

# Blue Shield Platinum 90 HMO 0/15 + Child Dental INF

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 PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.**

This plan is available only in certain California counties and cities ("Service Area") as described in the Benefit Summary Guide and the *Evidence of Coverage*. You must live and/or work in this select Service Area in order to enroll in this plan.

This health plan utilizes an Accountable Care Organization (ACO) for its provider network. Except for Emergency Services, Urgent Services when the member is out of the Service Area, or when prior authorized, all services must be obtained through the member's Personal Physician and within the Trio ACO HMO Provider Network to be covered.

**This health plan uses the Trio ACO HMO Provider Network**

|                                                                                                                                                                                                      |                                                |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|
| <b>Calendar Year Medical Deductible</b>                                                                                                                                                              | None                                           |
| <b>Calendar Year Out-of-Pocket Maximum<sup>1</sup></b>                                                                                                                                               | \$4,000 per individual /<br>\$8,000 per family |
| <b>Lifetime Benefit Maximum</b>                                                                                                                                                                      | None                                           |
| <b>Covered Services</b>                                                                                                                                                                              | <b>Member Copayment</b>                        |
| <b>PROFESSIONAL SERVICES</b>                                                                                                                                                                         |                                                |
| <b>Professional Benefits</b>                                                                                                                                                                         |                                                |
| Primary care physician office visits<br><small>(Note: A woman may self-refer to an OB/GYN or family practice physician in her personal physician's medical group or IPA for OB/GYN services)</small> | \$15 per visit                                 |
| Other practitioner office visit                                                                                                                                                                      | \$15 per visit                                 |
| Specialist physician office visit (also see the <b>Access+ Specialist<sup>SM</sup> Benefit</b> below)                                                                                                | \$40 per visit                                 |
| Teladoc consultation                                                                                                                                                                                 | \$5 per consultation                           |
| <b>Allergy Testing and Treatment Benefits</b>                                                                                                                                                        |                                                |
| Primary care physician office visits (includes visits for allergy serum injections)                                                                                                                  | \$15 per visit                                 |
| Specialist physician office visits (includes visits for allergy serum injections)                                                                                                                    | \$40 per visit                                 |
| Allergy serum purchased separately for treatment                                                                                                                                                     | 10%                                            |
| <b>Access+ Specialist<sup>SM</sup> Benefits<sup>2</sup></b>                                                                                                                                          |                                                |
| Office visit, examination or other consultation (self-referred office visits and consultations only)                                                                                                 | \$40 per visit                                 |
| <b>Preventive Health Benefits</b>                                                                                                                                                                    |                                                |
| Preventive health services (as required by applicable Federal and California law)                                                                                                                    | No Charge                                      |
| <b>OUTPATIENT SERVICES</b>                                                                                                                                                                           |                                                |
| <b>Hospital Benefits (Facility Services)</b>                                                                                                                                                         |                                                |
| Outpatient surgery performed at a free-standing ambulatory surgery center <sup>3</sup>                                                                                                               | \$250 per surgery                              |
| Outpatient surgery performed in a hospital or a hospital-affiliated ambulatory surgery center <sup>3</sup>                                                                                           | \$250 per surgery                              |
| Outpatient visit                                                                                                                                                                                     | 10%                                            |
| Outpatient services for treatment of illness or injury and necessary supplies (except as described under "Rehabilitation Benefits" and "Speech Therapy Benefits")                                    | 10%                                            |

