blue of california

Summary of Benefits

Group Plan
HMO Plan

Trio HMO Zero Admit 10

This Summary of Benefits shows the amount you will pay for Covered Services under this Blue Shield of California Plan. It is only a summary and it is included as part of the Evidence of Coverage (EOC).[1] Please read both documents carefully for details.

Medical Provider Network: **Trio ACO HMO Network**

This Plan uses a specific network of Health Care Providers, called the Trio ACO HMO provider network. Medical Groups, Independent Practice Associations (IPAs), and Physicians in this network are called Participating Providers. You must select a Primary Care Physician from this network to provide your primary care and help you access services, but there are some exceptions. Please review your Evidence of Coverage for details about how to access care under this Plan. You can find Participating Providers in this network at blueshieldca.com.

Calendar Year Deductibles (CYD)[2]

A Calendar Year Deductible (CYD) is the amount a Member pays each Calendar Year before Blue Shield pays for Covered Services under the Plan.

		When using a Participating Provider[3]
Calendar Year medical Deductible	*Individual coverage*	$0
	Family coverage	$0: individual $0: Family

Calendar Year Out-of-Pocket Maximum[4]

An Out-of-Pocket Maximum is the most a Member will pay for Covered Services each Calendar Year. Any exceptions are listed in the EOC.

	When using a Participating Provider[3]
Individual coverage	$1,500
Family coverage	$1,500: individual $3,000: Family

No Annual or Lifetime Dollar Limit

Under this Plan there is no annual or lifetime dollar limit on the amount Blue Shield will pay for Covered Services.

Blue Shield of California is an independent member of the Blue Shield Association

Benefits[5]	Your payment	
	When using a Participating Provider[3]	CYD[2] applies
Preventive Health Services[6]		
Preventive Health Services	$0	
California Prenatal Screening Program	$0	
Physician services		
Primary care office visit	$10/visit	
Trio+ specialist care office visit (self-referral)	$10/visit	
Other specialist care office visit (referred by PCP)	$10/visit	
Physician home visit	$10/visit	
Physician or surgeon services in an Outpatient Facility	$0	
Physician or surgeon services in an inpatient facility	$0	
Other professional services		
Other practitioner office visit *Includes nurse practitioners, physician assistants, and therapists.*	$10/visit	
Teladoc consultation	$0	
Family planning		
• Counseling, consulting, and education	$0	
• Injectable contraceptive, diaphragm fitting, intrauterine device (IUD), implantable contraceptive, and related procedure.	$0	
• Tubal ligation	$0	
• Vasectomy	$0	
Podiatric services	$10/visit	
Medical nutrition therapy, not related to diabetes	$0	
Pregnancy and maternity care		
Physician office visits: prenatal and postnatal	$0	
Abortion and abortion-related services	$0	
Emergency Services		
Emergency room services *If admitted to the Hospital, this payment for emergency room services does not apply. Instead, you pay the Participating Provider payment under Inpatient facility services/ Hospital services and stay.*	$100/visit	
Emergency room Physician services	$0	

Benefits[5]	Your payment	
	When using a Participating Provider[3]	**CYD[2] applies**
Urgent care center services	$10/visit	
Ambulance services	$100/transport	
This payment is for emergency or authorized transport.		
Outpatient Facility services		
Ambulatory Surgery Center	$0	
Outpatient Department of a Hospital: surgery	$0	
Outpatient Department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies	$0	
Inpatient facility services		
Hospital services and stay	$0	
Transplant services		
This payment is for all covered transplants except tissue and kidney. For tissue and kidney transplant services, the payment for Inpatient facility services/ Hospital services and stay applies.		
• Special transplant facility inpatient services	$0	
• Physician inpatient services	$0	
Diagnostic x-ray, imaging, pathology, and laboratory services		
This payment is for Covered Services that are diagnostic, non-Preventive Health Services, and diagnostic radiological procedures, such as CT scans, MRIs, MRAs, and PET scans. For the payments for Covered Services that are considered Preventive Health Services, see Preventive Health Services.		
Laboratory services		
Includes diagnostic Papanicolaou (Pap) test.		
• Laboratory center	$0	
• Outpatient Department of a Hospital	$0	
X-ray and imaging services		
Includes diagnostic mammography.		
• Outpatient radiology center	$0	
• Outpatient Department of a Hospital	$0	
Other outpatient diagnostic testing		
Testing to diagnose illness or injury such as vestibular function tests, EKG, ECG, cardiac monitoring, non-invasive vascular studies, sleep medicine testing, muscle and range of motion tests, EEG, and EMG.		
• Office location	$0	
• Outpatient Department of a Hospital	$0	

Benefits[5]	Your payment	
	When using a Participating Provider[3]	CYD[2] applies
Radiological and nuclear imaging services		
• Outpatient radiology center	$0	
• Outpatient Department of a Hospital	$0	
Rehabilitative and Habilitative Services		
Includes physical therapy, occupational therapy, respiratory therapy, and speech therapy services.		
Office location	$10/visit	
Outpatient Department of a Hospital	$10/visit	
Durable medical equipment (DME)		
DME	20%	
Breast pump	$0	
Orthotic equipment and devices	$0	
Prosthetic equipment and devices	$0	
Home health care services	$10/visit	
Up to 100 visits per Member, per Calendar Year, by a home health care agency. All visits count towards the limit, including visits during any applicable Deductible period. Includes home visits by a nurse, Home Health Aide, medical social worker, physical therapist, speech therapist, or occupational therapist, and medical supplies.		
Home infusion and home injectable therapy services		
Home infusion agency services	$0	
Includes home infusion drugs, medical supplies, and visits by a nurse.		
Hemophilia home infusion services	$0	
Includes blood factor products.		
Skilled Nursing Facility (SNF) services		
Up to 100 days per Member, per benefit period, except when provided as part of a Hospice program. All days count towards the limit, including days during any applicable Deductible period and days in different SNFs during the Calendar Year.		
Freestanding SNF	$0	
Hospital-based SNF	$0	
Hospice program services	$0	
Includes pre-Hospice consultation, routine home care, 24-hour continuous home care, short-term inpatient care for pain and symptom management, and inpatient respite care.		

Benefits[5]	Your payment	
	When using a Participating Provider[3]	CYD[2] applies
Other services and supplies		
Diabetes care services		
• Devices, equipment, and supplies	20%	
• Self-management training	$10/visit	
• Medical nutrition therapy	$10/visit	
Dialysis services	$0	
PKU product formulas and special food products	$0	
Allergy serum billed separately from an office visit	50%	

Mental Health and Substance Use Disorder Benefits	Your payment	
Mental health and substance use disorder Benefits are provided through Blue Shield's Mental Health Service Administrator (MHSA).	When using a MHSA Participating Provider[3]	CYD[2] applies
Outpatient services		
Office visit, including Physician office visit	$10/visit	
Teladoc mental health	$0	
Other outpatient services, including intensive outpatient care, electroconvulsive therapy, transcranial magnetic stimulation, Behavioral Health Treatment for pervasive developmental disorder or autism in an office setting, home, or other non-institutional facility setting, and office-based opioid treatment	$0	
Partial Hospitalization Program	$0	
Psychological Testing	$0	
Inpatient services		
Physician inpatient services	$0	
Hospital services	$0	
Residential Care	$0	

Notes

1 Evidence of Coverage (EOC):

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

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

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Outpatient Prescription Drug Rider

Group Rider
HMO/POS

Enhanced Rx $10/25/40 with $0 Pharmacy Deductible
Summary of Benefits

This Summary of Benefits shows the amount you will pay for covered Drugs under this prescription Drug Benefit.

Pharmacy Network:	**Rx Ultra**
Drug Formulary:	**Plus Formulary**

Calendar Year Pharmacy Deductible(CYPD)[1]

A Calendar Year Pharmacy Deductible (CYPD) is the amount a Member pays each Calendar Year before Blue Shield pays for covered Drugs under the outpatient prescription Drug Benefit. Blue Shield pays for some prescription Drugs before the Calendar Year Pharmacy Deductible is met, as noted in the Prescription Drug Benefits chart below.

		When using a Participating[2] Pharmacy
Calendar Year Pharmacy Deductible	*Per Member*	$0

Prescription Drug Benefits[3,4]	**Your payment**	
	When using a Participating Pharmacy[2]	**CYPD[1] applies**
Retail pharmacy prescription Drugs		
Per prescription, up to a 30-day supply.		
Contraceptive Drugs and devices	$0	
Tier 1 Drugs	$10/prescription	
Tier 2 Drugs	$25/prescription	
Tier 3 Drugs	$40/prescription	
Tier 4 Drugs	20% up to $250/prescription	
Retail pharmacy prescription Drugs		
Per prescription, up to a 90-day supply from a 90-day retail pharmacy.		
Contraceptive Drugs and devices	$0	
Tier 1 Drugs	$30/prescription	
Tier 2 Drugs	$75/prescription	
Tier 3 Drugs	$120/prescription	
Tier 4 Drugs	20% up to $750/prescription	
Mail service pharmacy prescription Drugs		
Per prescription, up to a 90-day supply.		
Contraceptive Drugs and devices	$0	
Tier 1 Drugs	$20/prescription	
Tier 2 Drugs	$50/prescription	
Tier 3 Drugs	$80/prescription	
Tier 4 Drugs	20% up to $500/prescription	

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Acupuncture and Chiropractic Services Rider

Group Rider
HMO/POS

Summary of Benefits

This Summary of Benefits shows the amount you will pay for Covered Services under this acupuncture and chiropractic services Benefit.

Benefits	**Your Payment**	
Covered Services must be determined as Medically Necessary by American Specialty Health Plans of California, Inc. (ASH Plans). *Up to 30 visits per Member, per Calendar Year. The 30 visit maximum is for acupuncture and chiropractic services combined.* *Services are not subject to the Calendar Year Deductible and do count towards the Calendar Year Out-of-Pocket Maximum.*	**When using an ASH Participating Provider**	**When using a Non-Participating Provider**
Acupuncture Services		
Office visit	$10/visit	Not covered
Chiropractic Services		
Office visit	$10/visit	Not covered
Chiropractic Appliances	All charges above $50	Not covered

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

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Introduction

In addition to the Benefits listed in your Evidence of Coverage, your rider provides coverage for acupuncture and chiropractic services as described in this supplement. The Benefits covered under this rider must be received from an American Specialty Health Plans of California, Inc. (ASH Plans) Participating Provider. These acupuncture and chiropractic Benefits are separate from your health Plan, but the general provisions, limitations, and exclusions described in your Evidence of Coverage do apply. A referral from your Primary Care Physician is not required.

All Covered Services, except for (1) the initial examination and treatment by an ASH Participating Provider; and (2) Emergency Services, must be determined as Medically Necessary by ASH Plans.

