Bronze Full PPO 4500/45 OffEx

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

Blue Shield of California

Effective January 1, 2016

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 Deductible[1] (Copayments for covered services from participating providers accrue to both the participating and non-participating provider calendar year medical deductibles.)	$4,500 per individual / $9,000 per family	$4,500 per individual / $9,000 per family
Calendar Year Out-of-Pocket Maximum[2] (Any calendar year medical deductible and any calendar year pharmacy deductible accrues to the calendar year out-of-pocket maximum. Copayments for covered services from participating providers accrue to both the participating and non-participating provider calendar year out-of-pocket maximums.)	$6,500 per individual / $13,000 per family	$10,000 per individual / $20,000 per family
Calendar Year Pharmacy Deductible[2] (Does not apply to contraceptive drugs and devices. Separate from the calendar year medical deductible. 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**	
	Participating Providers[2]	**Non-Participating Providers[2]**
PROFESSIONAL SERVICES		
Professional Benefits		
Primary care physician office visits	$45 per visit	50%
Other practitioner office visit	$45 per visit	50%
Specialist physician office visits	$45 per visit	50%
Allergy Testing and Treatment Benefits		
Primary care physician office visits (includes visits for allergy serum injections)	$45 per visit	50%
Specialist physician office visits (includes visits for allergy serum injections)	$45 per visit	50%
Allergy serum purchased separately for treatment	30%	50%
Preventive Health Benefits[4]		
Preventive health services (as required by applicable Federal and California law)	No Charge[4] (not subject to the calendar year medical deductible)	Not Covered
OUTPATIENT SERVICES		
Hospital Benefits (Facility Services)		
Outpatient surgery performed at a free-standing ambulatory surgery center[5]	30%	50%[6]
Outpatient surgery performed in a hospital or a hospital affiliated ambulatory surgery center[5]	30%	50%[6]
Outpatient visit	30%	50%
Outpatient services for treatment of illness or injury and necessary supplies (except as described under "Rehabilitation Benefits" and "Speech Therapy Benefits")	30%	50%[6]

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Bariatric surgery[7] (prior authorization required; medically necessary surgery for weight loss, for morbid obesity only)	30%	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 + 30%	50%[6]
Performed in a free-standing radiological center[3] (prior authorization is required)	30%	50%
Outpatient diagnostic x-ray and imaging (non- hospital based or affiliated)[3]	30%	50%[6]
Outpatient diagnostic laboratory and pathology (non-hospital based or affiliated)[3]	30%	50%[6]
HOSPITALIZATION SERVICES		
Hospital Benefits (Facility Services)		
Inpatient physician services	30%	50%
Inpatient non-emergency facility services (semi-private room and board, and medically-necessary services and supplies, including subacute care)	30%	50%[8]
Bariatric surgery[7] (prior authorization required; medically necessary surgery for weight loss, for morbid obesity only)	30%	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	30%	30%[10]
Skilled nursing unit of a hospital	30%	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)	$200 per visit + 30%	$200 per visit + 30%
Emergency room services resulting in admission – facility fee (when the member is admitted directly from the ER)	30%	30%
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)	30%	30%
Emergency room services resulting in admission – physician fee	30%	30%
Urgent care	$45 per visit	Not Covered
AMBULANCE SERVICES		
Emergency or authorized transport (ground or air)	30%	30%
	Participating Pharmacy	**Non-Participating Pharmacy**
PRESCRIPTION DRUG (PHARMACY) COVERAGE [11, 12, 13, 14, 16, 17]		
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% 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% per prescription	Not Covered
Network Specialty Pharmacies[12,16] (up to a 30-day supply)		
Tier 4 Drugs	30% per prescription	Not Covered
Oral anticancer medications	30% up to $200 maximum per prescription	Not Covered

	Participating Providers[2]	Non-Participating Providers[2]
PROSTHETICS/ORTHOTICS		
Prosthetic equipment and devices (separate office visit copayment may apply)	30%	Not Covered
Orthotic equipment and devices (separate office visit copayment may apply)	30%	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
	MHSA Participating Providers[2]	**MHSA Non-Participating Providers[2]**
MENTAL HEALTH SERVICES AND SUBSTANCE ABUSE SERVICES[18]		
Inpatient hospital services (prior authorization is required)	30%	50%[8]
Residential care (prior authorization is required)	30%	50%[8]
Inpatient professional (physician) services	30%	50%
Routine outpatient mental health and behavioral health services (includes professional/physician visits)	$45 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.)	30%	50%
SUBSTANCE USE DISORDER SERVICES[18]		
Inpatient hospital services (prior authorization is required)	30%	50%[8]
Residential care (prior authorization is required)	30%	50%[8]
Inpatient professional (physician) services	30%	50%
Routine outpatient substance use disorder services (includes professional/physician visits)	$45 per visit	50%
Non-routine outpatient substance use disorder services (includes intensive outpatient programs, partial hospitalization programs, office-based opioid treatment, and post discharge ancillary care. Some services may require prior authorization and facility charges.)	30%	50%
	Participating Providers[2]	**Non-Participating Providers[2]**
HOME HEALTH SERVICES		
Home health care agency services[9] (up to 100 prior authorized visits per calendar year)	30%	Not Covered[15]
Home infusion/home intravenous injectable therapy and infusion nursing visits provided by a home infusion agency	30%	Not Covered[15]
HOSPICE PROGAM 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 medica deductible)
ACUPUNCTURE BENEFITS		
Acupuncture services	$25 per visit	50%