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| <b>OUTPATIENT X-RAY, IMAGING, PATHOLOGY AND LABORATORY BENEFITS</b>                                                                                                                          |                                          |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|
| CT scans, MRIs, MRAs, PET scans, and cardiac diagnostic procedures utilizing nuclear medicine performed in a hospital or free-standing radiological center (prior authorization is required) | \$150 per visit                          |
| Outpatient diagnostic x-ray and imaging (non-hospital based or affiliated)                                                                                                                   | \$40 per visit                           |
| Outpatient diagnostic laboratory and pathology (non-hospital based or affiliated)                                                                                                            | \$20 per visit                           |
| <b>HOSPITALIZATION SERVICES</b>                                                                                                                                                              |                                          |
| <b>Hospital Benefits (Facility Services)</b>                                                                                                                                                 |                                          |
| Inpatient physician services                                                                                                                                                                 | \$40 per visit                           |
| Inpatient non-emergency facility services (semi-private room and board, and medically-necessary services and supplies, including subacute care)                                              | \$250 per day up to 5 days per admission |
| <b>INPATIENT SKILLED NURSING BENEFITS<sup>5</sup></b> (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                                                                                                                                         | \$150 per day up to 5 days per admission |
| Skilled nursing unit of a hospital                                                                                                                                                           | \$150 per day up to 5 days per admission |
| <b>EMERGENCY HEALTH COVERAGE</b>                                                                                                                                                             |                                          |
| Emergency room visit not resulting in admission – facility fee (copayment does not apply if the member is directly admitted to the hospital for inpatient services)                          | \$150 per visit                          |
| Emergency room visit resulting in admission – facility fee (when the member is admitted directly from the ER)                                                                                | \$250 per day up to 5 days per admission |
| Emergency room visit not resulting in admission – physician fee                                                                                                                              | No Charge                                |
| Emergency room visit resulting in admission – physician fee                                                                                                                                  | No Charge                                |
| <b>AMBULANCE SERVICES</b>                                                                                                                                                                    |                                          |
| Emergency or authorized transport (ground or air)                                                                                                                                            | \$150                                    |
| <b>PRESCRIPTION DRUG (PHARMACY) COVERAGE<sup>4,6,7,9,10,11,12</sup></b>                                                                                                                      |                                          |
| <b>Retail Pharmacies</b> (up to a 30-day supply)                                                                                                                                             |                                          |
| Contraceptive drugs and devices <sup>7</sup>                                                                                                                                                 | No Charge                                |
| Tier 1 Drugs                                                                                                                                                                                 | \$5 per prescription                     |
| Tier 2 Drugs                                                                                                                                                                                 | \$15 per prescription                    |
| Tier 3 Drugs                                                                                                                                                                                 | \$25 per prescription                    |
| Tier 4 Drugs (excluding Specialty Drugs)                                                                                                                                                     | 10% up to \$250 maximum per prescription |
| <b>Mail Service Pharmacies</b> (up to a 90-day supply)                                                                                                                                       |                                          |
| Contraceptive drugs and devices <sup>7</sup>                                                                                                                                                 | No Charge                                |
| Tier 1 Drugs                                                                                                                                                                                 | \$10 per prescription                    |
| Tier 2 Drugs                                                                                                                                                                                 | \$30 per prescription                    |
| Tier 3 Drugs                                                                                                                                                                                 | \$50 per prescription                    |
| Tier 4 Drugs (excluding Specialty Drugs)                                                                                                                                                     | 10% up to \$500 maximum per prescription |
| <b>Network Specialty Pharmacies<sup>6</sup></b> (up to a 30-day supply)                                                                                                                      |                                          |
| Tier 4 Drugs                                                                                                                                                                                 | 10% up to \$250 maximum per prescription |
| Oral anticancer medications                                                                                                                                                                  | 10% up to \$200 maximum per prescription |
| <b>PROSTHETICS/ORTHOTICS</b>                                                                                                                                                                 |                                          |
| Prosthetic equipment and devices (separate office visit copayment may apply)                                                                                                                 | No Charge                                |
| Orthotic equipment and devices (separate office visit copayment may apply)                                                                                                                   | No Charge                                |
| <b>DURABLE MEDICAL EQUIPMENT</b>                                                                                                                                                             |                                          |
| Breast pump                                                                                                                                                                                  | No Charge                                |
| Other durable medical equipment (member share is based upon allowed charges)                                                                                                                 | 10%                                      |