Note: ASH Plans will respond to all requests for Medical Necessity review within five business days from receipt of the request.

Covered Services received from providers who are not ASH Participating Providers will not be covered except for Emergency Services and in certain circumstances, in counties in California in which there are no ASH Participating Providers. If ASH Plans determines Covered Services from a provider other than a Participating Provider are Medically Necessary, you will be responsible for the Participating Provider Copayment amount.

Benefits

Acupuncture Services

Benefits are available for Medically Necessary acupuncture services for the treatment of Musculoskeletal and Related Disorders.

Benefits include an initial examination, acupuncture and adjunctive therapy, and subsequent office visits for the treatment of:

- headaches (tension-type and migraines);
- hip or knee joint pain associated with osteoarthritis (OA);
- other extremity joint pain associated with OA or mechanical irritation;
- other pain syndromes involving the joints and associated soft tissues;
- back and neck pain; and
- nausea associated with pregnancy, surgery, or chemotherapy.

Chiropractic Services

Benefits are available for Medically Necessary chiropractic services for the treatment of Musculoskeletal and Related Disorders.

Benefits include an initial examination, subsequent office visits and the following services:

- spinal and extra-spinal joint manipulation (adjustments);
- adjunctive therapy such as electrical muscle stimulation or therapeutic exercises;
- plain film x-ray services; and
- chiropractic supports and appliances.

Visits for acupuncture and chiropractic services are limited to a per Member per Calendar Year maximum as shown on the Summary of Benefits. Benefits must be provided in an office setting. You will be referred to your Primary Care Physician for evaluation of conditions not related to a Musculoskeletal and Related Disorder and for other services not covered under this rider such as diagnostic imaging (e.g. CAT scans or MRIs).

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Summary of Benefits

Group Plan
HMO Plan

Local Access+ HMO® Per Admit 20-500

This Summary of Benefits shows the amount you will pay for Covered Services under this Blue Shield of California Plan. It is only a summary and it is included as part of the Evidence of Coverage (EOC).[1] Please read both documents carefully for details.

Medical Provider Network: **Local Access+ HMO Network**

This Plan uses a specific network of Health Care Providers, called the Local Access+ HMO provider network. Medical Groups, Independent Practice Associations (IPAs), and Physicians in this network are called Participating Providers. You must select a Primary Care Physician from this network to provide your primary care and help you access services, but there are some exceptions. Please review your Evidence of Coverage for details about how to access care under this Plan. You can find Participating Providers in this network at blueshieldca.com.

Calendar Year Deductibles (CYD)[2]

A Calendar Year Deductible (CYD) is the amount a Member pays each Calendar Year before Blue Shield pays for Covered Services under the Plan.

		When using a Participating Provider[3]
Calendar Year medical Deductible	*Individual coverage*	$0
	Family coverage	$0: individual $0: Family

Calendar Year Out-of-Pocket Maximum[4]

An Out-of-Pocket Maximum is the most a Member will pay for Covered Services each Calendar Year. Any exceptions are listed in the EOC.

	When using a Participating Provider[3]
Individual coverage	$2,500
Family coverage	$2,500: individual $5,000: Family

No Annual or Lifetime Dollar Limit

Under this Plan there is no annual or lifetime dollar limit on the amount Blue Shield will pay for Covered Services.

Blue Shield of California is an independent member of the Blue Shield Association

Benefits[5]	Your payment	
	When using a Participating Provider[3]	CYD[2] applies
Preventive Health Services[6]		
Preventive Health Services	$0	
California Prenatal Screening Program	$0	
Physician services		
Primary care office visit	$20/visit	
Access+ specialist care office visit (self-referral)	$30/visit	
Other specialist care office visit (referred by PCP)	$20/visit	
Physician home visit	$20/visit	
Physician or surgeon services in an Outpatient Facility	$0	
Physician or surgeon services in an inpatient facility	$0	
Other professional services		
Other practitioner office visit	$20/visit	
Includes nurse practitioners, physician assistants, and therapists.		
Teladoc consultation	$0	
Family planning		
• Counseling, consulting, and education	$0	
• Injectable contraceptive, diaphragm fitting, intrauterine device (IUD), implantable contraceptive, and related procedure.	$0	
• Tubal ligation	$0	
• Vasectomy	$0	
Podiatric services	$20/visit	
Medical nutrition therapy, not related to diabetes	$0	
Pregnancy and maternity care		
Physician office visits: prenatal and postnatal	$0	
Abortion and abortion-related services	$0	
Emergency Services		
Emergency room services	$100/visit	
If admitted to the Hospital, this payment for emergency room services does not apply. Instead, you pay the Participating Provider payment under Inpatient facility services/ Hospital services and stay.		
Emergency room Physician services	$0	

Benefits[5]	Your payment	
	When using a Participating Provider[3]	CYD[2] applies
Urgent care center services	$20/visit	
Ambulance services	$100/transport	
This payment is for emergency or authorized transport.		
Outpatient Facility services		
Ambulatory Surgery Center	$100/surgery	
Outpatient Department of a Hospital: surgery	$300/surgery	
Outpatient Department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies	$0	
Inpatient facility services		
Hospital services and stay	$500/admission	
Transplant services		
This payment is for all covered transplants except tissue and kidney. For tissue and kidney transplant services, the payment for Inpatient facility services/ Hospital services and stay applies.		
• Special transplant facility inpatient services	$500/admission	
• Physician inpatient services	$0	
Diagnostic x-ray, imaging, pathology, and laboratory services		
This payment is for Covered Services that are diagnostic, non-Preventive Health Services, and diagnostic radiological procedures, such as CT scans, MRIs, MRAs, and PET scans. For the payments for Covered Services that are considered Preventive Health Services, see Preventive Health Services.		
Laboratory services		
Includes diagnostic Papanicolaou (Pap) test.		
• Laboratory center	$0	
• Outpatient Department of a Hospital	$0	
X-ray and imaging services		
Includes diagnostic mammography.		
• Outpatient radiology center	$0	
• Outpatient Department of a Hospital	$0	
Other outpatient diagnostic testing		
Testing to diagnose illness or injury such as vestibular function tests, EKG, ECG, cardiac monitoring, non-invasive vascular studies, sleep medicine testing, muscle and range of motion tests, EEG, and EMG.		
• Office location	$0	
• Outpatient Department of a Hospital	$0	

Benefits[5]	Your payment	
	When using a Participating Provider[3]	CYD[2] applies
Radiological and nuclear imaging services		
• Outpatient radiology center	$0	
• Outpatient Department of a Hospital	$0	
Rehabilitative and Habilitative Services		
Includes physical therapy, occupational therapy, respiratory therapy, and speech therapy services.		
Office location	$20/visit	
Outpatient Department of a Hospital	$20/visit	
Durable medical equipment (DME)		
DME	50%	
Breast pump	$0	
Orthotic equipment and devices	$0	
Prosthetic equipment and devices	$0	
Home health care services	$20/visit	
Up to 100 visits per Member, per Calendar Year, by a home health care agency. All visits count towards the limit, including visits during any applicable Deductible period. Includes home visits by a nurse, Home Health Aide, medical social worker, physical therapist, speech therapist, or occupational therapist, and medical supplies.		
Home infusion and home injectable therapy services		
Home infusion agency services	$0	
Includes home infusion drugs, medical supplies, and visits by a nurse.		
Hemophilia home infusion services	$0	
Includes blood factor products.		
Skilled Nursing Facility (SNF) services		
Up to 100 days per Member, per benefit period, except when provided as part of a Hospice program. All days count towards the limit, including days during any applicable Deductible period and days in different SNFs during the Calendar Year.		
Freestanding SNF	$100/day	
Hospital-based SNF	$100/day	
Hospice program services	$0	
Includes pre-Hospice consultation, routine home care, 24-hour continuous home care, short-term inpatient care for pain and symptom management, and inpatient respite care.		

Benefits[5]	Your payment	
	When using a Participating Provider[3]	CYD[2] applies
Other services and supplies		
Diabetes care services		
• Devices, equipment, and supplies	20%	
• Self-management training	$20/visit	
• Medical nutrition therapy	$20/visit	
Dialysis services	$0	
PKU product formulas and special food products	$0	
Allergy serum billed separately from an office visit	50%	

Mental Health and Substance Use Disorder Benefits	Your payment	
Mental health and substance use disorder Benefits are provided through Blue Shield's Mental Health Service Administrator (MHSA).	When using a MHSA Participating Provider[3]	CYD[2] applies
Outpatient services		
Office visit, including Physician office visit	$20/visit	
Teladoc mental health	$0	
Other outpatient services, including intensive outpatient care, electroconvulsive therapy, transcranial magnetic stimulation, Behavioral Health Treatment for pervasive developmental disorder or autism in an office setting, home, or other non-institutional facility setting, and office-based opioid treatment	$0	
Partial Hospitalization Program	$0	
Psychological Testing	$0	
Inpatient services		
Physician inpatient services	$0	
Hospital services	$500/admission	
Residential Care	$500/admission	

Notes

1 **Evidence of Coverage (EOC):**

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

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

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Summary of Benefits

Group Plan
HMO Plan

Access+ HMO® Per Admit 20-250

This Summary of Benefits shows the amount you will pay for Covered Services under this Blue Shield of California Plan. It is only a summary and it is included as part of the Evidence of Coverage (EOC).[1] Please read both documents carefully for details.

Medical Provider Network: **Access+ HMO Network**

This Plan uses a specific network of Health Care Providers, called the Access+ HMO provider network. Medical Groups, Independent Practice Associations (IPAs), and Physicians in this network are called Participating Providers. You must select a Primary Care Physician from this network to provide your primary care and help you access services, but there are some exceptions. Please review your Evidence of Coverage for details about how to access care under this Plan. You can find Participating Providers in this network at blueshieldca.com.

Calendar Year Deductibles (CYD)[2]

A Calendar Year Deductible (CYD) is the amount a Member pays each Calendar Year before Blue Shield pays for Covered Services under the Plan.

		When using a Participating Provider[3]
Calendar Year medical Deductible	*Individual coverage*	$0
	Family coverage	$0: individual $0: Family

Calendar Year Out-of-Pocket Maximum[4]

An Out-of-Pocket Maximum is the most a Member will pay for Covered Services each Calendar Year. Any exceptions are listed in the EOC.

	When using a Participating Provider[3]
Individual coverage	$2,000
Family coverage	$2,000: individual $4,000: Family

No Annual or Lifetime Dollar Limit

Under this Plan there is no annual or lifetime dollar limit on the amount Blue Shield will pay for Covered Services.

