Deep impinging overbite, where the lower incisors are destroying the soft tissue of the palate and tissue laceration and/or clinical attachment loss are present. (Contact only does not constitute deep impinging overbite).
- Crossbite of individual anterior teeth when clinical attachment loss and recession of the gingival margin are present (e.g., stripping of the labial gingival tissue on the lower incisors). Treatment of bi-lateral posterior crossbite is not a benefit of the program.
- Severe traumatic deviation must be justified by attaching a description of the condition.
- Overjet greater than 9mm or mandibular protusion (reverse overjet) greater than 3.5mm.
- The remaining conditions must score 26 or more to qualify (based on the HDL Index).

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

Endnotes for Bronze 60 PPO

1 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. The member is responsible for these charges in addition to the applicable copayment or coinsurance when accessing these providers, which amount can be substantial. Amounts applied to the calendar year

deductible accrue towards the applicable out-of-pocket maximum. Charges in excess of the allowable amount do not count toward the calendar year medical deductible or out-of-pocket maximum.

2 The covered services listed below are not subject to, and will not accrue to the calendar year medical deductible.

- First dollar coverage: first three physician office visits
- Durable medical equipment: breast pump
- Family planning benefits: counseling and consulting; diaphragm fitting procedure; implantable contraceptives; injectable contraceptives; insertion and/or removal of IUD device; IUD; and tubal ligation
- Outpatient prescription drug benefits: contraceptive drugs and devices
- Pediatric vision benefits
- Pregnancy and maternity care benefits: prenatal and preconception physician office visits
- Preventive health services
- Pediatric dental benefits

3 Copayments or coinsurance for covered services apply toward the calendar year out-of-pocket maximum, except copayments or coinsurance for the following: (a) charges in excess of specified benefit maximums; (b) covered travel expenses for bariatric surgery; and (c) dialysis center services from a non-participating provider. Copayments, coinsurance, and charges for services not accruing to the calendar year out-of-pocket maximum continue to be the member's responsibility after the calendar year out-of-pocket maximum is reached.

4 The allowable amount for non-emergency services and supplies received from a non-participating hospital or facility is limited to $500 per day. Members are responsible for the coinsurance and all charges that exceed $500 per day.

5 The allowable amount for non-emergency services and supplies received from an ambulatory surgery center is limited to $300 per day. Members are responsible for the coinsurance and all charges that exceed $300 per day. Participating ambulatory surgery centers may not be available in all areas; however, the member can obtain outpatient surgery services from a hospital or an ambulatory surgery center affiliated with a hospital, with payment according to the hospital services benefit.

6 The allowable amount for non-emergency services and supplies received from a non-participating radiology center is limited to $300 per day. Members are responsible for all charges that exceed $300 per day. The allowable amount for non-emergency services and supplies received from a non-participating hospital is limited to $500 per day. Members are responsible for all charges that exceed $500 per day.

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 Evidence of Coverage and Summary of Benefits for details.

8 This plan's prescription drug coverage provides less coverage on average than the standard benefit set by the federal government for Medicare Part D (also called non-creditable coverage). It is important to know that generally you may only enroll in a Medicare Part D plan from October 15th through December 7th of each year. If you do not enroll in a Medicare Part D plan when you are first eligible to join, you may be subject to a late enrollment penalty in addition to your Part D premium when you enroll at a later date. For more information about your current plan's prescription drug coverage, call the Customer Service telephone number on your identification card, Monday through Thursday between 8:00 a.m. and 5:00 p.m. or on Friday between 9:00 a.m. and 5:00 p.m. The hearing impaired may call the TTY number at (888) 239-6482.

9 Contraceptive drugs and devices covered under the outpatient prescription drug benefit do not require a copayment and will not be subject to any calendar year medical deductible; however, if a brand contraceptive drug is requested when a generic drug equivalent is available, the member is responsible for paying the difference between the cost to Blue Shield for the brand contraceptive drug and its generic drug equivalent. If the brand contraceptive drug is medically necessary, it may be covered without a copayment with prior authorization. The difference in cost that the member must pay does not accrue to any calendar year medical deductible or out-of-pocket maximum responsibility.

10 If a member or physician requests a brand drug when a generic drug equivalent is available, and the calendar year medical deductible has been satisfied, the member is responsible for paying the difference between the cost to Blue Shield for the brand drug and its generic drug equivalent, as well as the applicable generic drug copayment. The difference in cost that the member must pay does not accrue to any calendar year medical deductible or out-of-pocket maximum responsibility. Refer to the Evidence of Coverage and Summary of Benefits for details.

11 Blue Shield has contracted with a specialized health care service plan to act as our mental health services administrator (MHSA). The MHSA provides mental health and chemical dependency services, other than inpatient services for acute medical detoxification, through a separate network of MHSA participating providers. Inpatient acute medical detoxification is a medical benefit provided by Blue Shield participating or non-participating (not MHSA) providers.

12 Copayment shown is for physician's services. If the procedure is performed in a facility setting (hospital or outpatient surgery center), an additional facility copayment may apply.

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

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

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

16 A report from the provider and prior authorization from the Vision Plan Administrator is required.

This plan is pending regulatory approval.

Minimum Coverage PPO

This plan is only available to persons under age 30, or those age 30 and above who can provide a certification that they are without affordable coverage or are experiencing financial hardship.

Uniform Health Plan Benefits and Coverage Matrix

Blue Shield of California

Effective January 1, 2015

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 PPO plan uses the Exclusive PPO provider network.

	Participating Providers[1]	**Non-Participating Providers**[1]
Calendar Year Medical Deductible[2] (For family coverage, an individual is responsible for satisfying their own individual deductible and that amount accumulates to the family deductible.) Medical deductible applies to all benefits except those in endnote 2.	$6,600 per individual / $13,200 per family (all providers combined)	
Calendar Year Out-of-Pocket Maximum[3] (Includes the calendar year medical deductible. Copayments for participating providers apply to both participating and non-participating provider calendar year out-of-pocket maximum amounts.)	$6,600 per individual / $13,200 per family	$9,600 per individual / $19,200 per family
Calendar Year Brand Drug Deductible (Brand drugs are subject to the calendar year medical deductible)	$0	Not covered
Lifetime Benefit Maximum	None	

Covered Services	**Member Copayments**	
	Participating Providers[1]	**Non-Participating Providers**[1]
PROFESSIONAL SERVICES		
Professional (Physician) Benefits		
Physician office visits from internal medicine, family practice, pediatric, and OB/Gyn physicians (visit limit is a combination of any physician office visits, urgent care, outpatient mental health, behavioral health, outpatient substance abuse, and postnatal visits)	$0 for first 3 visits per calendar year prior to deductible[2], then $0 after deductible	50%
Specialist physician office visits	0%	50%
Outpatient diagnostic X-ray and imaging (non-hospital-based or -affiliated)	0%	50%
Outpatient diagnostic laboratory and pathology (non-hospital-based or -affiliated)	0%	50%
Preventive Health Benefits		
Preventive health services (as required by federal and California law)	$0[2]	Not covered
OUTPATIENT SERVICES		
Outpatient surgery in a hospital	0%	50%[4] 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 surgery performed at an ambulatory surgery center	0%	50%[5] 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 services for treatment of illness or injury and necessary supplies	0%	50%[4] The maximum allowed amount for non-participating providers is $500 per day. Members are responsible for 50% of this $500 per day, plus all charges in excess of $500

Covered Services	Member Copayments	
	Participating Providers[1]	**Non-Participating Providers**[1]
Outpatient diagnostic X-ray and imaging performed in a hospital	0%	50%[4] 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	0%	50%[4] 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 (prior authorization is required)	0%	50%[6] 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
HOSPITALIZATION SERVICES		
Inpatient physician services	0%	50%
Inpatient non-emergency facility services (semi-private room and board, services and supplies, including subacute care)	0%	50%[4] 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 (prior authorization is required; medically necessary surgery for weight loss is for morbid obesity only)[7]	0%	Not covered
EMERGENCY HEALTH COVERAGE		
Emergency room services not resulting in admission	0%	0%
Emergency room services resulting in admission (when the member is admitted directly from the ER)	0%	0%
Emergency room physician services	0%	0%
Urgent care (visit limit is a combination of any physician office visits, urgent care, outpatient mental health, behavioral health, outpatient substance abuse, and postnatal visits)	$0 for first 3 visits per calendar year prior to deductible[2], then $0 after deductible	50%
AMBULANCE SERVICES		
Emergency or authorized transport (ground or air)	0%	0%
PRESCRIPTION DRUG COVERAGE[8,9,10]	**Participating Pharmacy**	**Non-Participating Pharmacy**
Retail Prescriptions (up to a 30-day supply)		
Contraceptive drugs and devices[9]	$0[2]	Not covered
Generic drugs	0% per prescription	Not covered
Preferred brand drugs	0% per prescription	Not covered
Non-preferred brand drugs	0% per prescription	Not covered
Mail Service Prescriptions (up to a 90-day supply)		
Contraceptive drugs and devices[9]	$0[2]	Not covered
Generic drugs	0% per prescription	Not covered
Preferred brand drugs	0% per prescription	Not covered
Non-preferred brand drugs	0% per prescription	Not covered
Specialty Pharmacies (up to a 30-day supply)		
Specialty drugs (May require prior authorization from Blue Shield. Specialty drugs are covered only when dispensed by Network Specialty Pharmacies. Drugs from non-participating pharmacies are not covered except in emergency and urgent situations.)	0%	Not covered
Oral Anti-cancer Medications	0% up to a maximum of $200 per prescription	Not covered
	Participating Providers[1]	**Non-Participating Providers**[1]
PROSTHETICS/ORTHOTICS		
Prosthetic equipment and devices	0%	50%