| <b>MENTAL HEALTH AND BEHAVIORAL HEALTH SERVICES<sup>8</sup></b>                                                                                                                                                                                                                                                                                                                                                                                       |                                          |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|
| Inpatient hospital services (prior authorization required)                                                                                                                                                                                                                                                                                                                                                                                            | \$250 per day up to 5 days per admission |
| Residential care (prior authorization is required)                                                                                                                                                                                                                                                                                                                                                                                                    | \$250 per day up to 5 days per admission |
| Inpatient professional (physician) services (prior authorization required)                                                                                                                                                                                                                                                                                                                                                                            | \$40 per visit                           |
| Routine outpatient mental health and behavioral health services<br>(includes professional/physician visits; some services may require prior authorization and facility charges)                                                                                                                                                                                                                                                                       | \$15 per visit                           |
| Non-routine outpatient mental health and behavioral health services (includes behavioral health treatment, electroconvulsive therapy, intensive outpatient programs, partial hospitalization programs, psychological testing, 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) | No Charge                                |
| <b>SUBSTANCE USE DISORDER SERVICES<sup>8</sup></b>                                                                                                                                                                                                                                                                                                                                                                                                    |                                          |
| Inpatient hospital services (prior authorization is required)                                                                                                                                                                                                                                                                                                                                                                                         | \$250 per day up to 5 days per admission |
| Residential care (prior authorization is required)                                                                                                                                                                                                                                                                                                                                                                                                    | \$250 per day up to 5 days per admission |
| Inpatient professional (physician) services (prior authorization required)                                                                                                                                                                                                                                                                                                                                                                            | \$40 per visit                           |
| Routine outpatient substance use disorder services<br>(includes professional/physician visits; some services may require prior authorization and facility charges)                                                                                                                                                                                                                                                                                    | \$15 per visit                           |
| Non-routine outpatient substance use disorder services (includes intensive outpatient programs, partial hospitalization programs, and office-based opioid detoxification and/or maintenance therapy. 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)                                                                 | No Charge                                |
| <b>HOME HEALTH SERVICES</b>                                                                                                                                                                                                                                                                                                                                                                                                                           |                                          |
| Home health care agency services (up to 100 visits per calendar year)                                                                                                                                                                                                                                                                                                                                                                                 | \$20 per visit                           |
| Medical supplies (see "prescription drug coverage" for specialty drugs)                                                                                                                                                                                                                                                                                                                                                                               | No Charge                                |
| <b>HOSPICE PROGRAM BENEFITS</b>                                                                                                                                                                                                                                                                                                                                                                                                                       |                                          |
| Routine home care                                                                                                                                                                                                                                                                                                                                                                                                                                     | No Charge                                |
| Inpatient respite care                                                                                                                                                                                                                                                                                                                                                                                                                                | No Charge                                |
| 24-hour continuous home care                                                                                                                                                                                                                                                                                                                                                                                                                          | No Charge                                |
| Short-term inpatient care for pain and symptom management                                                                                                                                                                                                                                                                                                                                                                                             | No Charge                                |
| <b>CHIROPRACTIC BENEFITS</b>                                                                                                                                                                                                                                                                                                                                                                                                                          |                                          |
| Chiropractic services                                                                                                                                                                                                                                                                                                                                                                                                                                 | Not Covered                              |
| <b>ACUPUNCTURE BENEFITS</b>                                                                                                                                                                                                                                                                                                                                                                                                                           |                                          |
| Acupuncture services (benefits provided are for the treatment of nausea or as part of a comprehensive pain management program for the treatment of chronic pain only)                                                                                                                                                                                                                                                                                 | \$15 per visit                           |
| <b>PREGNANCY AND MATERNITY CARE BENEFITS</b>                                                                                                                                                                                                                                                                                                                                                                                                          |                                          |
| Prenatal and preconception physician office visits<br>(for inpatient hospital services, see "Hospitalization Services")                                                                                                                                                                                                                                                                                                                               | No Charge                                |
| Postnatal physician office visit: initial visit<br>(for inpatient hospital services, see "Hospitalization Services")                                                                                                                                                                                                                                                                                                                                  | No Charge                                |
| Delivery and all inpatient physician services                                                                                                                                                                                                                                                                                                                                                                                                         | \$40 per visit                           |
| Abortion services (an additional facility copayment may apply when services are rendered in a hospital or outpatient surgery center)                                                                                                                                                                                                                                                                                                                  | \$250 per surgery                        |
| <b>FAMILY PLANNING AND INFERTILITY BENEFITS</b>                                                                                                                                                                                                                                                                                                                                                                                                       |                                          |
| Counseling, consulting, and education (includes insertion of IUD, as well as injectable and implantable contraceptives for women)                                                                                                                                                                                                                                                                                                                     | No Charge                                |
| Infertility services <sup>1</sup> (Diagnosis and treatment of cause of infertility. Excludes services such as in vitro fertilization. Member share of cost for self-administered drugs for infertility is described under "Prescription Drug Coverage")                                                                                                                                                                                               | 50%                                      |
| Tubal ligation                                                                                                                                                                                                                                                                                                                                                                                                                                        | No Charge                                |
| Vasectomy (an additional facility copayment may apply when services are rendered in a hospital or outpatient surgery center)                                                                                                                                                                                                                                                                                                                          | \$250 per surgery                        |
| <b>REHABILITATION/HABILITATIVE BENEFITS (Physical, Occupational, and Respiratory Therapy)</b>                                                                                                                                                                                                                                                                                                                                                         |                                          |
| Office location                                                                                                                                                                                                                                                                                                                                                                                                                                       | \$15 per visit                           |

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**SPEECH THERAPY BENEFITS**

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Office location \$15 per visit

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**DIABETES CARE BENEFITS**

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Devices, equipment, and non-testing supplies (member share is based upon allowed charges; for testing supplies see "Prescription Drug Coverage") 10%

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Diabetes self-management training in an office setting No Charge

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**URGENT CARE BENEFITS** (BlueCard® Program)

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Urgent services outside your personal physician service area \$15 per visit

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**PEDIATRIC VISION BENEFITS<sup>17</sup>** – 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.

