

Bronze Full PPO 3750/65 OffEx

Benefit Summary (For groups 1 to 100)
(Uniform Health Plan Benefits and Coverage Matrix)

Blue Shield of California

Effective January 1, 2017

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

This health plan uses the Full PPO Provider Network

	Participating Providers ²	Non-Participating Providers ²
Calendar Year Medical Deductible² (Copayments for covered services from participating providers accrue to both the participating and non-participating provider calendar year medical deductibles.)	\$3,750 per individual / \$7,500 per family	\$7,500 per individual / \$15,000 per family
Calendar Year Out-of-Pocket Maximum¹ (Any calendar year medical deductible and any calendar year pharmacy deductible accrues to the calendar year out-of-pocket maximum. Copayments for covered services from participating providers accrue to both the participating and non-participating provider calendar year out-of-pocket maximums.)	\$6,800 per individual / \$13,600 per family	\$10,000 per individual / \$20,000 per family
Calendar Year Pharmacy Deductible² (Does not apply to contraceptive drugs and devices. Separate from the calendar year medical deductible or oral anticancer medications. Otherwise applicable to covered drugs in Tiers 2, 3 and 4. Accrues to the calendar year out-of-pocket maximum.)	\$225 per individual / \$450 per family	Not Covered
Lifetime Benefit Maximum	None	
Covered Services	Member Copayment	
PROFESSIONAL SERVICES	Participating Providers²	Non-Participating Providers²
Professional Benefits		
Primary care physician office visits	\$65 per visit	50%
Other practitioner office visit	\$65 per visit	50%
Specialist physician office visits	\$85 per visit	50%
Teladoc consultation	\$5 per consultation (not subject to the calendar year medical deductible)	Not Covered
Allergy Testing and Treatment Benefits		
Primary care physician office visits (includes visits for allergy serum injections)	\$65 per visit	50%
Specialist physician office visits (includes visits for allergy serum injections)	\$85 per visit	50%
Allergy serum purchased separately for treatment	10%	50%
Preventive Health Benefits⁴		
Preventive health services (as required by applicable Federal and California law)	No Charge (not subject to the calendar year medical deductible)	Not Covered

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OUTPATIENT SERVICES		
Hospital Benefits (Facility Services)		
Outpatient surgery performed at a free-standing ambulatory surgery center ⁵	10%	50% ⁶
Outpatient surgery performed in a hospital or a hospital affiliated ambulatory surgery center ⁵	10%	50% ⁶
Outpatient visit	10%	50% ⁶
Outpatient services for treatment of illness or injury and necessary supplies (except as described under "Rehabilitation Benefits" and "Speech Therapy Benefits")	10%	50% ⁶
Bariatric surgery ⁷ (prior authorization required; medically necessary surgery for weight loss, for morbid obesity only)	10%	50% ⁶
OUTPATIENT X-RAY, IMAGING, PATHOLOGY AND LABORATORY BENEFITS		
CT scans, MRIs, MRAs, PET scans, and cardiac diagnostic procedures utilizing nuclear medicine		
Performed in a hospital ³ (prior authorization is required)	\$100 per visit + 10%	50% ⁶
Performed in a free-standing radiological center ³ (prior authorization is required)	10%	50%
Outpatient diagnostic x-ray and imaging		
Performed in a hospital ³	10%	50% ⁶
Performed in a free-standing or affiliated facility ³	10%	50%
Outpatient diagnostic laboratory and pathology		
Performed in a hospital ³	10%	50% ⁶
Performed in a free-standing or affiliated facility ³	10%	50%
HOSPITALIZATION SERVICES		
Hospital Benefits (Facility Services)		
Inpatient physician services	10%	50%
Inpatient non-emergency facility services (semi-private room and board, and medically-necessary services and supplies, including subacute care)	10%	50% ⁸
Bariatric surgery ⁷ (prior authorization required; medically necessary surgery for weight loss, for morbid obesity only)	10%	50% ⁸
Inpatient Skilled Nursing Benefits^{9,10} (combined maximum of up to 100 days per benefit period; prior authorization is required; semi-private accommodations)		
Services by a free-standing skilled nursing facility	10%	10%
Skilled nursing unit of a hospital	10%	50% ⁸
EMERGENCY HEALTH COVERAGE		
Emergency room services not resulting in admission – facility fee (copayment does not apply if the Member is directly admitted to the hospital for inpatient services)	50%	50%
Emergency room services resulting in admission – facility fee (when the Member is admitted directly from the ER)	10%	10%
Emergency room services not resulting in admission – physician fee (copayment does not apply if the Member is directly admitted to the hospital for inpatient services)	10%	10%
Emergency room services resulting in admission – physician fee	10%	10%
Urgent care	\$65 per visit	Not Covered
AMBULANCE SERVICES		
Emergency or authorized transport (ground or air)	10%	10%
PRESCRIPTION DRUG (PHARMACY) COVERAGE^{11,12,13,14,16,17}		
	Participating Pharmacy	Non-Participating Pharmacy
Retail Pharmacies (up to a 30-day supply)		
Contraceptive drugs and devices ¹⁴	No Charge (not subject to the calendar year medical deductible)	Not Covered
Tier 1 drugs	\$15 per prescription	Not Covered
Tier 2 drugs	\$50 per prescription	Not Covered
Tier 3 drugs	\$75 per prescription	Not Covered
Tier 4 drugs (excluding Specialty Drugs)	30% up to \$500 maximum per prescription	Not Covered