Covered Services	Member Copayments	
	Participating Providers[1]	**Non-Participating Providers**[1]
(separate office visit copay may apply)		
Orthotic equipment and devices (separate office visit copay may apply)	0%	50%
DURABLE MEDICAL EQUIPMENT		
Breast pump	$0[2]	Not covered
Other durable medical equipment	0%	50%
MENTAL HEALTH SERVICES[11]		
Inpatient hospital services (prior authorization required)	0%	50%[4] 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 mental health services (visit limit is a combination of any physician office visits, urgent care, outpatient mental health, behavioral health, outpatient substance abuse, and postnatal visits; some services may require prior authorization and facility charges)	$0 for first 3 visits per calendar year prior to deductible[2], then $0 after deductible	50%
SUBSTANCE ABUSE SERVICES[11]		
Inpatient hospital services (prior authorization required)	0%	50%[4] 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 substance abuse services (visit limit is a combination of any physician office visits, urgent care, outpatient mental health, behavioral health, outpatient substance abuse, and postnatal visits; some services may require prior authorization and facility charges)	$0 for first 3 visits per calendar year prior to deductible[2], then $0 after deductible	50%
HOME HEALTH SERVICES		
Home health care agency services (up to 100 prior authorized visits per calendar year)	0%	Not covered (unless prior authorized)
OTHER		
Pregnancy and Maternity Care Benefits		
Prenatal physician office visits	$0[2]	50%
Postnatal physician office visits (visit limit is a combination of any physician office visits, urgent care, outpatient mental health, behavioral health, outpatient substance abuse, and postnatal visits)	$0 for first 3 visits per calendar year prior to deductible[2], then $0 after deductible	50%
Inpatient hospital services for normal delivery and cesarean section	0%	50%[4] 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
Abortion services[12]	0%	50%
Family Planning Benefits		
Injectable and implantable contraceptives	$0[2]	Not covered
Counseling and consulting	$0[2]	Not covered
Tubal ligation	$0[2]	Not covered
Vasectomy	0%	Not covered
Infertility services	Not covered	Not covered
Rehabilitation and Habilitation Benefits		
Office location	0%	50%
Outpatient department of a hospital	0%	50%[4] 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
Chiropractic Benefits		
Chiropractic services	Not covered	Not covered
Acupuncture Benefits		
Acupuncture services	0%	50%

Covered Services	Member Copayments	
	Participating Providers[1]	Non-Participating Providers[1]
Care Outside of California (benefits provided through the BlueCard® Program for out-of-state emergency and non-emergency care are provided at the preferred 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
Pediatric Dental Benefits – pediatric dental benefits are available for members through the end of the year in which the member turns 19		
Child Dental Diagnostic and Preventive		
Oral exam	No charge	20%
Preventive - cleaning	No charge	20%
Preventive - X-ray	No charge	20%
Sealants per tooth	No charge	20%
Topical fluoride application	No charge	20%
Caries risk management	No charge	20%
Space maintainers - fixed	No charge	20%
Child Dental Basic Services		
Amalgam fill - 1 surface	0%	30%
Child Dental Major Services[2]		
Root canal - molar	0%	50%
Gingivectomy per quad	0%	50%
Extraction - single tooth exposed root or	0%	50%
Extraction - complete bony	0%	50%
Porcelain with metal crown	0%	50%
Child Orthodontics[2]		
Medically necessary orthodontics	0%	50%
Pediatric Vision Benefits – for children up to age 19		
Comprehensive Eye Exam[13]: one per calendar year (includes dilation, if professionally indicated)		
Ophthalmologic - Routine ophthalmologic exam with refraction – new patient (S0620) - Routine ophthalmologic exam with refraction – established patient (S0621)	$0[2]	Covered up to a maximum allowance of $30[2]
Optometric - New patient exam (92002/92004) - Established patient exam (92012/92014)	$0[2]	Covered up to a maximum allowance of $30[2]
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. Polycarbonate lenses are covered in full for eligible members.	$0	Covered up to a maximum allowance of: $25 single vision[2] $35 lined bifocal[2] $45 lined trifocal[2] $45 lenticular[2]
Optional Lenses and Treatments		
UV coating (standard only)	$0[2]	Not covered
Anti-reflective coating (standard only)	$35[2]	Not covered
High-index lenses	$30[2]	Not covered
Photochromic lenses (glass or plastic)	$25[2]	Not covered
Polarized lenses	$45[2]	Not covered
Standard progressives	$55[2]	Not covered
Premium progressives	$95[2]	Not covered

Covered Services	Member Copayments	
	Participating Providers[1]	Non-Participating Providers[1]
Frame (one frame per calendar year) Collection frame Non-collection frame[14] Note: "Collection" frames are available at no cost at participating independent providers. Retail chain providers typically do not display the "Collection," but are required to maintain a comparable selection of frames that are covered in full.	$0[2] Covered up to a maximum allowance of $150[2]	Covered up to a maximum allowance $40[2]
Contact Lenses[15]		
Elective – standard hard (V2500, V2510)	$0[2] (1 pair per year)	Covered up to a maximum allowance of $75[2]
Elective – standard soft (V2520)	$0[2] (1 pair per month for up to 6 months)	Covered up to a maximum allowance of $75[2]
Elective – non-standard hard (V2501, V2502, V2503, V2511, V2512, V2513, V2599)	$0[2] (1 pair per year)	Covered up to a maximum allowance of $75[2]
Elective – non-standard soft (V2521, V2512, V2523)	$0[2] (1 pair per month for up to 3 months)	Covered up to a maximum allowance of $75[2]
Medically necessary	$0[2] (1 pair per year)	Covered up to a maximum allowance of $225 for medically necessary contact lenses[2]
Other Pediatric Vision Benefits		
Supplemental low-vision testing and equipment[16]	35%[2]	Not covered
Diabetes management referral	$0[2]	Not covered

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

Pediatric Dental Benefits Endnotes:

1 The Calendar Year Deductible and Copayments for Covered Services from Participating Dentists accrue to the Calendar Year Out-of-Pocket Maximum, including any Copayments for covered orthodontia services received from Participating Dentists. Costs for non-Covered Services, services from Non-Participating Dentists, charges in excess of benefit maximums, and Premiums, do not accrue to the Calendar Year Out-of-Pocket Maximum. The out-of-pocket maximum for the embedded pediatric dental benefit accumulates to the overall combined medical and dental out-of-pocket maximum amount. This maximum is calculated as follows: (Federal out-of-pocket maximum) minus (SADP or Family Dental Plan out-of-pocket maximum) equals (QHP out-of-pocket maximum); numerically this is $6,600 - $350 = $6,250.

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

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

Those immediate qualifying conditions are:

- Cleft lip and or palate deformities
- Craniofacial Anomalies including the following: Crouzon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, Hemi-facial atrophy, Hem-facial hypertrophy and other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by our dental consultants.
- Deep impinging overbite, where the lower incisors are destroying the soft tissue of the palate and tissue laceration and/or clinical attachment loss are present. (Contact only does not constitute deep impinging overbite).
- Crossbite of individual anterior teeth when clinical attachment loss and recession of the gingival margin are present (e.g., stripping of the labial gingival tissue on the lower incisors). Treatment of bi-lateral posterior crossbite is not a benefit of the program.
- Severe traumatic deviation must be justified by attaching a description of the condition.
- Overjet greater than 9mm or mandibular protusion (reverse overjet) greater than 3.5mm.
- The remaining conditions must score 26 or more to qualify (based on the HDL Index).

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

Endnotes for Minimum Coverage PPO

1 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. The member is responsible for these charges in addition to the applicable copayment or coinsurance when accessing these providers, which amount can be substantial. Amounts applied to the calendar year

deductible accrue towards the applicable out-of-pocket maximum. Charges in excess of the allowable amount do not count toward the calendar year medical deductible or out-of-pocket maximum.