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Comprehensive Eye Exam<sup>13</sup>: one per calendar year

(includes dilation, if professionally indicated)

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**Ophthalmologic**

- Routine ophthalmologic exam with refraction – new patient (S0620)

No Charge

- Routine ophthalmologic exam with refraction – established patient (S0621)

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**Optometric**

- New patient exams (92002/92004)

No Charge

- Established patient exams (92012/92014)

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**Eyeglasses**

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Lenses: one pair per calendar year

- Single vision (V2100-2199)

- Conventional (Lined) bifocal (V2200-2299)

- Conventional (Lined) trifocal (V2300-2399)

- Lenticular (V2121, V2221, V2321)

No Charge

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.

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**Optional Lenses and Treatments**

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UV coating

No Charge

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Polycarbonate lenses

No Charge

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Anti-reflective coating

\$35

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High-index lenses

\$30

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Photochromic lenses – plastic

No Charge

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Photochromic lenses – glass

\$25

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Polarized lenses

\$45

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Standard progressives

No Charge

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Premium progressives

\$95

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**Frame<sup>14</sup>**

(one frame per calendar year)

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**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

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Non-Collection frames (V2020)

Covered Up to \$150 maximum Allowance

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**Contact Lenses<sup>15</sup>**

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Non-Elective (Medically Necessary) – hard or soft<sup>22</sup>

No Charge

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Elective (Cosmetic/Convenience) – standard soft (V2500, V2510)

No Charge

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Elective (Cosmetic/Convenience) – standard soft (V2520)

(One pair per month, up to 6 months, per Calendar Year)

No Charge

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Elective (Cosmetic/Convenience) – non-standard hard (V2501-V2503, V2511-V2513, V2530-V2531)

No Charge

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Elective (Cosmetic/Convenience) – non-standard soft (V2521-V2523)

(One pair per month, up to 3 months, per Calendar Year)

No Charge

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**Other Pediatric Vision Benefits**

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Comprehensive low vision exam<sup>22</sup>

(Once every 5 Calendar Years)

No Charge

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|                                                                 |           |
|-----------------------------------------------------------------|-----------|
| Low vision devices <sup>22</sup><br>(One aid per Calendar Year) | No Charge |
| Diabetes management referral                                    | No Charge |

**PEDIATRIC DENTAL BENEFITS<sup>18</sup>** – Pediatric dental benefits are available for members through the end of the month in which the member turns 19. All pediatric dental benefits are provided by Dental Benefits Providers, Blue Shield's Dental Plan Administrator.

|                                       |                                                             |
|---------------------------------------|-------------------------------------------------------------|
| <b>Diagnostic and Preventive</b>      |                                                             |
| Oral exam                             | No Charge                                                   |
| Preventive – cleaning                 | No Charge                                                   |
| Preventive – x-ray                    | No Charge                                                   |
| Sealants per tooth                    | No Charge                                                   |
| Topical fluoride application          | No Charge                                                   |
| Space maintainers – fixed             | No Charge                                                   |
| <b>Basic Services<sup>19</sup></b>    |                                                             |
| Restorative procedures                | See Dental Copay Schedule in<br><i>Evidence of Coverage</i> |
| Periodontal maintenance services      |                                                             |
| <b>Major Services<sup>19</sup></b>    |                                                             |
| Crowns and casts                      | See Dental Copay Schedule in<br><i>Evidence of Coverage</i> |
| Endodontics                           |                                                             |
| Periodontics (other than maintenance) |                                                             |
| Prosthodontics                        |                                                             |
| Oral surgery                          |                                                             |
| <b>Orthodontics<sup>19,20</sup></b>   |                                                             |
| Medically necessary orthodontics      | \$1000                                                      |

- 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
- Family planning benefits: infertility services

Copayments 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 exact terms and conditions of coverage.