Mail Service Pharmacies (up to a 90-day supply)		
Contraceptive drugs and devices ¹⁴	No Charge (not subject to the calendar year medical deductible)	Not Covered
Tier 1 drugs	\$30 per prescription	Not Covered
Tier 2 drugs	\$100 per prescription	Not Covered
Tier 3 drugs	\$150 per prescription	Not Covered
Tier 4 drugs (excluding Specialty Drugs)	30% up to \$1,000 maximum per prescription	Not Covered
Network Specialty Pharmacies ^{12,16} (up to a 30-day supply)		
Tier 4 drugs	30% up to \$500 maximum per prescription	Not Covered
Oral anticancer medications	30% up to \$200 maximum per prescription	Not Covered
PROSTHETICS/ORTHOTICS	Participating Providers²	Non-Participating Providers²
Prosthetic equipment and devices (separate office visit copayment may apply)	10%	Not Covered
Orthotic equipment and devices (separate office visit copayment may apply)	10%	Not Covered
DURABLE MEDICAL EQUIPMENT		
Breast pump	No Charge (not subject to the calendar year medical deductible)	Not Covered
Other durable medical equipment	50%	Not Covered
MENTAL HEALTH SERVICES AND BEHAVIORAL HEALTH SERVICES¹⁸	MHSA Participating Providers²	MHSA Non-Participating Providers²
Inpatient hospital services (prior authorization is required)	10%	50% ⁸
Residential care (prior authorization is required)	10%	50% ⁸
Inpatient professional (physician) services	10%	50%
Routine outpatient mental health and behavioral health services (includes professional/physician visits)	\$65 per visit	50%
Non-routine outpatient mental health and behavioral health services (includes behavioral health treatment, electroconvulsive therapy, intensive outpatient programs, psychological testing, partial hospitalization programs, and transcranial magnetic stimulation. For partial hospitalization programs, a higher copayment and facility charges may apply per episode of care. Some services may require prior authorization and facility charges.)	10%	50%
SUBSTANCE USE DISORDER SERVICES¹⁸		
Inpatient hospital services (prior authorization is required)	10%	50% ⁸
Residential care (prior authorization is required)	10%	50% ⁸
Inpatient professional (physician) services	10%	50%
Routine outpatient substance use disorder services (includes professional/physician visits)	\$65 per visit	50%
Non-routine outpatient substance use disorder services (includes intensive outpatient programs, partial hospitalization programs, and office-based opioid detoxification and/or maintenance therapy. Some services may require prior authorization and facility charges.)	10%	50%
HOME HEALTH SERVICES	Participating Providers²	Non-Participating Providers²
Home health care agency services ⁹ (up to 100 prior authorized visits per calendar year)	10%	Not Covered ¹⁵
Home infusion/home intravenous injectable therapy and infusion nursing visits provided by a home infusion agency	10%	Not Covered ¹⁵
HOSPICE PROGRAM BENEFITS		
Routine home care	No Charge	Not Covered ¹⁵
Inpatient respite care	No Charge	Not Covered ¹⁵
24-hour continuous home care	No Charge	Not Covered ¹⁵
Short-term inpatient care for pain and symptom management	No Charge	Not Covered ¹⁵