REHABILITATION/HABILITATION BENEFITS (Physical, Occupational, and Respiratory Therapy)		
Office location	30%	50%
SPEECH THERAPY BENEFITS		
Office location	30%	50%
PREGNANCY AND MATERNITY CARE BENEFITS		
Prenatal and preconception physician office visits (for inpatient hospital services, see "Hospitalization Services")	No Charge (not subject to the calendar year medical deductible)	50%
Delivery and all inpatient physician services	30%	50%
Postnatal physician office visits (for inpatient hospital services, see "Hospitalization Services")	30%	50%
Abortion services (an additional facility copayment may apply when services are rendered in a hospital or outpatient surgery center)	30%	50%
FAMILY PLANNING BENEFITS		
Counseling and consulting[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)	30%	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	$45 per visit	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 BENEFITS[23] - Pediatric vision benefits are available for members through the end of the month in which the member turns 19. All pediatric vision benefits are provided through MESVision, Blue Shield's Vision Plan Administrator.

Comprehensive Eye Exam[19]: 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	Up to $30 Maximum Allowance
Optometric - New patient exams (92002/92004) - Established patient exams (92012/92014)	No Charge	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
Optional Lenses and Treatments		
UV coating	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
Frame[20] (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	Up to $40 Maximum Allowance
Non-Collection frames (V2020)	Up to $150 Maximum Allowance	Up to $40 Maximum Allowance
Contact Lenses[21]		
Non-Elective (Medically Necessary) hard or soft, one pair per calendar year	No Charge	Up to $225 Maximum Allowance
Elective (Cosmetic/Convenience) standard hard (V2500, V2510), one pair per calendar year	No Charge	Up to $75 Maximum Allowance
Elective (Cosmetic/Convenience) non-standard hard (V2501-V2503, V2511-V2513, V2530-V2531), one pair per calendar year	No Charge	Up to $75 Maximum Allowance
Elective (Cosmetic/Convenience) standard soft (V2520), one pair per month, up to 6 months per calendar year	No Charge	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	Up to $75 Maximum Allowance
Other Pediatric Vision Benefits		
Supplemental low-vision testing and equipment[22]	35%	Not Covered
Diabetes management referral	No Charge	Not Covered

PEDIATRIC DENTAL BENEFITS[24] – 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.

Child Dental Diagnostic and Preventive	Participating Dentists	Non-Participating Dentists[28]
Oral exam	No Charge	20%
Preventive – cleaning	No Charge	20%
Preventive - x-ray	No Charge	20%
Sealants per tooth	No Charge	20%
Topical fluoride application	No Charge	20%
Caries risk management	No Charge	20%
Space maintainers – fixed	No Charge	20%
Child Dental Basic Services		
Amalgam fill - 1 surface[26]	20%	30%
Child Dental Major Services[25]		
Root canal – molar	50%	50%
Gingivectomy per quad	50%	50%
Extraction - single tooth exposed root or erupted	50%	50%
Extraction - complete bony	50%	50%
Porcelain with metal crown	50%	50%
Child Orthodontics[25,27]		
Medically necessary orthodontics	50%	50%

OPTIONAL BENEFITS

Optional infertility, dental and vision benefits are available. If your employer purchased any of these benefits, a description of the benefit is provided separately.

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 within the family medical deductible. This means that the medical deductible will be met for an individual who meets the individual medical deductible prior to the family meeting the family medical deductible.

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. 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.

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 brand drug 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 anytime after you were first eligible to enroll in a Medicare prescription drug plan, you could be subject to a late enrollment penalty in addition to your 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 drug equivalent is available, the member is responsible for paying the difference between the cost to Blue Shield for the brand contraceptive and its Tier 1 drug equivalent. The difference in cost that the member must pay does not accrue to any calendar year medical or brand drug 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 once per calendar year. See the "Definitions" section in the *Evidence of Coverage* for the definitions of Elective Contact Lenses and Non-Elective (Medically Necessary) Contact Lenses. A report from the provider and prior authorization from the Vision Plan Administrator (VPA) is required.

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. Any calendar year pediatric dental services deductible, 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 major & orthodontic services

26 Posterior composite resin, or acrylic restorations are optional services, and Blue Shield will only pay the amalgam filling rate while the member will be responsible for the difference in cost between the posterior composite resin and amalgam filling.

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

Those immediate qualifying conditions are:

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

28 For covered services rendered by non-participating dentists, the member is responsible for all charges above the allowable amount.

Plan designs may be modified to ensure compliance with state and federal requirements.

The Full PPO Network is pending regulatory approval