2 The covered services listed below are not subject to, and will not accrue to the calendar year medical deductible.

- First dollar coverage: first three physician office visits
- Durable medical equipment: breast pump
- Family planning benefits: counseling and consulting; diaphragm fitting procedure; implantable contraceptives; injectable contraceptives; insertion and/or removal of IUD device; IUD; and tubal ligation
- Outpatient prescription drug benefits: contraceptive drugs and devices
- Pediatric comprehensive eye exam
- Pregnancy and maternity care benefits: prenatal and preconception physician office visits
- Preventive health services
- Pediatric dental benefits: Child dental and diagnostic services

3 Copayments or coinsurance for covered services apply toward the calendar year out-of-pocket maximum, except copayments or coinsurance for the following: (a) charges in excess of specified benefit maximums; (b) covered travel expenses for bariatric surgery; and (d) dialysis center services from a non-participating provider. Copayments, coinsurance, and charges for services not accruing to the calendar year out-of-pocket maximum continue to be the member's responsibility after the calendar year out-of-pocket maximum is reached.

4 The allowable amount for non-emergency services and supplies received from a non-participating hospital or facility is limited to $500 per day. Members are responsible for the coinsurance and all charges that exceed $500 per day.

5 The allowable amount for non-emergency services and supplies received from an ambulatory surgery center is limited to $300 per day. Members are responsible for the coinsurance and all charges that exceed $300 per day. Participating ambulatory surgery centers may not be available in all areas; however, the member can obtain outpatient surgery services from a hospital or an ambulatory surgery center affiliated with a hospital, with payment according to the hospital services benefit.

6 The allowable amount for non-emergency services and supplies received from a non-participating radiology center is limited to $300 per day. Members are responsible for all charges that exceed $300 per day. The allowable amount for non-emergency services and supplies received from a non-participating hospital is limited to $500 per day. Members are responsible for all charges that exceed $500 per day.

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 Evidence of Coverage and Summary of Benefits for details.

8 This plan's prescription drug coverage provides less coverage on average than the standard benefit set by the federal government for Medicare Part D (also called non-creditable coverage). It is important to know that generally you may only enroll in a Medicare Part D plan from October 15th through December 7th of each year. If you do not enroll in a Medicare Part D plan when you are first eligible to join, you may be subject to a late enrollment penalty in addition to your Part D premium when you enroll at a later date. For more information about your current plan's prescription drug coverage, call the Customer Service telephone number on your identification card, Monday through Thursday between 8:00 a.m. and 5:00 p.m. or on Friday between 9:00 a.m. and 5:00 p.m. The hearing impaired may call the TTY number at (888) 239-6482.

9 Contraceptive drugs and devices covered under the outpatient prescription drug benefit do not require a copayment and will not be subject to any calendar year medical deductible; however, if a brand contraceptive drug is requested when a generic drug equivalent is available, the member is responsible for paying the difference between the cost to Blue Shield for the brand contraceptive drug and its generic drug equivalent. If the brand contraceptive drug is medically necessary, it may be covered without a copayment with prior authorization. The difference in cost that the member must pay does not accrue to any calendar year medical deductible or out-of-pocket maximum responsibility.

10 If a member or physician requests a brand drug when a generic drug equivalent is available, and the calendar year medical deductible has been satisfied, the member is responsible for paying the difference between the cost to Blue Shield for the brand drug and its generic drug equivalent, as well as the applicable generic drug copayment. The difference in cost that the member must pay does not accrue to any calendar year medical deductible or out-of-pocket maximum responsibility. Refer to the Evidence of Coverage and Summary of Benefits for details.

11 Blue Shield has contracted with a specialized health care service plan to act as our mental health services administrator (MHSA). The MHSA provides mental health and chemical dependency services, other than inpatient services for acute medical detoxification, through a separate network of MHSA participating providers. Inpatient acute medical detoxification is a medical benefit provided by Blue Shield participating or non-participating (not MHSA) providers.

12 Copayment shown is for physician's services. If the procedure is performed in a facility setting (hospital or outpatient surgery center), an additional facility copayment may apply.

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

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

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

16 A report from the provider and prior authorization from the Vision Plan Administrator is required.

This plan is pending regulatory approval.

HSA-eligible, high-deductible health plan

HSA-eligible PPO plan at a glance

HSA-eligible plans are high-deductible health plans (HDHPs) that meet current health savings account (HSA) eligibility requirements. An HSA-eligible, HDHP offers affordable coverage and the option to open an HSA so you can plan ahead and put tax-advantaged money aside for healthcare expenses.*

Additional highlights include:

- Preventive care services without a copayment before meeting the annual deductible
- Compatible with an HSA, so you can enjoy potential tax savings
- 100% coverage for covered in-network services after meeting the annual out-of-pocket maximum

Our HSA-eligible PPO plan is available in the following counties

Contra Costa	El Dorado	Fresno	Imperial
Inyo	Kern	Kings	Los Angeles
Madera	Mariposa	Merced	Mono
Orange County	Placer	Riverside	Sacramento
San Bernardino	San Diego	San Francisco	San Joaquin
San Luis Obispo	San Mateo	Santa Barbara	Santa Clara
Stanislaus	Tulare	Ventura	Yolo

Provider network

The HSA-eligible PPO health plan offered by Blue Shield of California uses the Exclusive PPO Network. This network consists of participating doctors and hospitals. Visit **blueshieldca.com/fap** to see if your provider is in our network.

Access to care and limitations

Members who receive care from a provider in their plan's provider network are responsible for meeting the plan's calendar-year deductible and copayments or coinsurance up to the calendar year out-of-pocket maximum for covered services.

A PPO plan provides access to an Exclusive Network of participating doctors, specialists, and hospitals. Members have the freedom to see any doctor in our Exclusive PPO Network without a referral. Members have the option to receive care from non-participating providers, but are then responsible for meeting their plan's non-participating provider calendar-year deductible (if applicable), the copayment or coinsurance up to the non-participating provider calendar-year out-of-pocket maximum, and all charges that exceed Blue Shield's allowable amount. The Exclusive PPO Network includes fewer providers than Blue Shield's Full PPO Network.

Certain healthcare services may not be available in your area. You may be required to travel in excess of 30 minutes to access these services.

* Although most consumers who enroll in an HSA-compatible health plan are eligible to open an HSA, you should consult with a financial adviser to determine if an HSA/HDHP is a good financial fit for you. Blue Shield does not offer tax advice or HSAs. HSAs are offered through financial institutions. For more information about HSAs, eligibility, and the law's current provisions, ask your financial or tax adviser.

Bronze 60 HSA PPO (HSA-Compatible)

Uniform Health Plan Benefits and Coverage Matrix

Blue Shield of California

Effective January 1, 2015

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 HSA-eligible PPO plan uses the Exclusive PPO provider network.

	Participating Providers[1]	Non-Participating Providers[1]
Calendar Year Medical Deductible[2] (For family coverage, there is no individual deductible. Enrolled family members receive benefits for covered services once the family deductible has been satisfied by one, or any combination of family members. Medical deductible applies to all benefits except those in endnote 2.)	$4,500 for individuals / $9,000 for families (all providers combined)	
Calendar Year Out-of-Pocket Maximum[3] (Includes the calendar year medical deductible. Copayments for participating providers apply to both participating and non-participating provider calendar year out-of-pocket maximum amounts.)	$6,250 for individuals / $12,500 for families	$9,250 for individuals / $18,500 for families
Calendar Year Brand Drug Deductible (Brand drugs are subject to the calendar year medical deductible)	$0	Not covered
Lifetime Benefit Maximum	None	

Covered Services	**Member Copayments**	
	Participating Providers[1]	**Non-Participating Providers**[1]
PROFESSIONAL SERVICES		
Professional (Physician) Benefits		
Physician office visits from internal medicine, family practice, pediatric, and OB/Gyn physicians	40%	50%
Specialist physician office visits	40%	50%
Outpatient diagnostic X-ray and imaging (non-hospital-based or -affiliated)	40%	50%
Outpatient diagnostic laboratory and pathology (non-hospital-based or -affiliated)	40%	50%
Preventive Health Benefits		
Preventive health services (as required by federal and California law)	$0[2]	Not covered
OUTPATIENT SERVICES		
Outpatient surgery in a hospital	40%	50%[4] 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 surgery performed at an ambulatory surgery center	40%	50%[5] 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 services for treatment of illness or injury and necessary supplies	40%	50%[4] 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	40%	50%[4] 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	40%	50%[4] 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 (prior authorization is required)	40%	50%[6] 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
HOSPITALIZATION SERVICES		
Inpatient physician services	40%	50%
Inpatient non-emergency facility services (semi-private room and board, services and supplies, including subacute care)	40%	50%[4] 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 (prior authorization is required; medically necessary surgery for weight loss is for morbid obesity only)[7]	40%	Not covered
EMERGENCY HEALTH COVERAGE		
Emergency room services not resulting in admission	40%	40%
Emergency room services resulting in admission (when the member is admitted directly from the ER)	40%	40%
Emergency room physician services	40%	40%
Urgent care	40%	50%
AMBULANCE SERVICES		
Emergency or authorized transport (ground or air)	40%	40%
PRESCRIPTION DRUG COVERAGE[8,9,10]	**Participating Pharmacy**	**Non-Participating Pharmacy**
Retail Prescriptions (up to a 30-day supply)		
Contraceptive drugs and devices[9]	$0	Not covered
Generic drugs	40% per prescription	Not covered
Preferred brand drugs	40% per prescription	Not covered
Non-preferred brand drugs	40% per prescription	Not covered
Mail Service Prescriptions (up to a 90-day supply)		
Contraceptive drugs and devices[9]	$0	Not covered
Generic drugs	40% per prescription	Not covered
Preferred brand drugs	40% per prescription	Not covered
Non-preferred brand drugs	40% per prescription	Not covered
Specialty Pharmacies (up to a 30-day supply)		
Specialty drugs (May require prior authorization from Blue Shield. Specialty drugs are covered only when dispensed by Network Specialty Pharmacies. Drugs from non-participating pharmacies are not covered except in emergency and urgent situations.)	40%	Not covered
Oral Anti-cancer Medications	40% up to a maximum of $200 per prescription	Not covered
	Participating Providers[1]	**Non-Participating Providers**[1]
PROSTHETICS/ORTHOTICS		
Prosthetic equipment and devices (separate office visit copay may apply)	40%	50%
Orthotic equipment and devices (separate office visit copay may apply)	40%	50%
DURABLE MEDICAL EQUIPMENT		
Breast pump	$0[2]	Not covered
Other durable medical equipment	40%	50%
MENTAL HEALTH SERVICES[11]		