Blue Shield of California is an independent member of the Blue Shield Association

Benefits[5]	Your payment	
	When using a Participating Provider[3]	CYD[2] applies
Preventive Health Services[6]		
Preventive Health Services	$0	
California Prenatal Screening Program	$0	
Physician services		
Primary care office visit	$20/visit	
Access+ specialist care office visit (self-referral)	$30/visit	
Other specialist care office visit (referred by PCP)	$20/visit	
Physician home visit	$20/visit	
Physician or surgeon services in an Outpatient Facility	$0	
Physician or surgeon services in an inpatient facility	$0	
Other professional services		
Other practitioner office visit	$20/visit	
Includes nurse practitioners, physician assistants, and therapists.		
Teladoc consultation	$0	
Family planning		
• Counseling, consulting, and education	$0	
• Injectable contraceptive, diaphragm fitting, intrauterine device (IUD), implantable contraceptive, and related procedure.	$0	
• Tubal ligation	$0	
• Vasectomy	$0	
Podiatric services	$20/visit	
Medical nutrition therapy, not related to diabetes	$0	
Pregnancy and maternity care		
Physician office visits: prenatal and postnatal	$0	
Abortion and abortion-related services	$0	
Emergency Services		
Emergency room services	$150/visit	
If admitted to the Hospital, this payment for emergency room services does not apply. Instead, you pay the Participating Provider payment under Inpatient facility services/ Hospital services and stay.		
Emergency room Physician services	$0	

Benefits[5]	Your payment	
	When using a Participating Provider[3]	CYD[2] applies
Urgent care center services	$20/visit	
Ambulance services	$100/transport	
This payment is for emergency or authorized transport.		
Outpatient Facility services		
Ambulatory Surgery Center	$50/surgery	
Outpatient Department of a Hospital: surgery	$200/surgery	
Outpatient Department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies	$0	
Inpatient facility services		
Hospital services and stay	$250/admission	
Transplant services		
This payment is for all covered transplants except tissue and kidney. For tissue and kidney transplant services, the payment for Inpatient facility services/ Hospital services and stay applies.		
• Special transplant facility inpatient services	$250/admission	
• Physician inpatient services	$0	
Diagnostic x-ray, imaging, pathology, and laboratory services		
This payment is for Covered Services that are diagnostic, non-Preventive Health Services, and diagnostic radiological procedures, such as CT scans, MRIs, MRAs, and PET scans. For the payments for Covered Services that are considered Preventive Health Services, see Preventive Health Services.		
Laboratory services		
Includes diagnostic Papanicolaou (Pap) test.		
• Laboratory center	$0	
• Outpatient Department of a Hospital	$0	
X-ray and imaging services		
Includes diagnostic mammography.		
• Outpatient radiology center	$0	
• Outpatient Department of a Hospital	$0	
Other outpatient diagnostic testing		
Testing to diagnose illness or injury such as vestibular function tests, EKG, ECG, cardiac monitoring, non-invasive vascular studies, sleep medicine testing, muscle and range of motion tests, EEG, and EMG.		
• Office location	$0	
• Outpatient Department of a Hospital	$0	

Benefits[5]	Your payment	
	When using a Participating Provider[3]	CYD[2] applies
Radiological and nuclear imaging services		
• Outpatient radiology center	$0	
• Outpatient Department of a Hospital	$0	
Rehabilitative and Habilitative Services		
Includes physical therapy, occupational therapy, respiratory therapy, and speech therapy services.		
Office location	$20/visit	
Outpatient Department of a Hospital	$20/visit	
Durable medical equipment (DME)		
DME	20%	
Breast pump	$0	
Orthotic equipment and devices	$0	
Prosthetic equipment and devices	$0	
Home health care services	$20/visit	
Up to 100 visits per Member, per Calendar Year, by a home health care agency. All visits count towards the limit, including visits during any applicable Deductible period. Includes home visits by a nurse, Home Health Aide, medical social worker, physical therapist, speech therapist, or occupational therapist, and medical supplies.		
Home infusion and home injectable therapy services		
Home infusion agency services	$0	
Includes home infusion drugs, medical supplies, and visits by a nurse.		
Hemophilia home infusion services	$0	
Includes blood factor products.		
Skilled Nursing Facility (SNF) services		
Up to 100 days per Member, per benefit period, except when provided as part of a Hospice program. All days count towards the limit, including days during any applicable Deductible period and days in different SNFs during the Calendar Year.		
Freestanding SNF	$100/day	
Hospital-based SNF	$100/day	
Hospice program services	$0	
Includes pre-Hospice consultation, routine home care, 24-hour continuous home care, short-term inpatient care for pain and symptom management, and inpatient respite care.		

Benefits[5]	Your payment	
	When using a Participating Provider[3]	CYD[2] applies
Other services and supplies		
Diabetes care services		
• Devices, equipment, and supplies	20%	
• Self-management training	$20/visit	
• Medical nutrition therapy	$20/visit	
Dialysis services	$0	
PKU product formulas and special food products	$0	
Allergy serum billed separately from an office visit	50%	

Mental Health and Substance Use Disorder Benefits	Your payment	
Mental health and substance use disorder Benefits are provided through Blue Shield's Mental Health Service Administrator (MHSA).	When using a MHSA Participating Provider[3]	CYD[2] applies
Outpatient services		
Office visit, including Physician office visit	$20/visit	
Teladoc mental health	$0	
Other outpatient services, including intensive outpatient care, electroconvulsive therapy, transcranial magnetic stimulation, Behavioral Health Treatment for pervasive developmental disorder or autism in an office setting, home, or other non-institutional facility setting, and office-based opioid treatment	$0	
Partial Hospitalization Program	$0	
Psychological Testing	$0	
Inpatient services		
Physician inpatient services	$0	
Hospital services	$250/admission	
Residential Care	$250/admission	

Notes

1 **Evidence of Coverage (EOC):**

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

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Benefit Modification for Members with

Full PPO Combined Deductible 15-250 90/70

Effective January 1, 2023

This is a summary of specific benefit changes to your plan. For a list of legislative mandates and Blue Shield required changes, refer to the accompanying Contract and Benefit Changes list. Please contact your benefits administrator or call Customer Service for additional information regarding your plan.

	2022 Benefits		2023 Benefits	
	When using a Participating Provider	**When using a Non-Participating Provider**	**When using a Participating Provider**	**When using a Non-Participating Provider**
Other professional services Medical nutrition therapy, not related to diabetes	N/A	N/A	10% ✔	30% ✔
Acupuncture services	$25/visit	30%	$15/visit	30%
Chiropractic services	$25/visit	30%	$15/visit	30%

	2022 Benefits		2023 Benefits	
	When using a Participating Provider	**When using a Non-Participating Provider**	**When using a Participating Provider**	**When using a Non-Participating Provider**
Pregnancy and maternity care Abortion and abortion-related services	10% ✔	30% ✔	$0	$0

	2022 Benefits		2023 Benefits	
	When using a Participating Provider	**When using a Non-Participating Provider**	**When using a Participating Provider**	**When using a Non-Participating Provider**
Home infusion and home injectable therapy services			$45/visit	Not covered
Home visits by an infusion nurse	10%	Not covered	Benefit line item combined with Home infusion agency services	
Home infusion agency services	10%	Not covered	$45/visit	Not covered
Hemophilia home infusion services	10%	Not covered	$45/visit	Not covered

	2022 Benefits		2023 Benefits	
	When using a Participating Provider	**When using a Non-Participating Provider**	**When using a Participating Provider**	**When using a Non-Participating Provider**
Other services and supplies Diabetes care services • Medical nutrition therapy	N/A	N/A	$15/visit	30% ✔

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

Note: This document is only a summary for informational purposes. It is not a contract. Please refer to the *Evidence of Coverage* and the Plan Contract for the exact terms and conditions of coverage.

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Summary of Benefits

Group Plan
PPO Plan

Full PPO Combined Deductible 15-250 90/70

This Summary of Benefits shows the amount you will pay for Covered Services under this Blue Shield of California Plan. It is only a summary and it is included as part of the Evidence of Coverage (EOC).[1] Please read both documents carefully for details.

Medical Provider Network: **Full PPO Network**

This Plan uses a specific network of Health Care Providers, called the Full PPO provider network. Providers in this network are called Participating Providers. You pay less for Covered Services when you use a Participating Provider than when you use a Non-Participating Provider. You can find Participating Providers in this network at blueshieldca.com.

Calendar Year Deductibles (CYD)[2]

A Calendar Year Deductible (CYD) is the amount a Member pays each Calendar Year before Blue Shield pays for Covered Services under the Plan. Blue Shield pays for some Covered Services before the Calendar Year Deductible is met, as noted in the Benefits chart below.

		When using a Participating[3] or Non-Participating[4] Provider
Calendar Year medical Deductible	*Individual coverage*	$250
	Family coverage	$250: individual $750: Family

Calendar Year Out-of-Pocket Maximum[5]

An Out-of-Pocket Maximum is the most a Member will pay for Covered Services each Calendar Year. Any exceptions are listed in the Notes section at the end of this Summary of Benefits.

	When using a Participating Provider[3]	When using any combination of Participating[3] or Non-Participating[4] Providers
Individual coverage	$2,750	$10,250
Family coverage	$2,750: individual $5,500: Family	$10,250: individual $20,500: Family

No Annual or Lifetime Dollar Limit

Under this Plan there is no annual or lifetime dollar limit on the amount Blue Shield will pay for Covered Services.