- To use this option, members must select a personal physician who is affiliated with a medical group or IPA that is an Access+ provider group, which offers the Access+ Specialist feature. Members should then select a specialist within that medical group or IPA. Access+ Specialist visits for mental health or substance use disorder services must be provided by a MHSA network participating provider.
- 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.
- 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.
- Skilled nursing services are limited to 100 preauthorized days during a benefit period except when received through a hospice program provided by a participating hospice agency. This 100 preauthorized day maximum on skilled nursing services is a combined maximum between SNF in a hospital unit and skilled nursing facilities.
- Network Specialty Pharmacies dispense Specialty Drugs which require coordination of care, close monitoring, or extensive patient training that generally cannot be met by a retail pharmacy. Network Specialty Pharmacies also dispense Specialty Drugs 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.
- Contraceptive drugs and devices covered under the outpatient prescription drug benefits do not require a copayment. However, if a brand contraceptive is selected when a generic equivalent is available; the member is responsible for paying the difference between the cost to Blue Shield for the brand contraceptive and its generic drug equivalent. The difference in cost that the member must pay is not included in the calendar year out-of-pocket maximum responsibility calculation. The member or physician may request a medical necessity exception to the difference in cost as further described in the *Evidence of Coverage*. In addition, select brand contraceptives may need prior authorization to be covered without a copayment.

8. Mental Health/Behavioral Health and Substance use disorder services are accessed through Blue Shield's Mental Health Service Administrator (MHSA) using Blue Shield's MHSA participating providers. 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 participating providers.
9. 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.
10. If the member or physician selects a brand drug when a generic drug equivalent is available, the member is responsible for paying the difference in cost between the brand drug and its generic drug equivalent, in addition to the Tier 1 copayment. The difference in cost that the member must pay 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 details.
11. 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.
12. Drugs obtained at a non-participating pharmacy are not covered, unless medically necessary for a covered emergency.
13. The comprehensive examination benefit allowance includes fitting, evaluation and follow-up care fees for Non-Elective (Medically Necessary) Contact Lenses (hard or soft) or Elective Contact Lenses (standard hard or soft) in lieu of eyeglasses by Participating or Preferred Providers.
14. This benefit covers collection frames at no cost at participating independent and retail chain providers. Participating retail chain providers typically do not display the frames as "Collection" but are required to maintain a comparable selection of frames that are covered in full. For non-collection frames, the allowable amount is up to \$150; however, if (a) the participating provider uses wholesale pricing, then the wholesale allowable amount will be up to \$99.06, or if (b) the participating provider uses warehouse pricing, then the warehouse allowable amount will be up to \$103.64. Participating providers using wholesale pricing are identified in the provider directory. If frames are selected that are more expensive than the allowable amount established for this benefit, the member is responsible for the difference between the allowable amount and the provider's charge.
15. Contact lenses are covered in lieu of eyeglasses. See the "Definitions" section in the *Evidence of Coverage* for the definitions of Elective Contact Lenses and Non-Elective (Medically Necessary) Contact Lenses. A report from the provider and prior authorization from the Vision Plan Administrator (VPA) is required.
16. A report from the provider and prior authorization from the contracted Vision Plan Administrator is required.
17. All vision services must be provided through a participating vision care provider. For a list of participating vision providers, members can search in the "Find a Provider" section of blueshieldca.com. All pediatric vision benefits are provided through MESVision, Blue Shield's Vision Plan Administrator. Any vision services deductibles, copayments and coinsurance for covered vision services from participating vision providers accrue to the calendar year out-of-pocket maximum. Costs for non-covered services, services from non-participating vision providers, charges in excess of benefit maximums, and premiums, do not accrue to the calendar year out-of-pocket maximum.
18. Pediatric dental benefits are available through a DHMO network of participating dentists. With the exception of emergency dental services, all dental services must be provided through a participating dentist in this DHMO network. For a list of participating dentists, members can search in the "Find a Provider" section of blueshieldca.com. All pediatric dental benefits are provided by Dental Benefits Providers, Blue Shield's Dental Plan Administrator.  
  
Members should contact Dental Plan Member Services if they need assistance locating a Dental Plan Provider in the Service Area. Refer to the *Evidence of Coverage and Summary of Benefits* for details. The Plan will review and consider the request for services that cannot be reasonably obtained in network.  
  
Copayments for covered dental services accrue to the calendar year out-of-pocket maximum, including any copayments for covered orthodontia services. Costs for non-covered services, charges in excess of benefit maximums, and premiums, do not accrue to the calendar year out-of-pocket maximum.
19. There are no waiting periods for major & orthodontic services.
20. The Member's Copayment or Coinsurance for covered Medically Necessary Orthodontia services applies to a course of treatment even if it extends beyond a Calendar Year. This applies as long as the Member remains enrolled in the Plan.

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

**This plan is pending regulatory approval.**