CHIROPRACTIC BENEFITS		
Chiropractic services ^{1,9} (up to 12 visits per calendar year)	50% (not subject to the calendar year medical deductible)	50% (not subject to the calendar year medical deductible)
ACUPUNCTURE BENEFITS		
Acupuncture services	\$25 per visit	50%
REHABILITATION/HABILITATIVE BENEFITS (Physical, Occupational and Respiratory Therapy)		
Office location	\$65 per visit	50%
SPEECH THERAPY BENEFITS		
Office location	\$65 per visit	50%
PREGNANCY AND MATERNITY CARE BENEFITS		
Prenatal and preconception physician office visit: initial visit (for inpatient hospital services, see "Hospitalization Services")	No Charge (not subject to the calendar year medical deductible)	50%
Prenatal and preconception physician office visits: subsequent visits (for inpatient hospital services, see "Hospitalization Services")	10%	50%
Postnatal physician office visit: initial visit (for inpatient hospital services, see "Hospitalization Services")	No Charge (not subject to the calendar year medical deductible)	50%
Delivery and all inpatient physician services	10%	50%
Abortion services (an additional facility copayment may apply when services are rendered in a hospital or outpatient surgery center)	10%	50%
FAMILY PLANNING BENEFITS		
Counseling, consulting, and education ⁴ (includes insertion of IUD, as well as injectable and implantable contraceptive for women)	No Charge (not subject to the calendar year medical deductible)	Not Covered
Tubal ligation ⁴	No Charge (not subject to the calendar year medical deductible)	Not Covered
Vasectomy (an additional facility copayment may apply when services are rendered in a hospital or outpatient surgery center)	10%	Not Covered
DIABETES CARE BENEFITS		
Devices, equipment, and non-testing supplies (for testing supplies see outpatient prescription drug benefits.)	50%	Not Covered
Diabetes self-management training in an office setting	No Charge (not subject to the calendar year medical deductible)	50%
CARE OUTSIDE OF PLAN SERVICE AREA (benefits provided through the BlueCard [®] Program for out-of-state emergency and non-emergency care are provided at the participating level of the local Blue Plan allowable amount when you use a Blue Cross/Blue Shield provider)		
Within US: BlueCard Program	See Applicable Benefit	See Applicable Benefit
Outside of US: BlueCard Worldwide	See Applicable Benefit	See Applicable Benefit

PEDIATRIC VISION BENEFITS²³ – Pediatric vision benefits are available for Members through the end of the month in which the Member turns 19. All pediatric vision benefits are provided through MESVision, Blue Shield’s Vision Plan Administrator.

Comprehensive Eye Exam¹⁹: one per calendar year

(includes dilation, if professionally indicated)

Ophthalmologic - Routine ophthalmologic exam with refraction – new patient (S0620) - Routine ophthalmologic exam with refraction – established patient (S0621)	No Charge	Covered up to \$30 maximum Allowance
Optometric - New patient exams (92002/92004) - Established patient exams (92012/92014)	No Charge	Covered up to \$30 maximum Allowance

Eyeglasses

Lenses: one pair per calendar year - Single vision (V2100-2199) - Conventional (Lined) bifocal (V2200-2299) - Conventional (Lined) trifocal (V2300-2399) - Lenticular (V2121, V2221, V2321) Lenses include choice of glass, plastic, or polycarbonate lenses, all lens powers (single vision, bifocal, trifocal, lenticular), fashion and gradient tinting, scratch coating, oversized and glass-grey #3 prescription sunglass lenses.	No Charge	Covered up to a maximum Allowance of: \$25 single vision \$35 lined bifocal \$45 lined trifocal \$45 lenticular
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Optional Lenses and Treatments

UV coating	No Charge	Not Covered
Polycarbonate lenses	No Charge	Not Covered
Anti-reflective coating	\$35	Not Covered
High-index lenses	\$30	Not Covered
Photochromic lenses – plastic	\$25	Not Covered
Photochromic lenses – glass	\$25	Not Covered
Polarized lenses	\$45	Not Covered
Standard progressives	\$55	Not Covered
Premium progressives	\$95	Not Covered