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Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Preventive Health Services[7]				
Preventive Health Services	$0		Not covered	
California Prenatal Screening Program	$0		$0	
Physician services				
Primary care office visit	$15/visit		30%	✔
Specialist care office visit	$15/visit		30%	✔
Physician home visit	$15/visit		30%	✔
Physician or surgeon services in an Outpatient Facility	10%	✔	30%	✔
Physician or surgeon services in an inpatient facility	10%	✔	30%	✔
Other professional services				
Other practitioner office visit	$15/visit		30%	✔
Includes nurse practitioners, physician assistants, and therapists.				
Acupuncture services	$15/visit		30%	✔
Up to 20 visits per Member, per Calendar Year.				
Chiropractic services	$15/visit		30%	✔
Up to 20 visits per Member, per Calendar Year.				
Teladoc consultation	$0		Not covered	
Family planning				
• Counseling, consulting, and education	$0		Not covered	
• Injectable contraceptive, diaphragm fitting, intrauterine device (IUD), implantable contraceptive, and related procedure.	$0		Not covered	
• Tubal ligation	$0		Not covered	
• Vasectomy	10%	✔	Not covered	
Podiatric services	$15/visit		30%	✔
Medical nutrition therapy, not related to diabetes	10%	✔	30%	✔
Pregnancy and maternity care				
Physician office visits: prenatal and postnatal	10%	✔	30%	✔
Abortion and abortion-related services	$0		$0	

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Emergency Services				
Emergency room services	$150/visit plus 10%		$150/visit plus 10%	
If admitted to the Hospital, this payment for emergency room services does not apply. Instead, you pay the Participating Provider payment under Inpatient facility services/ Hospital services and stay.				
Emergency room Physician services	10%		10%	
Urgent care center services	$15/visit		30%	✔
Ambulance services	10%	✔	10%	✔
This payment is for emergency or authorized transport.				
Outpatient Facility services				
Ambulatory Surgery Center	5%	✔	30% Subject to a Benefit maximum of $350/day	✔
Outpatient Department of a Hospital: surgery	15%	✔	30% Subject to a Benefit maximum of $350/day	✔
Outpatient Department of a Hospital: treatment of illness or injury, radiation therapy, chemotherapy, and necessary supplies	10%	✔	30% Subject to a Benefit maximum of $350/day	✔
Inpatient facility services				
Hospital services and stay	10%	✔	30% Subject to a Benefit maximum of $600/day	✔
Transplant services				
This payment is for all covered transplants except tissue and kidney. For tissue and kidney transplant services, the payment for Inpatient facility services/ Hospital services and stay applies.				
• Special transplant facility inpatient services	10%	✔	Not covered	
• Physician inpatient services	10%	✔	Not covered	

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Bariatric surgery services, designated California counties				
This payment is for bariatric surgery services for residents of designated California counties. For bariatric surgery services for residents of non-designated California counties, the payments for Inpatient facility services/ Hospital services and stay and Physician inpatient and surgery services apply for inpatient services; or, if provided on an outpatient basis, the Outpatient Facility services and outpatient Physician services payments apply.				
Inpatient facility services	10%	✔	Not covered	
Outpatient Facility services	15%	✔	Not covered	
Physician services	10%	✔	Not covered	
Diagnostic x-ray, imaging, pathology, and laboratory services				
This payment is for Covered Services that are diagnostic, non-Preventive Health Services, and diagnostic radiological procedures, such as CT scans, MRIs, MRAs, and PET scans. For the payments for Covered Services that are considered Preventive Health Services, see Preventive Health Services.				
Laboratory services				
Includes diagnostic Papanicolaou (Pap) test.				
• Laboratory center	$15/visit	✔	30%	✔
• Outpatient Department of a Hospital	$40/visit	✔	30% Subject to a Benefit maximum of $350/day	✔
X-ray and imaging services				
Includes diagnostic mammography.				
• Outpatient radiology center	$15/visit	✔	30%	✔
• Outpatient Department of a Hospital	$40/visit	✔	30% Subject to a Benefit maximum of $350/day	✔
Other outpatient diagnostic testing				
Testing to diagnose illness or injury such as vestibular function tests, EKG, ECG, cardiac monitoring, non-invasive vascular studies, sleep medicine testing, muscle and range of motion tests, EEG, and EMG.				
• Office location	$15/visit	✔	30%	✔

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
• Outpatient Department of a Hospital	$40/visit	✔	30% Subject to a Benefit maximum of $350/day	✔
Radiological and nuclear imaging services				
• Outpatient radiology center	10%	✔	30%	✔
• Outpatient Department of a Hospital	20%	✔	30% Subject to a Benefit maximum of $350/day	✔
Rehabilitative and Habilitative Services				
Includes physical therapy, occupational therapy, respiratory therapy, and speech therapy services.				
Office location	$15/visit	✔	30%	✔
Outpatient Department of a Hospital	$15/visit	✔	30% Subject to a Benefit maximum of $350/day	✔
Durable medical equipment (DME)				
DME	10%	✔	30%	✔
Breast pump	$0		Not covered	
Orthotic equipment and devices	10%	✔	30%	✔
Prosthetic equipment and devices	10%	✔	30%	✔
Home health care services	10%	✔	Not covered	
Up to 100 visits per Member, per Calendar Year, by a home health care agency. All visits count towards the limit, including visits during any applicable Deductible period. Includes home visits by a nurse, Home Health Aide, medical social worker, physical therapist, speech therapist, or occupational therapist, and medical supplies.				
Home infusion and home injectable therapy services				
Home infusion agency services	$45/visit	✔	Not covered	
Includes home infusion drugs, medical supplies, and visits by a nurse.				
Hemophilia home infusion services	$45/visit	✔	Not covered	
Includes blood factor products.				

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Skilled Nursing Facility (SNF) services				
Up to 100 days per Member, per benefit period, except when provided as part of a Hospice program. All days count towards the limit, including days during any applicable Deductible period and days in different SNFs during the Calendar Year.				
Freestanding SNF	10%	✔	30%	✔
Hospital-based SNF	10%	✔	30% Subject to a Benefit maximum of $600/day	✔
Hospice program services	$0		Not covered	
Includes pre-Hospice consultation, routine home care, 24-hour continuous home care, short-term inpatient care for pain and symptom management, and inpatient respite care.				
Other services and supplies				
Diabetes care services				
• Devices, equipment, and supplies	10%	✔	30%	✔
• Self-management training	$15/visit		30%	✔
• Medical nutrition therapy	$15/visit		30%	✔
Dialysis services	10%	✔	30% Subject to a Benefit maximum of $350/day	✔
PKU product formulas and special food products	10%	✔	10%	✔
Allergy serum billed separately from an office visit	10%	✔	30%	✔

Mental Health and Substance Use Disorder Benefits	Your payment			
Mental health and substance use disorder Benefits are provided through Blue Shield's Mental Health Service Administrator (MHSA).	When using a MHSA Participating Provider[3]	CYD[2] applies	When using a MHSA Non-Participating Provider[4]	CYD[2] applies
Outpatient services				
Office visit, including Physician office visit	$15/visit		30%	✔
Teladoc mental health	$0		Not covered	

Mental Health and Substance Use Disorder Benefits	Your payment			
Mental health and substance use disorder Benefits are provided through Blue Shield's Mental Health Service Administrator (MHSA).	**When using a MHSA Participating Provider[3]**	**CYD[2] applies**	**When using a MHSA Non-Participating Provider[4]**	**CYD[2] applies**
Other outpatient services, including intensive outpatient care, electroconvulsive therapy, transcranial magnetic stimulation, Behavioral Health Treatment for pervasive developmental disorder or autism in an office setting, home, or other non-institutional facility setting, and office-based opioid treatment	$0	✔	30%	✔
Partial Hospitalization Program	$0	✔	30% Subject to a Benefit maximum of $350/day	✔
Psychological Testing	$0	✔	30%	✔
Inpatient services				
Physician inpatient services	10%	✔	30%	✔
Hospital services	10%	✔	30% Subject to a Benefit maximum of $600/day	✔
Residential Care	10%	✔	30% Subject to a Benefit maximum of $600/day	✔

Prior Authorization

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

- Radiological and nuclear imaging services
- Outpatient mental health services, except office visits and office-based opioid treatment
- Inpatient facility services
- Hospice program services

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

Notes

1 **Evidence of Coverage (EOC):**

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

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

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Outpatient Prescription Drug Rider

Group Rider
PPO

Enhanced Rx $10/25/40 with $0 Pharmacy Deductible
Summary of Benefits

This Summary of Benefits shows the amount you will pay for covered Drugs under this prescription Drug Benefit.

Pharmacy Network:	**Rx Ultra**
Drug Formulary:	**Plus Formulary**

Calendar Year Pharmacy Deductible(CYPD)[1]

A Calendar Year Pharmacy Deductible (CYPD) is the amount a Member pays each Calendar Year before Blue Shield pays for covered Drugs under the outpatient prescription Drug Benefit. Blue Shield pays for some prescription Drugs before the Calendar Year Pharmacy Deductible is met, as noted in the Prescription Drug Benefits chart below.

		When using a Participating[2] or Non-Participating[3] Pharmacy
Calendar Year Pharmacy Deductible	*Per Member*	$0

Prescription Drug Benefits[4,5]

Your payment

	When using a Participating Pharmacy[2]	**CYPD[1] applies**	**When using a Non-Participating Pharmacy[3]**	**CYPD[1] applies**
Retail pharmacy prescription Drugs *Per prescription, up to a 30-day supply.*				
Contraceptive Drugs and devices	$0		Applicable Tier 1, Tier 2, or Tier 3 Copayment	
Tier 1 Drugs	$10/prescription		25% plus $10/prescription	
Tier 2 Drugs	$25/prescription		25% plus $25/prescription	
Tier 3 Drugs	$40/prescription		25% plus $40/prescription	
Tier 4 Drugs	30% up to $250/prescription		30% up to $250/prescription plus 25% of purchase price	
Retail pharmacy prescription Drugs *Per prescription, up to a 90-day supply from a 90-day retail pharmacy.*				
Contraceptive Drugs and devices	$0		Not covered	
Tier 1 Drugs	$30/prescription		Not covered	
Tier 2 Drugs	$75/prescription		Not covered	
Tier 3 Drugs	$120/prescription		Not covered	
Tier 4 Drugs	30% up to $750/prescription		Not covered	

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Prescription Drug Benefits[4,5]	Your payment			
	When using a Participating Pharmacy[2]	**CYPD[1] applies**	**When using a Non-Participating Pharmacy[3]**	**CYPD[1] applies**
Mail service pharmacy prescription Drugs				
Per prescription, up to a 90-day supply.				
Contraceptive Drugs and devices	$0		Not covered	
Tier 1 Drugs	$20/prescription		Not covered	
Tier 2 Drugs	$50/prescription		Not covered	
Tier 3 Drugs	$80/prescription		Not covered	
Tier 4 Drugs	30% up to $500/prescription		Not covered	

Notes

1 Calendar Year Pharmacy Deductible (CYPD):

Calendar Year Pharmacy Deductible explained. A Calendar Year Pharmacy Deductible is the amount you pay each Calendar Year before Blue Shield pays for outpatient prescription Drugs under this Benefit.

If this Benefit has a Calendar Year Pharmacy Deductible, outpatient prescription Drugs subject to the Deductible are identified with a check mark (✔) in the Benefits chart above.

Any applicable Copayment, Coinsurance and CYPD you pay counts towards the Calendar Year Out-of-Pocket Maximum.

Outpatient prescription Drugs not subject to the Calendar Year Pharmacy Deductible. Some outpatient prescription Drugs received from Participating Pharmacies are paid by Blue Shield before you meet any Calendar Year Pharmacy Deductible. These outpatient prescription Drugs do not have a check mark (✔) next to them in the "CYPD applies" column in the Prescription Drug Benefits chart above.

2 Using Participating Pharmacies:

Participating Pharmacies have a contract to provide outpatient prescription Drugs to Members. When you obtain covered prescription Drugs from a Participating Pharmacy, you are only responsible for the Copayment or Coinsurance, once any Calendar Year Pharmacy Deductible has been met.