Inpatient hospital services (prior authorization required)	40%	50%[4] 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 mental health services (some services may require prior authorization and facility charges)	40%	50%
SUBSTANCE ABUSE SERVICES[11]		
Inpatient hospital (prior authorization required)	40%	50%[4] 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 substance abuse services (some services may require prior authorization and facility charges)	40%	50%
HOME HEALTH SERVICES		
Home health care agency services (up to 100 prior authorized visits per calendar year)	40%	Not covered (unless prior authorized)
OTHER		
Pregnancy and Maternity Care Benefits		
Prenatal physician office visits	$0[2]	50%
Postnatal physician office visits	40%	50%
Inpatient hospital services for normal delivery and cesarean section	40%	50%[4] 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
Abortion services[12]	40%	50%
Family Planning Benefits		
Injectable and implantable contraceptives	$0[2]	Not covered
Counseling and consulting	$0[2]	Not covered
Tubal ligation	$0[2]	Not covered
Vasectomy	40%	Not covered
Infertility services	Not covered	Not covered
Rehabilitation and Habilitation Benefits		
Office location	40%	50%
Outpatient department of a hospital	40%	50%[4] 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
Chiropractic Benefits		
Chiropractic services	Not covered	Not covered
Acupuncture Benefits		
Acupuncture services	40%	50%
Care Outside of California (benefits provided through the BlueCard® Program for out-of-state emergency and non-emergency care are provided at the preferred 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
Pediatric Dental Benefits – pediatric dental benefits are available for members through the end of the year in which the member turns 19		
$0 deductible for pediatric dental coverage		
Child Dental Diagnostic and Preventive		
Oral exam	No charge	20%
Preventive - cleaning	No charge	20%
Preventive - X-ray	No charge	20%
Sealants per tooth	No charge	20%
Topical fluoride application	No charge	20%
Caries risk management	No charge	20%
Space maintainers - fixed	No charge	20%
Child Dental Basic Services		

Amalgam fill - 1 surface	20%	30%
Child Dental Major Services[2]		
Root canal - molar	50%	50%
Gingivectomy per quad	50%	50%
Extraction - single tooth exposed root or	50%	50%
Extraction - complete bony	50%	50%
Porcelain with metal crown	50%	50%
Child Orthodontics[2]		
Medically necessary orthodontics	50%	50%
Pediatric Vision Benefits – for children up to age 19		
Comprehensive Eye Exam[13]: one per calendar year (includes dilation, if professionally indicated)		
Ophthalmologic - Routine ophthalmologic exam with refraction – new patient (S0620) - Routine ophthalmologic exam with refraction – established patient (S0621)	$0[2]	Covered up to a maximum allowance of $30[2]
Optometric - New patient exam (92002/92004) - Established patient exam (92012/92014)	$0[2]	Covered up to a maximum allowance of $30[2]
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. Polycarbonate lenses are covered in full for eligible members.	$0[2]	Covered up to a maximum allowance of: $25 single vision[2] $35 lined bifocal[2] $45 lined trifocal[2] $45 lenticular[2]
Optional Lenses and Treatments		
UV coating (standard only)	$0[2]	Not covered
Anti-reflective coating (standard only)	$35[2]	Not covered
High-index lenses	$30[2]	Not covered
Photochromic lenses (glass or plastic)	$25[2]	Not covered
Polarized lenses	$45[2]	Not covered
Standard progressives	$55[2]	Not covered
Premium progressives	$95[2]	Not covered
Frame (one frame per calendar year) Collection frame Non-collection frame[14] Note: "Collection" frames are available at no cost at participating independent providers. Retail chain providers typically do not display the "Collection," but are required to maintain a comparable selection of frames that are covered in full.	$0[2] Covered up to a maximum allowance of $150[2]	Covered up to a maximum allowance $40[2]
Contact Lenses[15]		
Elective – standard hard (V2500, V2510)	$0[2] (1 pair per year)	Covered up to a maximum allowance of $75[2]
Elective – standard soft (V2520)	$0[2] (1 pair per month for up to 6 months)	Covered up to a maximum allowance of $75[2]
Elective – non-standard hard (V2501, V2502, V2503, V2511, V2512, V2513, V2599)	$0[2] (1 pair per year)	Covered up to a maximum allowance of $75[2]
Elective – non-standard soft (V2521, V2512, V2523)	$0[2] (1 pair per month for up to 3 months)	Covered up to a maximum allowance of $75[2]
Medically necessary	$0[2] (1 pair per year)	Covered up to a maximum allowance of $225[2]
Other Pediatric Vision Benefits		
Supplemental low-vision testing and equipment[16]	35%[2]	Not covered
Diabetes management referral	$0[2]	Not covered

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

Pediatric Dental Benefits Endnotes:

1 The Calendar Year Deductible and Copayments for Covered Services from Participating Dentists accrue to the Calendar Year Out-of-Pocket Maximum, including any Copayments for covered orthodontia services received from Participating Dentists. Costs for non-Covered Services, services from Non-Participating Dentists, charges in excess of benefit maximums, and Premiums, do not accrue to the Calendar Year Out-of-Pocket Maximum. The out-of-pocket maximum for the embedded pediatric dental benefit accumulates to the overall combined medical and dental out-of-pocket maximum amount. This maximum is calculated as follows: (Federal out-of-pocket maximum) minus (SADP or Family Dental Plan out-of-pocket maximum) equals (QHP out-of-pocket maximum); numerically this is $6,600 - $350 = $6,250.

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

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

Those immediate qualifying conditions are:

- Cleft lip and or palate deformities
- Craniofacial Anomalies including the following: Crouzon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, Hemi-facial atrophy, Hem-facial hypertrophy and other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by our dental consultants.
- Deep impinging overbite, where the lower incisors are destroying the soft tissue of the palate and tissue laceration and/or clinical attachment loss are present. (Contact only does not constitute deep impinging overbite).
- Crossbite of individual anterior teeth when clinical attachment loss and recession of the gingival margin are present (e.g., stripping of the labial gingival tissue on the lower incisors). Treatment of bi-lateral posterior crossbite is not a benefit of the program.
- Severe traumatic deviation must be justified by attaching a description of the condition.
- Overjet greater than 9mm or mandibular protusion (reverse overjet) greater than 3.5mm.
- The remaining conditions must score 26 or more to qualify (based on the HDL Index).

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

Endnotes for Bronze 60 HSA PPO (HSA-Compatible)

1 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. The member is responsible for these charges in addition to the applicable copayment or coinsurance when accessing these providers, which amount can be substantial. Amounts applied to the calendar year deductible accrue towards the applicable out-of-pocket maximum. Charges in excess of the allowable amount do not count toward the calendar year medical deductible or out-of-pocket maximum.

2 The covered services listed below are not subject to, and will not accrue to the calendar year medical deductible.

- Durable medical equipment: breast pump
- Family planning benefits: counseling and consulting; diaphragm fitting procedure; implantable contraceptives; injectable contraceptives; insertion and/or removal of IUD device; IUD; and tubal ligation
- Outpatient prescription drug benefits: contraceptive drugs and devices
- Pediatric vision benefits
- Pregnancy and maternity care benefits: prenatal and preconception physician office visits
- Preventive health services
- Pediatric dental benefits

3 Copayments or coinsurance for covered services apply toward the calendar year out-of-pocket maximum, except copayments or coinsurance for the following: (a) charges in excess of specified benefit maximums; (b) covered travel expenses for bariatric surgery; and (c) dialysis center services from a non-participating provider. Copayments, coinsurance, and charges for services not accruing to the calendar year out-of-pocket maximum continue to be the member's responsibility after the calendar year out-of-pocket maximum is reached.