Frame²⁰

(one frame per calendar year)

Collection frames Note: "Collection" frames are available at no cost at participating independent providers. Retail chain providers typically do not display the "Collection," but are required to maintain a comparable selection of frames that are covered in full.	No Charge	Covered up to \$40 maximum Allowance
Non-Collection frames (V2020)	Covered up to \$150 maximum Allowance	Covered up to \$40 maximum Allowance

Contact Lenses²¹

Non-Elective (Medically Necessary) –hard or soft ²²	No Charge	Covered up to \$225 maximum Allowance
Elective (Cosmetic/Convenience) –standard hard (V2500, V2510)	No Charge	Covered up to \$75 maximum Allowance
Elective (Cosmetic/Convenience) – standard soft (V2520) (One pair per month, up to 6 months, per Calendar Year)	No Charge	Covered up to \$75 maximum Allowance
Elective (Cosmetic/Convenience) – non-standard hard (V2501-V2503, V2511-V2513, V2530-V2531)	No Charge	Covered up to \$75 maximum Allowance
Elective (Cosmetic/Convenience) – non-standard soft (V2521-V2523) (One pair per month, up to 3 months, per Calendar Year)	No Charge	Covered up to \$75 maximum Allowance

Other Pediatric Vision Benefits

Comprehensive low vision exam ²² (Once every 5 Calendar Years)	35%	Not Covered
Low vision devices ²² (One aid per Calendar Year)	35%	Not Covered
Diabetes management referral	No Charge	Not Covered

PEDIATRIC DENTAL BENEFITS²⁴ – Pediatric dental benefits are available for Members through the end of the month in which the Member turns 19. All pediatric dental benefits are provided by Blue Shield’s Dental Plan Administrator.

Diagnostic and Preventive	Participating Dentists	Non-Participating Dentists ²⁷
Oral exam	No Charge	20%
Preventive – cleaning	No Charge	20%
Preventive – x-ray	No Charge	20%
Sealants per tooth	No Charge	20%
Topical fluoride application	No Charge	20%
Space maintainers – fixed	No Charge	20%
Basic Services²⁵		
Restorative procedures	20%	30%
Periodontal maintenance services	20%	30%
Major Services²⁵		
Crowns and casts	50%	50%
Endodontics	50%	50%
Periodontics (other than maintenance)	50%	50%
Prosthodontics	50%	50%
Oral surgery	50%	50%
Orthodontics^{25,26}		
Medically necessary orthodontics	50%	50%

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

Copayments or coinsurance for covered services accrue to the calendar year out-of-pocket maximum except copayments or coinsurance for:

- Charges in excess of specified benefit maximums
- Bariatric surgery: covered travel expenses for bariatric surgery
- Chiropractic benefits
- Dialysis center benefits: dialysis services from a non-participating provider

Copayments, coinsurance and charges for services not accruing to the Member’s calendar year out-of-pocket maximum continue to be the Member’s responsibility after the calendar year out-of-pocket maximum is reached. Please refer to the Summary of Benefits and *Evidence of Coverage* for additional details.

2 The Calendar Year Medical Deductible accrues to the Calendar Year Out-of-Pocket Maximum. A Calendar Year Medical Deductible for Covered Services by Preferred, Participating and Other Providers accrues to the Calendar Year Out-of-Pocket Maximum for Services by Preferred, Participating and Other Providers. A Calendar Year Medical Deductible for any combination of Preferred, Participating, Other Providers, Non-Preferred and Non-Participating Providers accrues to the Calendar Year Out-of-Pocket Maximum for Services by any combination of Preferred, Participating, Other Providers, Non-Preferred and Non-Participating Providers.

The Calendar Year Pharmacy Deductible accrues to the Calendar Year Out-of-Pocket Maximum.

For family coverage, there is an individual medical deductible and a separate individual pharmacy deductible within the family medical and pharmacy deductibles. This means that the medical and pharmacy deductibles will be met for an individual who meets the individual medical and pharmacy deductibles prior to meeting the family medical and pharmacy deductibles. Covered Services by Non-Preferred and Non-Participating Providers that are prior authorized as Preferred or Participating will be covered as a Preferred or Participating Provider Benefit.