Participating Pharmacies and Drug Formulary. You can find a Participating Pharmacy and the Drug Formulary by visiting www.blueshieldca.com/pharmacy.

3 Using Non-Participating Pharmacies:

Non-Participating Pharmacies do not have a contract to provide outpatient prescription Drugs to Members. When you obtain prescription Drugs from a Non-Participating Pharmacy, you must pay all charges for the prescription, then submit a completed claim form for reimbursement. You will be reimbursed based on the price you paid for the Drug.

4 Outpatient Prescription Drug Coverage:

Medicare Part D-creditable coverage-

This 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 prescription Drug coverage is creditable, you do not have to enroll in Medicare Part D while you maintain this coverage; however, you should be aware that if you do not enroll in Medicare Part D within 63 days following termination of this coverage, you could be subject to Medicare Part D premium penalties.

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Summary of Benefits

Group Dental Plan
DHMO Plan

Dental HMO Deluxe

This Summary of Benefits shows the amount you will pay for Covered Services under this Blue Shield of California Plan. It is only a summary and it is included as part of the Evidence of Coverage (EOC)[1]. Please read both documents carefully for details.

Dental Provider Network: **DHMO Network**

This Plan uses a specific network of dental care providers, called the DHMO provider network. Dentists in this network are called Participating Dentists. You must select a Participating Dentist from this network to provide your primary dental care and help you access services, but there are some exceptions. Please review your Evidence of Coverage for details about how to access care under this Plan. You can find Participating Dentists in this network at blueshieldca.com.

Calendar Year Deductible (CYD)[2]

A Calendar Year Deductible (CYD) is the amount a Member pays each Calendar Year before Blue Shield pays for Covered Services under the Plan.

		When using a Participating Dentist[3]
Calendar Year Deductible	*Individual coverage*	$0 per individual
	Family coverage	$0

Calendar Year Benefit Maximum

This Plan pays up to the maximum payment amount as listed for Covered Services and supplies per year.

	When using a Participating Dentist[3]
Calendar Year Benefit Maximum	No maximum

Waiting Period

A waiting period is the length of time you must be covered under the Plan before Blue Shield will pay for Covered Services.

Waiting period	No waiting period

No Lifetime Dollar Limit

Under this Plan there is no dollar limit on the total amount Blue Shield will pay for Covered Services in a Member's lifetime.

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Benefits[4,5] **Your payment**

Covered Services are listed with the American Dental Association (ADA) procedure code.

ADA Code	Services	When using a Participating[3] Dentist
	Diagnostic services (exams and x-rays)	
D0120	Periodic oral evaluation	$0
D0140	Limited oral evaluation – problem focused	$0
D0145	Oral evaluation for a patient under three years of age	$0
D0150	Comprehensive oral evaluation	$0
D0160	Detailed and extensive oral evaluation – problem focused	$0
D0170	Re-evaluation – limited, problem focused (not post-operative visit)	$0
D0180	Comprehensive periodontal evaluation	$0
D0190	Screening of a patient	$0
D0191	Assessment of a patient	$0
D0210	Intraoral complete series radiographs - includes bitewings (once every 36 months)	$0
D0220	Intraoral periapical radiograph – first film	$0
D0230	Intraoral periapical radiograph – each additional film	$0
D0240	Intraoral occlusal radiograph	$0
D0270	Bitewing radiograph – single film	$0
D0272	Bitewing radiograph – two films	$0
D0273	Bitewing radiograph – three films	$0
D0274	Bitewing radiograph – four films	$0
D0330	Panoramic radiograph film (once every 36 months)	$0
D0431	Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities, including premalignant and malignant lesions (not to include cytology or biopsy procedures)	$0
D0460	Pulp vitality tests	$0
D0470	Diagnostic casts	$0
D0480	Accession of exfoliative cytologic smears, microscopic examination, preparation and transmission of written report	$0
D0601	Caries risk assessment and documentation, with a finding of low risk	$0
D0602	Caries risk assessment and documentation, with a finding of moderate risk	$0
D0603	Caries risk assessment and documentation, with a finding of high risk	$0
D0701	Panoramic radiographic - image capture only	$0
D0702	2-D cephalometric radiographic image – image capture only	$0
D0706	Intraoral – occlusal radiographic image – image capture only	$0
D0707	Intraoral – periapical radiographic image – image capture only	$0
D0708	Intraoral – bitewing radiographic image – image capture only Image axis may be horizontal or vertical	$0
D0709	Intraoral – complete series of radiographic images – image capture only	$0

Benefits[4,5] — Your payment

Covered Services are listed with the American Dental Association (ADA) procedure code.

ADA Code	Services	When using a Participating[3] Dentist
	Preventive services (cleanings and fluoride)	
D1110	Prophylaxis – adult (twice every consecutive 12 months)	$0
D1110	Prophylaxis – adult (additional within the consecutive 12-month period)	$45
D1110	Enhanced dental cleaning for pregnant women	$0
D1120	Prophylaxis – child (twice every consecutive 12 months)	$0
D1120	Prophylaxis – child (additional within the consecutive 12-month period)	$35
D1206	Topical application of fluoride varnish	$0
D1208	Topical application of fluoride – excluding varnish	$0
D1330	Oral hygiene instructions	$0
D1351	Sealant – per tooth	$0
D1352	Preventive resin restoration in a moderate to high caries risk patient – permanent tooth – child through age 18	$0
D1510	Space maintainer – fixed - unilateral - per quadrant	$5
D1516	Space maintainer – fixed – bilateral, maxillary	$5
D1517	Space maintainer – fixed – bilateral, mandibular	$5
D1520	Space maintainer – removable - unilateral - per quadrant	$5
D1526	Space maintainer – removable – bilateral, maxillary	$5
D1527	Space maintainer – removable – bilateral, mandibular	$5
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	$5
D1552	Re-cement or re-bond bilateral space maintainer – mandibular	$5
D1553	Re-cement or re-bond unilateral space maintainer – per quadrant	$5
D1556	Removal of fixed unilateral space maintainer – per quadrant	$0
D1557	Removal of fixed bilateral space maintainer – maxillary	$0
D1558	Removal of fixed bilateral space maintainer – mandibular	$0
D1575	Distal shoe space maintainer – fixed – unilateral – per quadrant	$5
	Minor Restorative services (fillings)	
D2140	Amalgam – one surface, primary or permanent	$0
D2150	Amalgam – two surfaces, primary or permanent	$0
D2160	Amalgam – three surfaces, primary or permanent	$0
D2161	Amalgam – four or more surfaces, primary or permanent	$0
D2330	Resin-based composite – one surface, anterior	$0
D2331	Resin-based composite – two surfaces, anterior	$0
D2332	Resin-based composite – three surfaces, anterior	$0
D2335	Resin-based composite – four or more surfaces or involving incisal angle, anterior	$0
D2390	Resin-based composite – crown, anterior	$150

Benefits[4,5] **Your payment**

Covered Services are listed with the American Dental Association (ADA) procedure code.

ADA Code	Services	When using a Participating[3] Dentist
D2391	Resin-based composite – one surface, posterior	$61/tooth
D2392	Resin-based composite – two surfaces, posterior	$72
D2393	Resin-based composite – three surfaces, posterior	$93
D2394	Resin-based composite – four or more surfaces, posterior	$114
D2510	Inlay – metallic – one surface	$125
D2520	Inlay – metallic – two surfaces	$125
D2530	Inlay – metallic – three or more surfaces	$125
	Major Restorative services (crowns)	
D2542	Onlay – metallic – two surfaces	$125
D2543	Onlay – metallic – three surfaces	$125
D2544	Onlay – metallic – four or more surfaces	$125
D2610	Inlay – porcelain/ceramic – one surface	$250
D2620	Inlay – porcelain/ceramic – two surfaces	$260
D2630	Inlay – porcelain/ceramic – three or more surfaces	$275
D2642	Onlay – porcelain/ceramic – two surfaces	$250
D2643	Onlay – porcelain/ceramic – three surfaces	$260
D2644	Onlay – porcelain/ceramic – four or more surfaces	$275
D2650	Inlay – resin-based composite – one surface	$215
D2651	Inlay – resin-based composite – two surfaces	$225
D2652	Inlay – resin-based composite – three or more surfaces	$245
D2662	Onlay – resin-based composite – two surfaces	$215
D2663	Onlay – resin-based composite – three surfaces	$225
D2664	Onlay – resin-based composite – four or more surfaces	$245
D2710	Crown – resin-based composite – indirect	$165/crown
D2720	Crown – resin with high noble metal	$260/crown[6]
D2721	Crown – resin with predominantly base metal	$195/crown[6]
D2722	Crown – resin with noble metal	$225/crown[6]
D2740	Crown – porcelain/ceramic	$125/crown[6]
D2750	Crown – porcelain fused to high noble metal	$125/crown[6]
D2751	Crown – porcelain fused to predominantly base metal	$125/crown[6]
D2752	Crown – porcelain fused to noble metal	$125/crown[6]
D2753	Crown - porcelain fused to titanium and titanium alloys	$125/crown[6]
D2780	Crown – 3/4 cast high noble metal	$125/crown[6]
D2781	Crown – 3/4 cast predominantly base metal	$125/crown[6]
D2782	Crown – 3/4 cast noble metal	$125/crown[6]

Benefits[4,5] **Your payment**

Covered Services are listed with the American Dental Association (ADA) procedure code.

ADA Code	Services	When using a Participating[3] Dentist
D2783	Crown – 3/4 porcelain/ceramic	$125/crown[6]
D2790	Crown – full cast high noble metal	$125/crown[6]
D2791	Crown – full cast predominantly base metal	$125/crown[6]
D2792	Crown – full cast noble metal	$125/crown[6]
D2794	Crown – titanium and titanium alloys	$125/crown[6]
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	$9
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	$10
D2920	Re-cement or re-bond crown	$5
D2928	Prefabricated porcelain/ceramic crown – permanent tooth	$15
D2930	Prefabricated stainless steel crown – primary tooth	$5
D2931	Prefabricated stainless steel crown – permanent tooth	$15
D2932	Prefabricated resin crown	$25
D2933	Prefabricated stainless steel crown with resin window	$20
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth	$20
D2940	Protective restoration	$10
D2950	Core buildup, including any pins when required	$24
D2951	Pin retention – per tooth, in addition to restoration	$5/tooth
D2952	Post and core in addition to crown – indirectly fabricated	$36
D2953	Each additional indirectly fabricated post – same tooth	$25
D2954	Prefabricated post and core in addition to crown	$30
D2955	Post removal	$0
D2957	Each additional prefabricated post – same tooth	$16
D2980	Crown repair necessitated by restorative material failure	$25
D2981	Inlay repair necessitated by restorative material failure	$10
D2982	Onlay repair necessitated by restorative material failure	$15
	Endodontic services (root canals)	
	PORCELAIN FUSED TO HIGH NOBLE CROWN	
D3110	Pulp cap – direct (excluding final restoration)	$0
D3120	Pulp cap – indirect (excluding final restoration)	$0
D3220	Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament	$5
D3221	Pulpal debridement – primary and permanent tooth	$10
D3310	Endodontic therapy – anterior tooth (excluding final restoration)	$50
D3320	Endodontic therapy – premolar tooth (excluding final restoration)	$80
D3330	Endodontic therapy – molar tooth (excluding final restoration)	$145

Benefits[4,5] **Your payment**

Covered Services are listed with the American Dental Association (ADA) procedure code.