4 The allowable amount for non-emergency services and supplies received from a non-participating hospital or facility is limited to $500 per day. Members are responsible for the coinsurance and all charges that exceed $500 per day.

5 The allowable amount for non-emergency services and supplies received from an ambulatory surgery center is limited to $300 per day. Members are responsible for the coinsurance and all charges that exceed $300 per day. Participating ambulatory surgery centers may not be available in all areas; however, the member can obtain outpatient surgery services from a hospital or an ambulatory surgery center affiliated with a hospital, with payment according to the hospital services benefit.

6 The allowable amount for non-emergency services and supplies received from a non-participating radiology center is limited to $300 per day. Members are responsible for all charges that exceed $300 per day. The allowable amount for non-emergency services and supplies received from a non-participating hospital is limited to $500 per day. Members are responsible for all charges that exceed $500 per day.

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 Evidence of Coverage and Summary of Benefits for details.

8 This plan's prescription drug coverage provides less coverage on average than the standard benefit set by the federal government for Medicare Part D (also called non-creditable coverage). It is important to know that generally you may only enroll in a Medicare Part D plan from October 15th through December 7th of each year. If you do not enroll in a Medicare Part D plan when you are first eligible to join, you may be subject to a late enrollment penalty in addition to your Part D premium when you enroll at a later date. For

more information about your current plan's prescription drug coverage, call the Customer Service telephone number on your identification card, Monday through Thursday between 8:00 a.m. and 5:00 p.m. or on Friday between 9:00 a.m. and 5:00 p.m. The hearing impaired may call the TTY number at (888) 239-6482.

9 Contraceptive drugs and devices covered under the outpatient prescription drug benefit do not require a copayment and will not be subject to any calendar year medical deductible; however, if a brand contraceptive drug is requested when a generic drug equivalent is available, the member is responsible for paying the difference between the cost to Blue Shield for the brand contraceptive drug and its generic drug equivalent. If the brand contraceptive drug is medically necessary, it may be covered without a copayment with prior authorization. The difference in cost that the member must pay does not accrue to any calendar year medical deductible or out-of-pocket maximum responsibility.

10 If a member or physician requests a brand drug when a generic drug equivalent is available, and the calendar year medical deductible has been satisfied, the member is responsible for paying the difference between the cost to Blue Shield for the brand drug and its generic drug equivalent, as well as the applicable generic drug copayment. The difference in cost that the member must pay does not accrue to any calendar year medical deductible or out-of-pocket maximum responsibility. Refer to the Evidence of Coverage and Summary of Benefits for details.

11 Blue Shield has contracted with a specialized health care service plan to act as our mental health services administrator (MHSA). The MHSA provides mental health and chemical dependency services, other than inpatient services for acute medical detoxification, through a separate network of MHSA participating providers. Inpatient acute medical detoxification is a medical benefit provided by Blue Shield participating or non-participating (not MHSA) providers

12 Copayment shown is for physician's services. If the procedure is performed in a facility setting (hospital or outpatient surgery center), an additional facility copayment may apply.

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

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

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

16 A report from the provider and prior authorization from the Vision Plan Administrator is required.

This plan is pending regulatory approval.

Dental + vision package and dental plans

Dental + vision package and dental plans at a glance

Family dental plans

Blue Shield offers affordable and comprehensive dental plans for the whole family that are available with or without a Blue Shield medical plan.[1] We also offer a dental + vision package – Specialty Duo℠[,2] – that includes comprehensive dental and vision coverage to give you the additional protection your mouth and eyes deserve.

Dental plan highlights:

- Dental PPO plans use a dental PPO network which includes over 27,800 general care and specialty dentist locations in California.[3]
- Dental HMO plans use a dental HMO network which includes nearly 18,800 dental provider locations in California.[3]
- A wide range of dental benefits, including most diagnostic and preventive services at no additional cost when using a dental network provider.
- No waiting period for diagnostic or preventive services.
- Affordable copayments for both basic and major services.
- A wide variety of plans, including child-only, adult-only, and family plans.

Specialty Duo dental + vision package

- Specialty Duo offers dental and vision care protection.
- Dental benefits are identical to the benefits of the Dental PPO plan.
- Vision benefits include access to more than 6,600 contracted vision care provider locations in California,[3] including retail chains open on evenings and weekends.

1 To qualify for a dental plan or Specialty Duo package, you must be a California resident. If you were previously enrolled in a Blue Shield individual or family dental plan or dental + vision package, you must wait six months from the date of cancellation before you can reapply.Pediatric dental care is an essential health benefit embedded in every medical plan.

2 Specialty Duo is underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life).

3 Dental providers in California are available through the contracted dental plan administrator. Vision providers in California are available through the contracted vision plan administrator. Visit **blueshieldca.com/fap** to find a provider.

Blue Shield of California
Dental PPO Plan

Enhanced Dental PPO 25/500*

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.

	In-Network Coverage	Out-of-Network Coverage
Calendar Year Deductible	$25 per member/$75 per family	$25 per member/$75 per family
Deductible applies to	Basic & Major services only	All services
Calendar year maximum per member	$500	

Covered Services	Member Coinsurance Amounts	
	In-Network Coverage	**Out-of-Network Coverage**
Diagnostic and Preventive Services – cleanings, exams, x-rays, caries risk management (CAMBRA)[1]	No charge	20%
Basic Restorative Services[1] – minor restorations, oral surgery	20%	40%
Major Restorative[2] – bridges, crowns, dentures, endodontics, periodontics	50%	50%

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

* Pending regulatory approval

1 Caries Risk Management - CAMBRA (Caries Management by Risk Assessment) is an evaluation of a child's risk level for caries (decay). Children assessed as having a "high risk" for caries (decay) will be allowed up to 4 fluoride varnish treatments during the calendar year along with their biannual cleanings; "medium risk" children will be allowed up to 3 fluoride varnish treatments in addition to their biannual cleanings; and "low risk" children will be allowed up to two fluoride varnish treatments in addition to biannual cleanings. When requesting additional fluoride varnish treatments, the provider must provide a copy of the completed American Dental Association (ADA) CAMBRA form (available on the ADA website).

2 Waiting Periods
- No waiting periods for cleanings, exams and X-Rays
- 6 month waiting period for Basic Services
- 12-month waiting period for Major Services

Blue Shield of California
Dental PPO Plan

Enhanced Dental PPO 50/1250*

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	In-Network Coverage	Out-of-Network Coverage
Calendar Year Deductible	$50 per member/$150 per family	$150 per member/$450 per family
Deductible applies to	Basic & Major services only	All services
Calendar year maximum per member	$1,250	

Covered Services	Member Coinsurance Amounts	
	In-Network Coverage	**Out-of-Network Coverage**
Diagnostic and Preventive Services – cleanings, exams, x-rays, caries risk management (CAMBRA)[1]	No charge	20%
Basic Restorative Services[1] – minor restorations, oral surgery	20%	40%
Major Restorative[2] – bridges, crowns, dentures, endodontics, implants, periodontics	50%	50%

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

* Pending regulatory approval

1 Caries Risk Management - CAMBRA (Caries Management by Risk Assessment) is an evaluation of a child's risk level for caries (decay). Children assessed as having a "high risk" for caries (decay) will be allowed up to 4 fluoride varnish treatments during the calendar year along with their biannual cleanings; "medium risk" children will be allowed up to 3 fluoride varnish treatments in addition to their biannual cleanings; and "low risk" children will be allowed up to two fluoride varnish treatments in addition to biannual cleanings. When requesting additional fluoride varnish treatments, the provider must provide a copy of the completed American Dental Association (ADA) CAMBRA form (available on the ADA website).

2 Waiting Periods
- No waiting periods for cleanings, exams and X-Rays
- 6 month waiting period for Basic Services
- 12-month waiting period for Major Services

Blue Shield of California
Individual and Family Dental PPO Plan

Dental PPO Plan*

Benefit summary

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

Finding a network dentist

It's easy to choose a dentist. With a broad network of PPO dentists to pick from, you should be able to find one near you. The dental PPO directory is available online in the *Find a Provider* section at **blueshieldca.com,** or by calling Customer Service at **(888) 702-4171.** When you receive care from a network dentist, you pay only the applicable deductibles and copayments, and there are no claim forms to file.

Using a dentist that's not in the network

Select any licensed dentist. If you use a dentist that's not in the network, your total out-of-pocket expenses may be higher. You pay at the time of service and afterwards you can file a claim with Blue Shield to receive reimbursement of covered service or you can choose to have the reimbursement sent to your out-of-network dentist.