Member is responsible for copayment in addition to any charges above allowable amounts. The coinsurance indicated is a percentage of allowable amounts. Participating providers accept Blue Shield’s allowable amount as full payment for covered services. Non-participating providers can charge more than these amounts. When Members use non-participating providers, they must pay the applicable deductibles, copayments or coinsurance plus any amount that exceeds Blue Shield’s allowable amount. Charges above the allowable amount do not count toward the calendar year medical deductible or out-of-pocket maximum.

3 Participating non-hospital based (“freestanding”) outpatient x-ray, pathology and laboratory facilities may not be available in all areas; however the Member can obtain outpatient x-ray, pathology and laboratory services from a hospital or an ambulatory surgery center affiliated with a hospital, with payment according to your hospital services benefits.

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

5 Participating ambulatory surgery centers may not be available in all areas. Outpatient surgery services may also be obtained from a hospital or an ambulatory surgery center that is affiliated with a hospital, and paid according to the hospital services benefits.

6 The allowable amount for non-emergency surgery and services performed in a non-participating ambulatory surgery center or outpatient unit of a non-participating hospital is \$350 per day. Members are responsible for 50% of the coinsurance and all charges in excess of \$350. Charges that exceed the allowable amount do not count toward the calendar year out-of-pocket maximum and continue to be owed after the maximum is reached.