ADA Code	Services	When using a Participating[3] Dentist
D3331	Treatment of root canal obstruction – non-surgical access	$25
D3332	Incomplete endodontic therapy – inoperable, unrestorable or fractured tooth	$40
D3346	Retreatment of previous root canal therapy – anterior	$50
D3347	Retreatment of previous root canal therapy – bicuspid	$70
D3348	Retreatment of previous root canal therapy – molar	$90
D3410	Apicoectomy – anterior – first root	$20
D3421	Apicoectomy – premolar – first root	$20
D3425	Apicoectomy – molar – first root	$20
D3426	Apicoectomy – each additional root	$20
D3430	Retrograde filling – per root	$23
D3450	Root amputation – per root	$100
D3471	Surgical repair of a root resorption – anterior – first root	$20
D3472	Surgical repair of a root resorption – molar – for surgery on root of premolar tooth – first root. Does not include placement of restoration.	$20
D3473	Surgical repair of a root resorption – molar – for surgery on root of molar tooth – first root. Does not include placement of restoration.	$20
D3911	Intraorifice barrier	$61
D3920	Hemisection, including any root removal (not including root canal therapy)	$25
D3950	Canal preparation and fitting of preformed dowel or post	$0
	Periodontic services (gum disease)	
D4210	Gingivectomy/gingivoplasty – four or more contiguous teeth or tooth bounded spaces – per quadrant	$75
D4211	Gingivectomy/gingivoplasty – one to three contiguous teeth or tooth bounded spaces – per quadrant	$15
D4212	Gingivectomy/gingivoplasty – to allow access for restorative procedure – per tooth	$0
D4240	Gingival flap procedure, including root planing – four or more teeth – per quadrant	$125
D4241	Gingival flap procedure, including root planing – one to three teeth – per quadrant	$63
D4260	Osseous surgery, including elevation of a full thickness flap and closure – four or more contiguous teeth or tooth bounded spaces – per quadrant	$125
D4261	Osseous surgery, including elevation of full thickness flap and closure – one to three contiguous teeth or tooth bounded spaces – per quadrant	$63
D4263	Bone replacement graft – retained natural tooth – first site in quadrant	$58
D4264	Bone replacement graft – retained natural tooth – each additional site in quadrant	$43

Covered Services are listed with the American Dental Association (ADA) procedure code.

ADA Code	Services	When using a Participating[3] Dentist
D4266	Guided tissue regeneration – resorbable barrier – per site	$72
D4267	Guided tissue regeneration – non-resorbable barrier – per site, includes membrane removal	$83
D4270	Pedicle soft tissue graft procedure	$70
D4273	Autogenous connective tissue graft procedure, including donor and recipient surgical sites – first tooth – implant or edentulous tooth position in graft	$90
D4277	Free soft tissue graft procedure, including recipient and donor surgical sites –first tooth, implant, or edentulous tooth position in graft	$75
D4278	Free soft tissue graft procedure, including recipient and donor surgical sites – each additional contiguous tooth, implant, or edentulous tooth position in same graft site	$45
D4341	Periodontal scaling and root planing – four or more teeth – per quadrant	$10
D4342	Periodontal scaling and root planing – one to three teeth – per quadrant	$5
D4346	Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation (11 years of age and older; once per 12 months)	$45
D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit	$10
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue – per tooth	$6
D4910	Periodontal maintenance	$5
	Removable prosthetic services (dentures)	
D5110	Complete denture – maxillary	$100/denture
D5120	Complete denture – mandibular	$100/denture
D5130	Immediate denture – maxillary	$100/denture
D5140	Immediate denture – mandibular	$100/denture
D5211	Maxillary partial denture – resin base, including retentive/clasping materials, rests and teeth	$175/denture
D5212	Mandibular partial denture – resin base, including retentive/clasping materials, rests and teeth	$175/denture
D5213	Maxillary partial denture – cast metal framework with resin denture bases, including retentive/clasping materials, rests and teeth	$175/denture[6]
D5214	Mandibular partial denture – cast metal framework with resin denture bases, including retentive/clasping materials, rests and teeth	$175/denture[6]
D5225	Maxillary partial denture – flexible base, including retentive/clasping materials, rests and teeth	$175/denture
D5226	Mandibular partial denture – flexible base, including retentive/clasping materials, rests and teeth	$175/denture
D5282	Removable unilateral partial denture – one-piece cast metal, including retentive /clasping materials and teeth, maxillary	$175/denture[6]

Benefits[4,5] **Your payment**

Covered Services are listed with the American Dental Association (ADA) procedure code.

ADA Code	Services	When using a Participating[3] Dentist
D5283	Removable unilateral partial denture – one-piece cast metal, including retentive/clasping materials and teeth, mandibular	$175/denture[6]
D5284	Removable unilateral partial denture – one piece flexible base (including retentive/clasping materials and teeth) – per quadrant	$175/denture
D5286	Removable unilateral partial denture – one piece resin (including retentive/clasping materials and teeth) – per quadrant	$175/denture
D5410	Adjust complete denture – maxillary	$25
D5411	Adjust complete denture – mandibular	$25
D5421	Adjust partial denture – maxillary	$25
D5422	Adjust partial denture – mandibular	$25
D5511	Repair broken complete denture base – mandibular	$25[7]
D5512	Repair broken complete denture base – maxillary	$25[7]
D5520	Replace missing or broken teeth – complete denture – each tooth	$25[7]
D5611	Repair resin partial denture base – mandibular	$25[7]
D5612	Repair resin partial denture base – maxillary	$25[7]
D5621	Repair cast partial framework – mandibular	$25[7]
D5622	Repair cast partial framework – maxillary	$25[7]
D5630	Repair or replace broken retentive/clasping materials – per tooth	$25[7]
D5640	Replace broken teeth – per tooth	$25[7]
D5650	Add tooth to existing partial denture	$25[7]
D5660	Add clasp to existing partial denture – per tooth	$25[7]
D5670	Replace all teeth and acrylic on cast metal framework – maxillary	$105[7]
D5671	Replace all teeth and acrylic on cast metal framework – mandibular	$105[7]
D5710	Rebase – complete maxillary denture	$25
D5711	Rebase – complete mandibular denture	$25
D5720	Rebase – partial maxillary denture	$25
D5721	Rebase – partial mandibular denture	$25
D5725	Rebase –hybrid prosthesis	$25
D5730	Reline complete maxillary denture – direct	$25/denture[8]
D5731	Reline complete mandibular denture – direct	$25/denture[8]
D5740	Reline maxillary partial denture – direct	$25/denture[8]
D5741	Reline mandibular partial denture – direct	$25/denture[8]
D5750	Reline complete maxillary denture – indirect	$50/denture[8]
D5751	Reline complete mandibular denture – indirect	$50/denture[8]
D5760	Reline maxillary partial denture – indirect	$50/denture[8]
D5761	Reline mandibular partial denture – indirect	$50/denture[8]

Benefits[4,5] **Your payment**

Covered Services are listed with the American Dental Association (ADA) procedure code.

ADA Code	Services	When using a Participating[3] Dentist
D5765	Soft liner for complete or partial removable denture – indirect	$5
D5850	Tissue conditioning – maxillary	$5/denture unit
D5851	Tissue conditioning – mandibular	$5/denture unit
	Partial Denture – Resin Base	
	Implant services	
D6010	Surgical placement of implant body – endosteal implant	$1,375
D6056	Prefabricated abutment – includes modifications and placement	$500
D6057	Custom fabricated abutment – includes placement	$600
D6058	Abutment supported porcelain/ceramic crown	$1,250
D6059	Abutment supported porcelain fused to metal crown – high noble metal	$1,250
D6060	Abutment supported porcelain fused to metal crown – predominately base metal	$1,150
D6061	Abutment supported porcelain fused to metal crown – noble metal	$900
D6062	Abutment supported cast metal crown – high noble metal	$1,000
D6063	Abutment supported cast metal crown – predominately base metal	$962
D6064	Abutment supported cast metal crown – noble metal	$825
D6065	Implant supported porcelain/ceramic crown	$1,250
D6066	Implant supported crown – porcelain fused to high noble alloys	$1,250
D6067	Implant supported crown – high noble alloys	$1,300
D6080	Implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prostheses and abutments	$225
D6082	Implant supported crown – porcelain fused to predominantly base alloys	$1,150
D6083	Implant supported crown – porcelain fused to noble alloys	$900
D6084	Implant supported crown – porcelain fused to titanium and titanium alloys	$1,150
D6086	Implant supported crown – predominantly base alloys	$962
D6087	Implant supported crown – noble alloys	$825
D6088	Implant supported crown – titanium and titanium alloys	$962
D6090	Repair implant supported prosthesis, by report	$288
D6092	Re-cement or re-bond implant/abutment supported crown	$109
D6094	Abutment supported crown – titanium and titanium alloys	$913
D6095	Repair implant abutment, by report	$300
D6096	Remove broken implant retaining screw	$0
D6097	Abutment supported crown – porcelain fused to titanium and titanium alloys	$1,150
D6098	Implant supported retainer – porcelain fused to predominantly base alloys	$1,150
D6100	Implant removal, by report	$500
	Bridges, abutments or pontic services	

Benefits[4,5] **Your payment**

Covered Services are listed with the American Dental Association (ADA) procedure code.