	In-Network	Out-of-Network
Calendar Year Deductible (per calendar year for services other than diagnostic and preventive services, enhanced dental benefits for pregnant women, and orthodontic services)	$50	
Annual Benefit Maximum (charges for services above the maximum are your responsibility)	$1,000 (In-Network); $500 (Out-of-Network); No more than $1,000 for In- and Out-of-Network combined	

Covered Services	In-Network Member Pays	Out-of-Network Max. Plan Payment:
Diagnostic and Preventive Services		
Comprehensive oral evaluation	$0	$40
Periodic oral evaluation	$0	$16
Intraoral radiographs - complete series (including bitewings) (x-rays)	$0	$56
Caries risk management[3]	$0	$16
Prophylaxis (adult) every 6 months	$0	$48
Sealant - per tooth (covered to age 15)	$0	$22
Basic Services†		
Filling (one surface resin composite)	$37 per tooth	$30 per tooth
Anterior root canal	$156 per tooth	$125 per tooth
Molar root canal	$234 per tooth	$187 per tooth
Periodontal scaling and root planing - four or more teeth per quadrant	$65 per quadrant	$52 per quadrant
Extraction of erupted tooth or exposed root	$40 per tooth	$32 per tooth
Major Services†		
Crown - porcelain/ceramic substrate	$265 each crown[1]	$212 each crown[1]
Crown - Full cast high noble metal	$320 each crown[1]	$256 each crown[1]
Osseous surgery (four or more teeth)	$263 per quadrant	$210 per quadrant
Surgical placement of implant body: endosteal implant	$612	Not covered
Pontic - porcelain fused to high noble metal	$293 each tooth replaced[1]	$234 each tooth replaced[1]
Denture (full upper or lower)	$388 per denture	$310 per denture
Removal of impacted tooth - complete bony	$113 per tooth	$90 per tooth
Orthodontic Services†		
Fully banded (two year) case - child[2]	$2,350	Not covered
Fully banded (two year) case - adult[2]	$2,650	Not covered

* Pending regulatory approval

† Subject to a waiting period.

1 Precious metals, if used will be charged to the member at the dentist's cost.

2 There is a 12 month waiting period for orthodontic services. In order to be covered, orthodontic treatment: must be received in one continuous course of treatment; and must be received in consecutive months. Orthodontic treatment must not exceed 24 consecutive months.

3 Caries Risk Management - CAMBRA (Caries Management by Risk Assessment) is an evaluation of a child's risk level for caries (decay). Children assessed as having a "high risk" for caries (decay) will be allowed up to 4 fluoride varnish treatments during the calendar year along with their biannual cleanings; "medium risk" children will be allowed up to 3 fluoride varnish treatments in addition to their biannual cleanings; and "low risk" children will be allowed up to two fluoride varnish treatments in addition to biannual cleanings. When requesting additional fluoride varnish treatments, the provider must provide a copy of the completed American Dental Association (ADA) CAMBRA form (available on the ADA website).

Many benefits have pre-determined annual schedules and frequency limitations based on last delivery date and dental necessity. If you are unsure about the frequency of when a benefit can be accessed, you can call **(800) 585-8111**.

This is only a summary of the Blue Shield Dental PPO Plan. For exact terms and conditions of coverage, including exclusions and limitations, please refer to the *Evidence of Coverage and Health Services Agreement*.

Blue Shield of California Life & Health Insurance Company
Individual and Family Dental Plan

Specialty Duo[SM] Dental Plan*

(Dental plan included in the Specialty Duo Plan Package)

Benefit summary

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

Finding a network dentist

It's easy to choose a dentist. With a broad network of PPO dentists to pick from, you should be able to find one near you. The dental PPO directory is available online in the *Find a Provider* section at **blueshieldca.com,** or by calling Customer Service at **(888) 702-4171.** When you receive care from a network dentist, you pay only the applicable deductibles and copayments, and there are no claim forms to file.

Using a dentist that's not in the network

Select any licensed dentist. If you use a dentist that's not in the network, your total out-of-pocket expenses may be higher. You pay at the time of service and afterwards you can file a claim with Blue Shield Life to receive reimbursement of covered service or you can choose to have the reimbursement sent to your out-of-network dentist.

	In-Network	Out-of-Network
Calendar Year Deductible (per calendar year for services other than diagnostic and preventive services, enhanced dental benefits for pregnant women, and orthodontic services)	$50	
Annual Benefit Maximum (charges for services above the maximum are your responsibility)	$1,000 (In-Network); $500 (Out-of-Network); No more than $1,000 for In- and Out-of-Network combined	

Covered Services	In-Network Member Pays	Out-of-Network Max. Plan Payment:
Diagnostic and Preventive Services		
Comprehensive oral evaluation	$0	$40
Periodic oral evaluation	$0	$16
Intraoral radiographs - complete series (including bitewings) (x-rays)	$0	$56
Prophylaxis (adult) every 6 months	$0	$48
Caries risk management[3]	$0	$16
Sealant - per tooth (covered to age 15)	$0	$22
Basic Services †		
Filling (one surface resin composite)	$37 per tooth	$30 per tooth
Anterior root canal	$156 per tooth	$125 per tooth
Molar root canal	$234 per tooth	$187 per tooth
Periodontal scaling and root planing - four or more teeth per quadrant	$65 per quadrant	$52 per quadrant
Extraction of erupted tooth or exposed root	$40 per tooth	$32 per tooth
Major Services†		
Crown - porcelain/ceramic substrate	$265 each crown[1]	$212 each crown[1]
Crown - Full cast high noble metal	$320 each crown[1]	$256 each crown[1]
Osseous surgery (four or more teeth)	$263 per quadrant	$210 per quadrant
Pontic - porcelain fused to high noble metal	$293 each tooth replaced[1]	$234 each tooth replaced[1]
Surgical placement of implant body: endosteal implant	$612	Not covered
Denture (full upper or lower)	$388 per denture	$310 per denture
Removal of impacted tooth - complete bony	$113 per tooth	$90 per tooth
Orthodontic Services†		
Fully banded (two year) case - child[2]	$2,350	Not covered
Fully banded (two year) case - adult[2]	$2,650	Not covered

* Pending regulatory approval.

† Subject to a waiting period.

1 Precious metals, if used will be charged to the member at the dentist's cost.

2 There is a 12 month waiting period for orthodontic services. In order to be covered, orthodontic treatment: must be received in one continuous course of treatment; and must be received in consecutive months. Orthodontic treatment must not exceed 24 consecutive months.

3 Caries Risk Management - CAMBRA (Caries Management by Risk Assessment) is an evaluation of a child's risk level for caries (decay). Children assessed as having a "high risk" for caries (decay) will be allowed up to 4 fluoride varnish treatments during the calendar year along with their biannual cleanings;

"medium risk" children will be allowed up to 3 fluoride varnish treatments in addition to their biannual cleanings; and "low risk" children will be allowed up to two fluoride varnish treatments in addition to biannual cleanings. When requesting additional fluoride varnish treatments, the provider must provide a copy of the completed American Dental Association (ADA) CAMBRA form (available on the ADA website).

Many benefits have pre-determined annual schedules and frequency limitations based on last delivery date and dental necessity. If you are unsure about the frequency of when a benefit can be accessed, you can call **(800) 585-8111**.

This is only a summary of the Specialty Duo℠ Dental PPO Plan. For exact terms and conditions of coverage, including exclusions and limitations, please refer to the *Policy*.

Blue Shield of California Life & Health Insurance Company
Individual and Family Vision Plan

Specialty Duo[SM] Vision Plan*

(Vision plan included in the Specialty Duo Plan Package)

Benefit summary

Exam copayment $0, materials copayment $25, frame allowance $100

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

Using your vision plan

With this vision plan, you have access to an extensive network of vision providers in California and nationwide[1]. Many of the providers are conveniently located in optical centers at retail stores[2] such as Costco (warehouse[3], membership required), LensCrafters, Wal-Mart (wholesale[3]), Sears, and Target Optical. When you use a network provider, most of your eyecare services are provided at no additional charge.

What your vision plan covers

Service and eyewear (90 day waiting period applies to all services)	Coverage when provided by network providers (after applicable copayment)	Maximum payment when provided by non-network provider
Comprehensive Examination - every 12 months		
Ophthalmologic	100%	up to a maximum of $60
Optometric	100%	up to a maximum of $50
Lenses[4] - every 24 months[5]		
Single Vision	100%	up to a maximum of $43
Bifocal	100%	up to a maximum of $60
Trifocal	100%	up to a maximum of $75
Lenticular or Aphakic Monofocal	100%	up to a maximum of $120
Lenticular or Aphakic Multifocal	100%	up to a maximum of $200
Polycarbonate Lenses for Dependent Children	up to a maximum of $100	up to a maximum of $75
Frame allowance - every 24 months	up to a maximum of $100[4]	up to a maximum of $40
Contact Lenses[6] - every 24 months[5]		
Non-Elective (Medically Necessary) - Hard[7]	100%	up to a maximum of $200
Non-Elective (Medically Necessary) - Soft[7]	100%	up to a maximum of $250
Elective (Cosmetic/Convenience) - Hard/Soft	up to a maximum of $120	up to a maximum of $120
Plano (Non-Prescription) Sunglasses[6, 8]	up to a maximum of $100[4]	Not Covered
Diabetes Management Referral[9]	100%	Not Covered

* Pending regulatory approval.