- 7 Bariatric surgery is covered when prior authorized by Blue Shield; however, for Members residing in Imperial, Kern, Los Angeles, Orange, Riverside, San Bernardino, San Diego, Santa Barbara and Ventura Counties ("Designated Counties"), bariatric surgery services are covered only when performed at designated contracting bariatric surgery facilities and by designated contracting surgeons. Coverage is not available for bariatric services from any other participating provider and there is no coverage for bariatric services from non-participating providers. In addition, if prior authorized by Blue Shield, a Member in a Designated County who is required to travel more than 50 miles to a designated bariatric surgery facility will be eligible for limited reimbursement for specified travel expenses for the Member and one companion. Refer to the Summary of Benefits and *Evidence of Coverage* for further details.
- 8 The allowable amount for non-emergency hospital services received from a non-participating hospital is \$2,000 per day. Members are responsible for 50% of the coinsurance and all charges in excess of \$2,000 per day. Charges that exceed the allowable amount do not count toward the calendar year out-of-pocket maximum and continue to be owed after the maximum is reached.
- 9 For plans with a calendar year medical deductible amount, services with a day or visit limit accrue to the calendar year day or visit limit maximum regardless of whether the calendar year medical deductible has been met.
- 10 Services may require prior authorization. When services are prior authorized, a Member's share-of-cost is paid at the participating provider amount.
- 11 If the Member or physician selects a brand drug when a Tier 1 drug equivalent is available, the Member is responsible for paying the difference in cost between the brand drug and its Tier 1 drug equivalent, in addition to the Tier 1 drug copayment. The difference in cost that the Member must pay does not accrue to any calendar year medical or pharmacy deductible and is not included in the calendar year out-of-pocket maximum responsibility calculation. The Member or physician may request a medical necessity exception to the difference in cost as further described in the *Evidence of Coverage*. Refer to the *Evidence of Coverage* and Summary of Benefits for detail.
- 12 Network Specialty Pharmacies dispense Specialty Drugs which require coordination of care, close monitoring, or extensive patient training that generally cannot be met by a retail pharmacy. Network Specialty Pharmacy also dispense Specialty Drugs requiring special handling or manufacturing processes, restriction to certain Physicians or pharmacies, or reporting of certain clinical events to the FDA. Specialty Drugs are generally high cost.
- 13 This plan's prescription drug coverage is on average equivalent to or better than the standard benefit set by the federal government for Medicare Part D (also called creditable coverage). Because this plan's prescription drug coverage is creditable, you do not have to enroll in a Medicare prescription drug plan while you maintain this coverage. However, you should be aware that if you have a subsequent break in this coverage of 63 days or more any time after you were first eligible to enroll in a Medicare prescription drug plan, you could be subject to a late enrollment penalty in addition to your Part D premium.
- 14 Contraceptive drugs and devices covered under the outpatient prescription drug benefits do not require a copayment and are not subject to the calendar year medical deductible. However, if a brand contraceptive is selected when a Tier 1 equivalent is available, the Member is responsible for paying the difference between the cost to Blue Shield for the brand contraceptive and its Tier 1 drug equivalent. The difference in cost that the Member must pay does not accrue to any calendar year medical or pharmacy deductible and is not included in the calendar year out-of-pocket maximum responsibility calculation. The Member or physician may request a medical necessity exception to the difference in cost as further described in the *Evidence of Coverage*. In addition, select contraceptives may need prior authorization to be covered without a copayment.
- 15 Services from non-participating providers, home health care, home infusion and hospice services are not covered unless prior authorized. When these services are prior authorized, a Member's share-of-cost is paid at the participating provider amount.
- 16 Specialty drugs are available from a Network Specialty Pharmacy. A Network Specialty Pharmacy provides specialty drugs by mail or upon Member request, at an associated retail store for pickup.
- 17 Blue Shield's Short-Cycle Specialty Drug Program allows initial prescriptions for select Specialty Drugs to be dispensed for a 15-day trial supply, as further described in the *Evidence of Coverage*. In such circumstances, the applicable Specialty Drug copayment or coinsurance will be pro-rated.
- 18 Mental Health and Substance Use Disorder Services are accessed through Blue Shield's Mental Health Service Administrator (MHSA) using Blue Shield's MHSA participating and non-participating providers. Only Mental Health and Substance Use Disorder Services rendered by Blue Shield MHSA participating providers are administered by the Blue Shield MHSA. Mental Health and Substance Use Disorder Services rendered by non-participating providers are administered by Blue Shield. For a listing of severe mental illnesses, including serious emotional disturbances of a child, and other benefit details, please refer to the Summary of Benefits and *Evidence of Coverage*. Inpatient services for acute medical detoxification are covered under the medical benefit; see the Hospital Benefits (Facility Services) section of the *Evidence of Coverage* for benefit details. Services for acute medical detoxification are accessed through Blue Shield using Blue Shield's participating providers or non-participating providers.
- 19 The comprehensive examination benefit allowance does not include fitting and evaluation fees for contact lenses.
- 20 This benefit covers collection frames at no cost at participating independent and retail chain providers. Participating retail chain providers typically do not display the frames as "Collection" but are required to maintain a comparable selection of frames that are covered in full. For non-collection frames, the allowable amount is up to \$150; however, if (a) the participating provider uses wholesale pricing, then the wholesale allowable amount will be up to \$99.06, or if (b) the participating provider uses warehouse pricing, then the warehouse allowable amount will be up to \$103.64. Participating providers using wholesale pricing are identified in the provider directory. If frames are selected that are more expensive than the allowable amount established for this benefit, the Member is responsible for the difference between the allowable amount and the provider's charge.
- 21 Contact lenses are covered in lieu of eyeglasses. See the "Definitions" section in the *Evidence of Coverage* for the definitions of Elective Contact Lenses and Non-Elective (Medically Necessary) Contact Lenses. A report from the provider and prior authorization from the Vision Plan Administrator (VPA) is required.
- 22 A report from the provider and prior authorization from the contracted VPA is required.

- 23 Members can search for vision care providers in the "Find a Provider" section of blueshieldca.com. All pediatric vision benefits are provided through MESVision, Blue Shield's Vision Plan Administrator. Any vision services deductibles, copayments and coinsurance for covered vision services accrue to the calendar year out-of-pocket maximum. Charges in excess of benefit maximums and premiums do not accrue to the calendar year out-of-pocket maximum.
- 24 Members can search for dental network providers in the "Find a Provider" section of blueshieldca.com. All pediatric dental benefits are provided by Blue Shield's Dental Plan Administrator. Copayments and coinsurance for covered dental services accrue to the calendar year out-of-pocket maximum, including any copayments for covered orthodontia services. Charges in excess of benefit maximums and premiums do not accrue to the calendar year out-of-pocket maximum.
- 25 There are no waiting periods for pediatric dental services.
- 26 The Member's Copayment or Coinsurance for covered Medically Necessary Orthodontia services applies to a course of treatment even if it extends beyond a Calendar Year. This applies as long as the Member remains enrolled in the Plan.
- 27 For covered services rendered by non-participating dentists, the Member is responsible for all charges above the allowable amount.

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

This plan is pending regulatory approval.