ADA Code	Services	When using a Participating[3] Dentist
D6205	Pontic – indirect resin-based composite	$125/tooth replaced[6]
D6210	Pontic – cast high noble metal	$125[6]
D6211	Pontic – cast predominantly base metal	$125[6]
D6212	Pontic – cast noble metal	$125[6]
D6214	Pontic – titanium and titanium alloys	$125[6]
D6240	Pontic – porcelain fused to high noble metal	$125[6]
D6241	Pontic – porcelain fused to predominantly base metal	$125[6]
D6242	Pontic – porcelain fused to noble metal	$125[6]
D6243	Pontic – porcelain fused to titanium and titanium alloys	$125[6]
D6245	Pontic – porcelain/ceramic	$125[6]
D6250	Pontic – resin with high noble metal	$125[6]
D6251	Pontic – resin with predominantly base metal	$125[6]
D6252	Pontic – resin with noble metal	$125[6]
D6545	Retainer – cast metal for resin bonded fixed prosthesis	$125[6]
D6548	Retainer – porcelain/ceramic for resin bonded fixed prosthesis	$125[6]
D6600	Retainer inlay – porcelain/ceramic – two surfaces	$125[6]
D6601	Retainer inlay – porcelain/ceramic – three or more surfaces	$125[6]
D6602	Retainer inlay – cast high noble metal – two surfaces	$125[6]
D6603	Retainer inlay – cast high noble metal – three or more surfaces	$125[6]
D6604	Retainer inlay – cast predominantly base metal – two surfaces	$125[6]
D6605	Retainer inlay – cast predominantly base metal – three or more surfaces	$125[6]
D6606	Retainer inlay – cast noble metal – two surfaces	$125[6]
D6607	Retainer inlay – cast noble metal – three or more surfaces	$125[6]
D6608	Retainer onlay – porcelain/ceramic – two surfaces	$125[6]
D6609	Retainer onlay – porcelain/ceramic – three or more surfaces	$125[6]
D6610	Retainer onlay – cast high noble metal – two surfaces	$125[6]
D6611	Retainer onlay – cast high noble metal – three or more surfaces	$125[6]
D6612	Retainer onlay – cast predominantly base metal – two surfaces	$125[6]
D6613	Retainer onlay – cast predominantly base metal – three or more surfaces	$125[6]
D6614	Retainer onlay – cast noble metal – two surfaces	$125[6]
D6615	Retainer onlay – cast noble metal – three or more surfaces	$125[6]
D6710	Retainer crown – indirect resin-based composite	$125[6]
D6720	Retainer crown – resin with high noble metal	$125[6]
D6721	Retainer crown – resin with predominantly base metal	$125[6]

Covered Services are listed with the American Dental Association (ADA) procedure code.

ADA Code	Services	When using a Participating[3] Dentist
D6722	Retainer crown – resin with noble metal	$125[6]
D6740	Retainer crown – porcelain/ceramic	$125[6]
D6750	Retainer crown – porcelain fused to high noble metal	$125[6]
D6751	Retainer crown – porcelain fused to predominantly base metal	$125[6]
D6752	Retainer crown – porcelain fused to noble metal (anterior and premolar teeth only)	$125[6]
D6753	Retainer crown – porcelain fused to titanium and titanium alloys	$125[6]
D6780	Retainer crown – 3/4 cast high noble metal	$125[6]
D6781	Retainer crown – 3/4 cast predominantly base metal	$125[6]
D6782	Retainer crown – 3/4 cast noble metal	$125[6]
D6783	Retainer crown – 3/4 porcelain/ceramic (anterior and premolar teeth only)	$125[6]
D6784	Retainer crown – 3/4 titanium and titanium alloys	$125[6]
D6790	Retainer crown – full cast high noble metal	$125[6]
D6791	Retainer crown – full cast predominantly base metal	$125[6]
D6792	Retainer crown – full cast noble metal	$125[6]
D6794	Retainer crown – titanium and titanium alloys	$125
D6930	Re-cement or re-bond fixed partial denture	$0
D6980	Fixed partial denture repair necessitated by restorative material failure	$5[7]
	Oral surgery services	
D7111	Extraction – coronal remnants – primary tooth	$3/tooth
D7140	Extraction – erupted tooth or exposed root, including elevation and/or forceps removal	$6/tooth
D7210	Extraction – erupted tooth requiring removal of bone and/or sectioning of tooth, including elevation of mucoperiosteal flap if indicated	$15/tooth
D7220	Removal of impacted tooth – soft tissue	$20/tooth
D7230	Removal of impacted tooth – partially bony	$40/tooth
D7240	Removal of impacted tooth – completely bony	$65/tooth
D7241	Removal of impacted tooth – completely bony with unusual surgical complications	$65/tooth
D7250	Removal of residual tooth roots – cutting procedure	$30
D7251	Coronectomy – intentional partial tooth removal	$38
D7260	Oroantral fistula closure	$70
D7285	Incisional biopsy of oral tissue – hard – bone or tooth	$13[7]
D7286	Incisional biopsy of oral tissue – soft	$10[7]
D7287	Exfoliative cytological sample collection	$10
D7288	Brush biopsy – transepithelial sample collection	$5

Covered Services are listed with the American Dental Association (ADA) procedure code.

ADA Code	Services	When using a Participating[3] Dentist
D7310	Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces – per quadrant	$38
D7311	Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces – per quadrant	$10
D7320	Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces – per quadrant	$30
D7321	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces – per quadrant	$15
D7471	Removal of lateral exostosis – maxilla or mandible	$53
D7472	Removal of torus palatinus	$63
D7473	Removal of torus mandibularis	$60
D7510	Incision and drainage of abscess – intraoral soft tissue	$20
D7511	Incision and drainage of abscess – intraoral soft tissue – complicated, includes drainage of multiple facial spaces	$28
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	$44
D7961	Buccal/labial frenectomy (frenulectomy)	$38
D7962	Lingual frenectomy (frenulectomy)	$38/visit
D7963	Frenuloplasty	$41
D7970	Excision of hyperplastic tissue – per arch	$43
D7971	Excision of pericoronal gingiva	$20
D7972	Surgical reduction of fibrous tuberosity	$60
	Orthodontic services	
D8070	Comprehensive Orthodontic treatment of the transitional dentition – (child through age 13)	$1,200[9]
D8080	Comprehensive Orthodontic treatment of the adolescent dentition	$1,200[9]
D8090	Comprehensive Orthodontic treatment of the adult dentition	$1,500[9]
D8210	Removable appliance therapy	$360[9]
D8220	Fixed appliance therapy	$406[9]
D8660	Pre-Orthodontic treatment examination to monitor growth and development	$250[9]
D8670	Periodic Orthodontic treatment visit	$0/visit[9]
D8680	Orthodontic retention, including removal of appliances, construction and placement of retainer(s)	$250/retainer[9]
D8696	Repair of Orthodontic appliance – maxillary	$88[9]
D8697	Repair of orthodontic appliance – mandibular	$88[9]
	Adjunctive general services	
D9110	Palliative emergency treatment of dental pain – minor procedure	$20/visit[10]
D9120	Fixed partial denture sectioning	$37

Benefits[4,5] **Your payment**

Covered Services are listed with the American Dental Association (ADA) procedure code.

ADA Code	Services	When using a Participating[3] Dentist
D9210	Local anesthesia not in conjunction with operative or surgical procedures	$0
D9211	Regional block anesthesia	$0
D9212	Trigeminal division block anesthesia	$0
D9215	Local anesthesia in conjunction with operative or surgical procedures	$0
D9220	General anesthesia - first 30 minutes	$0
D9221	General anesthesia - each additional 15 minutes	$0
D9222	Deep sedation/general anesthesia – first 15 minutes	$0
D9223	Deep sedation/general anesthesia – each subsequent 15 minute increment	$0
D9239	Intravenous moderate conscious sedation/anesthesia – first 15 minutes	$0
D9241	IV sedation – first 30 minutes	$0
D9242	IV sedation – each additional 15 minutes	$0
D9243	Intravenous moderate (conscious) sedation/analgesia – each subsequent 15 minute increment	$0
D9310	Consultation – diagnostic consultation provided by dentist or physician other than requesting dentist or physician (as necessary)	$0
D9430	Office visit for observation during regularly scheduled hours – no other services performed	$6/visit
D9440	Office visit – after regularly scheduled hours	$40/visit
D9910	Application of desensitizing medicament	$10
D9941	Fabrication of athletic mouthguard (for ages 12 and older)	$34
D9942	Repair and/or reline of occlusal guard	$40
D9943	Occlusal guards adjustment – coverage is limited to only soft guards that are a Plan covered benefit	$0
D9944	Occlusal guards – hard appliance, full arch	$80
D9945	Occlusal guards – soft appliance, full arch	$80
D9946	Occlusal guards – hard appliance, partial arch	$80
D9951	Occlusal adjustment – limited	$25
D9952	Occlusal adjustment – complete	$25
D9995	Teledentistry – synchronous; real-time encounter	$0/visit
D9996	Teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review	$0/visit
	Other services	
D9999	Failed Appointment without 24-hour notice – per 15 minutes of appointment time	$20/visit

Summary of Benefits

Group Dental Plan
DPPO Plan

Smile℠ Spectrum Premier Rollover 50/1500/No Ortho/U90

This Summary of Benefits shows the amount you will pay for Covered Services under this Blue Shield of California Plan. It is only a summary and it is included as part of the Evidence of Coverage (EOC)[1]. Please read both documents carefully for details.

Dental Provider Network: **DPPO Network**

This Plan uses a specific network of dental care providers, called the DPPO provider network. Dentists in this network are called Participating Dentists. You pay less for Covered Services when you use a Participating Dentist than when you use a Non-Participating Dentist. You can find Participating Dentists in this network at blueshieldca.com.

Calendar Year Deductible (CYD)[2]

A Calendar Year Deductible (CYD) is the amount a Member pays each Calendar Year before Blue Shield pays for Covered Services under the Plan. Blue Shield pays for some Covered Services before the Calendar Year Deductible is met, as noted in the Benefits chart below.

		When using a Participating[3] or Non-Participating[4] Dentist
Calendar Year Deductible	*Individual coverage*	$50 per individual
	Family coverage	$50: individual $150: Family

Calendar Year Benefit Maximum[5]

This Plan pays up to the maximum payment amount as listed for Covered Services and supplies per year.

	When using a Participating[3] or Non-Participating[4] Dentist
Calendar Year Benefit Maximum	$1,500: individual

Waiting Period

A waiting period is the length of time you must be covered under the Plan before Blue Shield will pay for Covered Services.

Waiting period	No waiting period

No Lifetime Dollar Limit

Under this Plan there is no dollar limit on the total amount Blue Shield will pay for Covered Services in a Member's lifetime.