Accessing your vision benefits is easy, just follow these steps:

1. Prior to receiving a service, review your benefit information outlined in the chart on the previous page.
2. Call and make an appointment with a network provider.
   Or:
3. Login to MESVisionOptics.com to access the online network provider to purchase contact lenses online using your benefits. Note, you may choose to take the materials you purchased online to your preferred eye care provider for adjustments however you may incur a fitting or adjustment fee which is not covered under your vision insurance plan.

Or:

If you use a non-network provider, you're required to pay the provider's bill at the time of service. You can get reimbursement by obtaining a claim form or by logging on to **blueshieldca.com.** Click *Member Forms* and select the *Vision Benefit Claim Form (C-4669-61)* link.Complete and submit the claim form with the itemized receipt and a copy of your prescription to:

Blue Shield of California Life & Health Insurance Company
P.O. Box 25208
Santa Ana, CA 92799-5208

You will be reimbursed for your expenses up to the maximum payment allowed (see table on previous page). Note that when your dependents submit a claim form for reimbursement, payment will be made to you. Be sure to use your Blue Shield member identification number when filling out the form.

LASIK discount program[10]

LASIK and PRK correction surgery, an alternative to contacts or glasses, is one of the fastest-growing vision treatments. The discount program gives insured persons access to:

- A 15% discount through the NVISION Laser Eye Centers provider network in California, or
- A 20% discount through the QualSight, Inc. provider network in California and nationwide.

Discount Vision Program[10]

Vision plan members can receive a 20% discount off the published retail prices when they use a participating California provider in the Discount Vision Program network for these services and supplies:

- Routine eye examinations
- Frames and lenses
- Photochromic lenses
- Hard contact lenses
- Tints and coatings
- Extra pair of glasses
- Non-prescription sunglasses

Your vision coverage is underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life) and administered by a contracted vision plan administrator.

This is only a summary of the Blue Shield Life Specialty Duo[SM] Vision Plan. Please refer to the *Policy* for a detailed description of covered benefits and limitations.

Find a network provider nearest you by going to the *Find a Provider* section on **blueshieldca.com,** or calling Member Services at **(877) 601-9083.** You'll find a complete listing of ophthalmologists, optometrists, and opticians.

1 California and Nationwide vision providers are available by arrangement through a contracted vision plan administrator.

2 Availability of retail store locations varies by state. Refer to blueshieldcavision.com for out-of-state retail locations.

3 When the network provider uses wholesale or warehouse pricing, the maximum allowable frame allowance will be as follows: wholesale allowance: $66.04, warehouse allowance $69.09. Network providers using wholesale or warehouse pricing are identified in the Directory of Network Vision Providers. You pay any cost above the allowed amount.

4 Fit any frame with an eye size less than 61 mm

5 A change in standard lenses (excludes unusual lenses, such as oversize, no-line bifocal, or a material other than ordinary plastic) or contact lenses is covered per 12-month period if required by qualified prescription change, defined as a change in prescription of 0.50 diopters or more in one or both eyes; a shift in axis of astigmatism of 15 degrees; a difference in vertical prism greater than one prism diopter; or a change in lens type.

6 In lieu of lenses and frame.

7 A report from the provider and prior authorization from a contracted vision plan administrator is required.

8 For insured persons who have had PRK, LASIK, or custom LASIK vision correction surgery only, this benefit of plano sunglasses allowance is equal to the plan's frame allowance. An eye exam by a network provider is required to verify laser surgery or a note from the surgeon who performed the laser surgery is required to verify laser surgery.

9 The diabetes disease management referral program is available to insured persons who enroll in both Blue Shield medical and vision coverage.

10 The network of practitioners and facilities in the discount programs are managed by the external program administrators identified below, including any screening and credentialing of providers. Blue Shield does not review the services provided by discount program providers for medical necessity or efficacy. Nor does Blue Shield make any recommendations, representations, claims, or guarantees regarding the practitioners, their availability, fees, services, or products.
Some services offered through the discount program may already be included as part of the Blue Shield plan covered benefits. Insured persons should access those covered services prior to using the discount program.
Insured persons who are not satisfied with products or services received from the discount program may use Blue Shield's grievance process described in the Grievance Process section of the Certificate of Insurance or policy. Blue Shield reserves the right to terminate this program at any time without notice.
Discount programs administered by or arranged through the following independent companies:

1. Discount Vision program - MESVision
2. LASIK Discount Program:
   a. NVISION Laser Eye Centers, Inc (within California)
   b. QualSight, Inc. (California and nationwide)

Blue Shield of California
Dental HMO Plan

Enhanced Dental HMO $0*

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.

Calendar year deductible per member	None
Calendar year maximum per member	None
Waiting Period	None

ADA Code	ADA Description	Member Pays
	Office visit	$0
	Diagnostic & Preventive Services	
D0120	Periodic oral evaluation - established patient	$0
D0150	Comprehensive oral evaluation - new or established patient	$0
D0210	Intraoral - complete series of radiographic images	$0
D601-603	Caries risk management[2]	$0
D1110	Prophylaxis - adult	$0
D1351	Sealant - per tooth	$0
	Routine Services	
D2330	Resin based composite - one surface, anterior	$20
D3310	Endodontic therapy - anterior tooth (excluding final restoration)	$175
D3330	Endodontic therapy - molar tooth (excluding final restoration)	$355
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	$75
D7111	Extraction of coronal remnants - deciduous tooth	$20
	Major Services	
D2740	Crown - porcelain/ceramic substrate	$350[1]
D5110	Complete denture - maxillary	$400[1]
D5120	Complete denture - mandibular	$400[1]
D6240	Pontic - porcelain fused to high noble metal	$350[1]
	Orthodontic Services	
D8080	Comprehensive orthodontic treatment of the adolescent dentition	$2,350
D8090	Comprehensive orthodontic treatment of the adult dentition	$2,650

Please Note:

* Pending regulatory approval

[1] Precious and semi-precious metals and porcelain on molar crowns, if used will be charged to the member at the dentist's cost.

[2] Caries Risk Management - CAMBRA (Caries Management by Risk Assessment) is an evaluation of a child's risk level for caries (decay). Children assessed as having a "high risk" for caries (decay) will be allowed up to 4 fluoride varnish treatments during the calendar year along with their biannual cleanings; "medium risk" children will be allowed up to 3 fluoride varnish treatments in addition to their biannual cleanings; and "low risk" children will be allowed up to two fluoride varnish treatments in addition to biannual cleanings. When requesting additional fluoride varnish treatments, the provider must

provide a copy of the completed American Dental Association (ADA) CAMBRA form (available on the ADA website).
Benefits are subject to modification for subsequently enacted state or federal legislation.
Some procedures may require costs in addition to the Member copayments. Please refer to the Summary of Benefits for additional information.

Blue Shield of California
Individual and Family Dental HMO Plan

Dental HMO Plan*

Benefit summary

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

Using your dental HMO plan

With our dental HMO plan, you'll have access to an extensive network of dental providers without paying deductibles or filling out claim forms. Plus, it's easy. First, choose a dental provider from our network during enrollment. Then, contact this dental provider for your dental care, including referrals for consultation with plan specialists and emergency services. If you have questions or want to switch providers, call Customer Service at **(800) 585-8111.**

	In-Network
Calendar Year Deductible	$0
Annual Benefit Maximum	Not Applicable

Covered Services	Member pays
Diagnostic and Preventive Services	
Comprehensive oral evaluation	$0
Periodic oral evaluation	$0
Intraoral radiographs - complete series (including bitewings) (x-rays)	$0
Caries risk management[3]	$0
Prophylaxis (adult) every 6 months	$0
Sealant - per tooth (covered to age 15)	$0
Basic Services	
Filling (one surface resin composite)	$18 per tooth
Anterior root canal	$155 per tooth
Molar root canal	$290 per tooth
Periodontal scaling and root planing - four or more teeth per quadrant	$55 per quadrant
Extraction of erupted tooth or exposed root	$34 per tooth
Major Services	
Crown - porcelain/ceramic substrate	$300 each crown[1]
Crown - Full cast high noble metal	$300 each crown[1]
Osseous surgery (four or more teeth)	$265 per quadrant
Pontic - porcelain fused to high noble metal	$300 each tooth replaced[1]
Surgical placement of implant body: endosteal implant	$1,375
Denture (full upper or lower)	$400 per denture
Removal of impacted tooth - complete bony	$125 per tooth
Orthodontic Services	
Fully banded (two year) case - child[2]	$2,350
Fully banded (two year) case - adult[2]	$2,650

* Pending regulatory approval

1 Precious and semi-precious metals, if used, will be charged to the patient at the additional cost of the metal. Porcelain on molar crowns are subject to an additional charge of $75.00.

2 There is a 12 month waiting period for orthodontic services. In order to be covered, orthodontic treatment: must be received in one continuous course of treatment; and must be received in consecutive months. Orthodontic treatment must not exceed 24 consecutive months.

3 Caries Risk Management - CAMBRA (Caries Management by Risk Assessment) is an evaluation of a child's risk level for caries (decay). Children assessed as having a "high risk" for caries (decay) will be allowed up to 4 fluoride varnish treatments during the calendar year along with their biannual cleanings; "medium risk" children will be allowed up to 3 fluoride varnish treatments in addition to their biannual cleanings; and "low risk" children will be allowed up to two fluoride varnish treatments in addition to biannual cleanings. When requesting additional fluoride varnish treatments, the provider must provide a copy of the completed American Dental Association (ADA) CAMBRA form (available on the ADA website).

Many benefits have pre-determined annual schedules and frequency limitations based on last delivery date and dental necessity. If you are unsure about the frequency of when a benefit can be accessed, you can call **(800) 585-8111**.

This is only a summary of the Blue Shield Dental HMO Plan. For exact terms and conditions of coverage, including exclusions and limitations, please refer to the *Evidence of Coverage and Health Services Agreement*.

Vision plan

Vision plan at a glance

Routine eye exams can help detect both eye and systemic health problems. When detected early, many serious health conditions can be managed more effectively – with less costly treatment and a better chance for a healthy outcome.

Blue Shield vision plans offer access to a network with a variety of vision providers. Members have access to more than 22,000 ophthalmologists, optometrists, and opticians nationwide and more than 6,600 in California.[1] These providers include retail locations such as Wal-Mart, Lenscrafters, Pearle Vision, Site for Sore Eyes, For Eyes Optical, Target Optical, and Costco.[2] Many of these retail locations are conveniently open evenings and weekends, making accessing your vision care even easier.

1 Vision providers in California are available through the contracted vision plan administrator. Visit **blueshieldca.com/fap** to find a provider.

2 Must be a Costco member.

Blue Shield of California Life & Health Insurance Company
Individual and Family Vision Plan

Ultimate Vision 15/25/150

Benefit summary

Exam copayment $15, materials copayment $25, frame allowance $150

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

Using your vision plan

With this vision plan, you have access to an extensive network of vision providers in California and nationwide[1]. Many of the providers are conveniently located in optical centers at retail stores[2] such as Costco (warehouse[3], membership required), LensCrafters, Wal-Mart (wholesale[3]), Sears, and Target Optical. When you use a network provider, many of your eyecare services are provided at no additional charge.

What your vision plan covers

Service and eyewear (90 day waiting period applies to all services)	Coverage when provided by network providers (after applicable copayment)	Maximum payment when provided by non-network provider
Comprehensive Examination - every 12 months		
Ophthalmologic	100%	up to a maximum of $60
Optometric	100%	up to a maximum of $50
Lenses[4] - every 12 months		
Single Vision	100%	up to a maximum of $43
Bifocal	100%	up to a maximum of $60
Trifocal	100%	up to a maximum of $75
Lenticular or Aphakic Monofocal	100%	up to a maximum of $120
Lenticular or Aphakic Multifocal	100%	up to a maximum of $200
Polycarbonate Lenses for Dependent Children	up to a maximum of $100	up to a maximum of $75
Progressive Lenses (no-line bifocals)	up to a maximum of $140	up to a maximum of $100
Anti-Reflective Lens Coating	up to a maximum of $50	up to a maximum of $35
Photochromic Lenses		
Single Vision	up to a maximum of $115	up to a maximum of $85
Bifocal	up to a maximum of $130	up to a maximum of $95
Trifocal	up to a maximum of $150	up to a maximum of $110
Progressive	up to a maximum of $200	up to a maximum of $150
Polycarbonate Photochromic Single Vision Lens for Dependent Children	up to a maximum of $160	up to a maximum of $115
Frame allowance - every 12 months	up to a maximum of $150[3]	up to a maximum of $40
Contact Lenses[5] - every 12 months		
Non-Elective (Medically Necessary) – Hard[6]	100%	up to a maximum of $200
Non-Elective (Medically Necessary) – Soft[6]	100%	up to a maximum of $250
Elective (Cosmetic/Convenience) - Hard/Soft	up to a maximum of $120	up to a maximum of $120
Supplemental Low-Vision Testing and Equipment - covered up to $1000[6]	75% (Member Copayment for Materials is not applicable)	Not Covered
Plano (Non-Prescription) Sunglasses[5, 7]	up to a maximum of $150[3]	Not Covered
Diabetes Management Referral[8]	100%	Not Covered

Accessing your vision benefits is easy, just follow these steps:

1. Prior to receiving a service, review your benefit information outlined in the chart on the previous page.
2. Call and make an appointment with a network provider.
   Or:
3. Login to MESVisionOptics.comto access the online network provider to purchase contact lenses online using your benefits. Note, you may choose to take the materials you purchased online to your preferred eye care provider for adjustments however you may incur a fitting or adjustment fee which is not covered under your vision insurance plan.

Or:

If you use a non-network provider, you're required to pay the provider's bill at the time of service. You can get reimbursement by obtaining a claim form by logging on to **blueshieldca.com.** Click Member Forms and select the Vision Benefit Claim Form (C-4669-61) link. Complete and submit the claim form with the itemized receipt and a copy of your prescription to:

Blue Shield of California Life & Health Insurance Company
P.O. Box 25208
Santa Ana, CA 92799-5208

You will be reimbursed for your expenses up to the maximum payment allowed (see table on previous page). Note that when your dependents submit a claim form for reimbursement, payment will be made to you. Be sure to use your Blue Shield member identification number when filling out the form.

LASIK discount program[9]

LASIK and PRK correction surgery, an alternative to contacts or glasses, is one of the fastest-growing vision treatments. The discount program gives insured persons access to:

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- Tints and coatings
- Extra pair of glasses
- Non-prescription sunglasses

Your vision coverage is underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life) and administered by a contracted vision plan administrator.

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Find a network provider nearest you by going to the *Find a Provider* section on **blueshieldca.com,** or calling Member Services at **(877) 601-9083.** You'll find a complete listing of ophthalmologists, optometrists, and opticians.

1 California and nationwide vision providers are available by arrangement through a contracted vision plan administrator.

2 Availability of retail store locations varies by state. Refer to blueshieldcavision.com for out-of-state retail locations.

3 When the network provider uses wholesale or warehouse pricing, the maximum allowable frame allowance will be as follows: wholesale allowance: $99.06, warehouse allowance $103.64. Network providers using wholesale or warehouse pricing are identified in the Directory of Network Vision Providers. You pay any cost above the allowed amount.

4 Fit any frame with an eye size less than 61 mm.

5 In lieu of lenses and frame.

6 A report from the provider and prior authorization from a contracted vision plan administrator is required.

7 For insured persons who have had PRK, LASIK, or custom LASIK vision correction surgery only, this benefit of plano sunglasses allowance is equal to the plan's frame allowance. An eye exam by a network provider is required to verify laser surgery or a note from the surgeon who performed the laser surgery is required to verify laser surgery.

8 The diabetes disease management referral program is available to insured persons who enroll in both Blue Shield medical and vision coverage.

9 The network of practitioners and facilities in the discount programs are managed by the external program administrators identified below, including any screening and credentialing of providers. Blue Shield does not review the services provided by discount program providers for medical necessity or efficacy. Nor does Blue Shield make any recommendations, representations, claims, or guarantees regarding the practitioners, their availability, fees, services, or products.
Some services offered through the discount program may already be included as part of the Blue Shield plan covered benefits. Insured persons should access those covered services prior to using the discount program.
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Discount programs administered by or arranged through the following independent companies:

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2. LASIK Discount Program:
   a. NVISION Laser Eye Centers, Inc. (within California)
   b. QualSight, Inc. (California and nationwide)

Individual term life insurance coverage

Life insurance plans at a glance

Facing financial burdens after the loss of a loved one can be overwhelming – having life insurance helps. Affordable individual term life insurance from Blue Shield of California Life & Health Insurance Company (Blue Shield Life) can help you protect your loved ones from the unexpected. Proceeds can help contribute toward funeral costs, mortgage payments, your child's education, and other daily living expenses in uncertain times.

Why Blue Shield Life?

For more than 50 years, Blue Shield Life has provided life insurance to Californians. With an "A" (Excellent) rating from A.M. Best, Blue Shield Life has the financial stability to meet our members' needs, both now and in the future.

We offer the financial protection and security of $10,000, $30,000, $60,000, $90,000, or $100,000 in term life insurance coverage for applicants ages 1 to 64,[1] and your benefit amount will never decrease as you age.

We also offer the option to return a policy within 10 days (30 days if the insured is age 60 to 64) for a full refund if you are dissatisfied for any reason.

Eligibility

Individual term life insurance coverage is available to you, your spouse, or domestic partner, and to dependents over the age of 1 year, with or without a medical plan.[2]

For complete details on individual term life insurance, you can request a sample copy of the policy by calling Blue Shield at **(888) 256-3650**.

1 Applicants ages 1 to 18 are eligible only for $10,000 and $30,000 levels of coverage.

2 All applicants are subject to Evidence of Insurability.

blue of california

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Blue Shield of California is an independent member of the Blue Shield Association A16646-PPO (1/15)