Blue Shield of California is an independent member of the Blue Shield Association

Benefits[6,7,8]

	Your payment			
	When using a Participating Dentist[3]	CYD[2] applies	When using a Non-Participating Dentist[4]	CYD[2] applies
Diagnostic and preventive services				
Oral exam	$0		$0	
Preventive – cleaning	$0		$0	
Preventive – x-ray	$0		$0	
Topical fluoride application	$0		$0	
Periodontal maintenance	$0		$0	
Enhanced dental benefits for pregnant women	$0		$0	
Basic services				
Sealants per tooth	20%	✔	20%	✔
Space maintainers – fixed	20%	✔	20%	✔
Restorative procedures	20%	✔	20%	✔
Oral Surgery	20%	✔	20%	✔
Endodontics	20%	✔	20%	✔
Periodontics (other than maintenance)	20%	✔	20%	✔
Major services				
Crowns and casts	50%	✔	50%	✔
Prosthodontics	50%	✔	50%	✔
Implants	50%	✔	50%	✔
Orthodontics	Not covered		Not covered	

Dental Smile Rollover Rewards[9]

Initial Maximum Calendar Year Benefit	Annual Claim Threshold	Annual Account Reward	Annual Network Reward	Total Annual Reward	Total Reward Account Maximum	Potential Maximum Calendar Year Benefit (Initial Maximum Calendar Year Benefit + Total Reward Account Maximum)
$1,500	$750	$400	$100	$500	$1,500	$3,000

Notes

1 Evidence of Coverage (EOC):

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

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

Notes

2 Calendar Year Deductible (CYD):

Calendar Year Deductible explained. A Deductible is the amount you pay each Calendar Year before Blue Shield pays for Covered Services under the Plan.

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

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

Family coverage has an individual Deductible within the Family Deductible. This means that the Deductible will be met for an individual with Family coverage who meets the individual Deductible prior to the Family meeting the Family Deductible within a Calendar Year. Any amount you have paid toward the Deductible for your individual plan will be applied to both the individual Deductible and the Family Deductible for your new plan.

3 Using Participating Dentists:

Participating Dentists have a contract to provide Dental Care Services to Members. When you receive Covered Services from a Participating Dentist, you are only responsible for the Copayment or Coinsurance, once any Calendar Year Deductible has been met.

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

- Coinsurance is calculated from the Allowable Amount.

4 Using Non-Participating Dentists:

Non-Participating Dentists do not have a contract to provide Dental Care Services to Members. When you receive Covered Services from a Non-Participating Dentist, you are responsible for both:

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

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

- Coinsurance is calculated from the Allowable Amount.
- Any charges above the Allowable Amount are not covered, do not count towards any Benefit maximums, and are your responsibility for payment to the provider. This out-of-pocket expense can be significant.

The Non-Participating Dentist reimbursement amount is the usual, customary, and reasonable rate or UCR rate. The UCR rate is the cost for a typical service within a specified region and it may differ depending on where you receive services. When you receive services from a Non-Participating Dentist, you pay any amount above the UCR rate. The Allowable Amount is based off the 90th percentile of UCR.

5 Benefit Maximum(s):

Your payment after you reach any Benefit maximum. You will pay 100% of all charges after you reach a Benefit maximum.

All Covered Services count towards the Calendar Year Benefit maximum. The Plan pays up to the maximum payment amount as listed for Covered Services and supplies.

Enhanced dental benefits for pregnant women do not apply towards the Calendar Year Benefit Maximum.

6 Separate Member Payments When Multiple Covered Services are Received:

Each time you receive multiple Covered Services, you might have separate payments (Copayment or Coinsurance) for each service. When this happens, you may be responsible for multiple Copayments or Coinsurance.

Notes

7 Dental Care Services:

All dental Benefits are provided through Blue Shield's Dental Plan Administrator (DPA).

Dental Care Covered Services. All Covered Services must be Medically Necessary and must be provided by the Member's Dental Center or other Participating Dentist when referred by the Member's Dental Center and Authorized by the contracted Dental Plan Administrator.

8 Prior Authorization:

Prior Authorization or precertification for Covered Services. Before any course of treatment expected to cost more than $250 is started, you should obtain prior authorization of Benefits, except in an emergency.

9 Dental Smile Rewards Program:

With the Dental Smile Rollover Rewards Program, Blue Shield rewards you for getting diagnostic and preventive care from your Dentist during the year. Your reward accumulates, will be carried over each year, and is available for use beginning in the next benefit period (see the Dental Smile Rollover Rewards section of the Evidence of Coverage for details on how the program works).

If the Member's Plan has different Participating and Non-Participating Initial Maximum Calendar Year Benefits, the Annual Account Reward amount will be determined by the Non-Participating Initial Maximum Calendar Year Benefit amount.

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

Group Vision Plan

Blue Shield of California Life & Health Insurance Company
Summary of Benefits

Vision Standard 15/25/130

This Summary of Benefits shows the amount you will pay for Covered Services under this Blue Shield of California Life & Health Insurance Company (Blue Shield Life) Plan. It is only a summary and it is included as part of the Certificate of Insurance (COI).[1] Please read both documents carefully for details.

Provider Network:

This Plan uses a contracted network of vision care providers. Providers in this network are called Participating Providers. You pay less for Covered Services when you use a Participating Provider than when you use a Non-Participating Provider. You can find Participating Providers in this network at blueshieldca.com.

Benefit Frequency Limits

This Plan pays up to the Allowance and frequency limits as listed for Covered Services.

Comprehensive exam	One every 12 consecutive months
Eyeglass lenses or contact lenses	Once every 24 consecutive months
Eyeglass frame	One every 24 consecutive months
Low vision testing	One every 24 consecutive months
Diabetes management referral	One every Calendar Year

Waiting Period

A waiting period is the length of time you must be covered under the Plan before Blue Shield Life will pay for Covered Services.

Waiting period	No waiting period

No Deductible

Under this Plan there is no dollar amount an Insured must pay before Blue Shield Life will pay for Covered Services.

No Lifetime Dollar Limit

Under this Plan there is no dollar limit on the total amount Blue Shield Life will pay for Covered Services in an Insured's lifetime.

Blue Shield of California Life & Health Insurance Company is an independent licensee of the Blue Shield Association

Benefits[2]	Your payment	
	When using a Participating Provider[3]	**When using a Non-Participating Provider[4]**
Eye examinations		
Comprehensive exam		
One per Insured every 12 months.		
Ophthalmologic visit	$15	All charges above $60
Optometric visit	$15	All charges above $50
Retinal Imaging	$39	Not covered
One per Insured every 12 months by a Participating Provider instead of a standard comprehensive exam with dilation.		
Standard contact lens fitting and evaluation	Not covered	Not covered
One per Insured every 12 months by a Participating Provider if administered at the same time as the comprehensive exam.		
Eyewear/Materials		
Eyeglass frame	$25 plus all charges above $130	All charges above $40
One per Insured every 24 months.		
Plano (non-prescription) sunglasses	$25 plus all charges above $130	Not covered
One per Insured every 24 months instead of an eyeglass frame when prescribed by a Participating Provider or surgeon after vision correction surgery.		
Eyeglass lenses and lens treatments		
One pair of lenses per Insured every 24 months or every 12 months if the examination indicates a Prescription Change. Each pair of eyeglass lenses includes pink or rose tint #1 or #2 in the Allowance and up to 61mm in size.		
• Single vision	$25	All charges above $43
• Lined bifocal	$25	All charges above $60
• Lined trifocal	$25	All charges above $75
• 7.25 diopter, or more	$25	All charges above $12
• Aphakic monofocal	$25	All charges above $120
• Aphakic multifocal	$25	All charges above $200
• Lenticular monofocal	$25	All charges above $120
• Lenticular multifocal	$25	All charges above $200
• Prism 1 1/2 to 4 diopters	$25	All charges above $10
• Prism 4 1/2 to 10 diopters	$25	All charges above $16
• Slab-off prism (per lens)	$25	All charges above $35
• Polycarbonate lenses (for Dependent children only)	$25 plus all charges above $100	All charges above $75

Benefits[2]	Your payment	
	When using a Participating Provider[3]	**When using a Non-Participating Provider[4]**
• Polycarbonate photochromic single vision lenses (for Dependent children only)	$25 plus all charges above $160	All charges above $115
• Premium progressive lenses (no-line bifocals)	$25 plus all charges above $140	All charges above $100
• Anti-reflective lens coating	$25 plus all charges above $50	All charges above $35
• Photochromic lenses		
Single vision	$25 plus all charges above $115	All charges above $85
Lined bifocal	$25 plus all charges above $130	All charges above $95
Lined trifocal	$25 plus all charges above $150	All charges above $110
Premium progressive (no-line bifocals)	$25 plus all charges above $200	All charges above $150
Contact lenses *Elective or Non-Elective Contact Lenses are provided per Insured every 24 months or every 12 months if the examination indicates a Prescription Change. Benefits are provided instead of eyeglass frames and lenses up to the Allowance.*		
• Elective (cosmetic/convenience) - hard or soft	$25 plus all charges above $130	All charges above $130
• Non-Elective (Medically Necessary) - hard *Requires a report from the provider and prior authorization from the VPA.*	$25	All charges above $200
• Non-Elective (Medically Necessary) - soft *Requires a report from the provider and prior authorization from the VPA.*	$25	All charges above $250
Other services		
Low-vision testing and equipment *One per Insured every 24 months by a Participating Provider. Exam must be Medically Necessary, requires a report from the provider and prior authorization from the VPA.*	25% plus all charges above $1,000	Not covered
Diabetes management referral *One per Insured, per Calendar Year to a Participating Provider when you are known to have or be at risk for diabetes.*	$0	Not covered

Notes

1 Certficate of Insurance (COI):

The Certificate of Insurance (COI) describes the Benefits, limitations, and exclusions that apply to coverage under this Plan. Please review the COI for more details of coverage outlined in this Summary of Benefits. You can request a copy of the COI at any time.

Capitalized terms are defined in the COI. Refer to the COI for an explanation of the terms used in this Summary of Benefits.

2 Vision Care Services:

All vision Benefits are provided through Blue Shield Life's Vision Plan Administrator (VPA).

Contact lenses. The Allowance for contact lenses may be used towards the fitting fees. If you receive Elective or Non-Elective Contact Lenses, no Benefits will be available for eyeglass frames and lenses until you satisfy the Benefit frequency.

3 Using Participating Providers:

Participating Providers have a contract to provide vision care services to Insureds. When you receive Covered Services from a Participating Provider, you are responsible for:

- the Copayment, and
- any charges above the stated Allowance, which is the Benefit maximum.

When the Participating Provider uses wholesale or warehouse pricing, the maximum frame Allowances are:

- wholesale Allowance: $84.91.
- warehouse Allowance: $88.83.

Note: This pricing replaces the frame Allowance shown in the Summary of Benefits. If a more expensive frame is selected at a provider location that uses wholesale or warehouse pricing, the Insured Person is responsible for the additional cost above the wholesale or warehouse Allowance. Participating Providers using wholesale or warehouse pricing are identified in the directory of Participating Providers at blueshieldca.com.

Participating Providers maintain a selection of frames that retail within the Allowance of this plan with lenses that fit an eye size less than 61 millimeters.

4 Using Non-Participating Providers:

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

- the Copayment, and
- any charges above the stated Allowance, which is the Benefit maximum.

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