blue of california

Summary of Benefits

Group Plan
PPO Plan

Full PPO Combined Deductible Value 10-1000 90/70

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

Medical Provider Network: Full PPO Network

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

Calendar Year Deductibles (CYD)[2]

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

		When using a Participating[3] or Non-Participating[4] Provider
Calendar Year medical Deductible	*Individual coverage*	$1,000
	Family coverage	$1,000: individual $3,000: Family

Calendar Year Out-of-Pocket Maximum[5]

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

	When using a Participating Provider[3]	When using any combination of Participating[3] or Non-Participating[4] Providers
Individual coverage	$4,000	$6,000
Family coverage	$4,000: individual $8,000: Family	$6,000: individual $12,000: Family

No Annual or Lifetime Dollar Limit

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

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

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

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
Bariatric surgery services, designated California counties				
This payment is for bariatric surgery services for residents of designated California counties. For bariatric surgery services for residents of non-designated California counties, the payments for Inpatient facility services/ Hospital services and stay and Physician inpatient and surgery services apply for inpatient services; or, if provided on an outpatient basis, the Outpatient Facility services and outpatient Physician services payments apply.				
Inpatient facility services	10%	✔	Not covered	
Outpatient Facility services	15%	✔	Not covered	
Physician services	10%	✔	Not covered	
Diagnostic x-ray, imaging, pathology, and laboratory services				
This payment is for Covered Services that are diagnostic, non-Preventive Health Services, and diagnostic radiological procedures. For the payments for Covered Services that are considered Preventive Health Services, see Preventive Health Services.				
Laboratory and pathology services				
Includes diagnostic Papanicolaou (Pap) test.				
• Laboratory center	$10/visit	✔	30%	✔
• Outpatient Department of a Hospital	$35/visit	✔	30% Subject to a Benefit maximum of $350/day	✔
Basic imaging services				
Includes plain film X-rays, ultrasounds, and diagnostic mammography.				
• Outpatient radiology center	$10/visit	✔	30%	✔
• Outpatient Department of a Hospital	$35/visit	✔	30% Subject to a Benefit maximum of $350/day	✔
Other outpatient non-invasive diagnostic testing				
Testing to diagnose illness or injury such as vestibular function tests, EKG, cardiac monitoring, non-invasive vascular studies, sleep medicine testing, muscle and range of motion tests, EEG, and EMG.				
• Office location	$10/visit	✔	30%	✔

Benefits[6]	Your payment			
	When using a Participating Provider[3]	CYD[2] applies	When using a Non-Participating Provider[4]	CYD[2] applies
• Outpatient Department of a Hospital	$35/visit	✔	30% Subject to a Benefit maximum of $350/day	✔
Advanced imaging services *Includes diagnostic radiological and nuclear imaging such as CT scans, MRIs, MRAs, and PET scans.*				
• Outpatient radiology center	10%	✔	30%	✔
• Outpatient Department of a Hospital	20%	✔	30% Subject to a Benefit maximum of $350/day	✔
Rehabilitative and Habilitative Services *Includes physical therapy, occupational therapy, respiratory therapy, and speech therapy services.*				
Office location	$10/visit	✔	30%	✔
Outpatient Department of a Hospital	$10/visit	✔	30% Subject to a Benefit maximum of $350/day	✔
Durable medical equipment (DME)				
DME	10%	✔	30%	✔
Breast pump	$0		Not covered	
Orthotic equipment and devices	10%	✔	30%	✔
Prosthetic equipment and devices	10%	✔	30%	✔
Home health care services *Up to 100 visits per Member, per Calendar Year, by a home health care agency. All visits count towards the limit, including visits during any applicable Deductible period. Includes home visits by a nurse, Home Health Aide, medical social worker, physical therapist, speech therapist, or occupational therapist, and medical supplies.*	10%	✔	Not covered	
Home infusion and home injectable therapy services				
Home infusion agency services *Includes home infusion drugs, medical supplies, and visits by a nurse.*	$45/visit	✔	Not covered	
Hemophilia home infusion services *Includes blood factor products.*	$45/visit	✔	Not covered	

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

Mental Health and Substance Use Disorder Benefits	Your payment			
Mental health and substance use disorder Benefits are provided through Blue Shield's Mental Health Service Administrator (MHSA).	When using a MHSA Participating Provider[3]	CYD[2] applies	When using a MHSA Non-Participating Provider[4]	CYD[2] applies
Outpatient services				
Office visit, including Physician office visit	$10/visit		30%	✔
Teladoc mental health	$0		Not covered	

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

Prior Authorization

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

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

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

Notes

1 Evidence of Coverage (EOC):

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

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

Notes

2 Calendar Year Deductible (CYD):

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

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

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

Family coverage has an individual Deductible within the Family Deductible. This means that the Deductible will be met for an individual with Family coverage who meets the individual Deductible prior to the Family meeting the Family Deductible within a Calendar Year.

3 Using Participating Providers:

Participating Providers have a contract to provide health care services to Members. When you receive Covered Services from a Participating Provider, you are only responsible for the Copayment or Coinsurance, once any Calendar Year Deductible has been met.

Teladoc. Teladoc mental health and substance use disorder consultations are provided through Teladoc. These services are not administered by Blue Shield's Mental Health Service Administrator (MHSA).

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

- Coinsurance is calculated from the Allowable Amount.

4 Using Non-Participating Providers:

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

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

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

- Coinsurance is calculated from the Allowable Amount, which is subject to any stated Benefit maximum.
- Charges above the Allowable Amount do not count towards the Out-of-Pocket Maximum, and are your responsibility for payment to the provider. This out-of-pocket expense can be significant.

5 Calendar Year Out-of-Pocket Maximum (OOPM):

Calendar Year Out-of-Pocket Maximum explained. The Out-of-Pocket Maximum is the most you are required to pay for Covered Services in a Calendar Year. Once you reach your Out-of-Pocket Maximum, Blue Shield will pay 100% of the Allowable Amount for Covered Services for the rest of the Calendar Year.

Your payment after you reach the Calendar Year OOPM. You will continue to pay all charges for services that are not covered and charges above the Allowable Amount.

Any Deductibles count towards the OOPM. Any amounts you pay that count towards the medical Calendar Year Deductible also count towards the Calendar Year Out-of-Pocket Maximum.

This Plan has a Participating Provider OOPM as well as a combined Participating Provider and Non-Participating Provider OOPM. This means that any amounts you pay towards your Participating Provider OOPM also count towards your combined Participating and Non-Participating Provider OOPM.

Notes

Family coverage has an individual OOPM within the Family OOPM. This means that the OOPM will be met for an individual with Family coverage who meets the individual OOPM prior to the Family meeting the Family OOPM within a Calendar Year.

6 Separate Member Payments When Multiple Covered Services are Received:

Each time you receive multiple Covered Services, you might have separate payments (Copayment or Coinsurance) for each service. When this happens, you may be responsible for multiple Copayments or Coinsurance. For example, you may owe an office visit payment in addition to an allergy serum payment when you visit the doctor for an allergy shot.

7 Preventive Health Services:

If you only receive Preventive Health Services during a Physician office visit, there is no Copayment or Coinsurance for the visit. If you receive both Preventive Health Services and other Covered Services during the Physician office visit, you may have a Copayment or Coinsurance for the visit.

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

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Outpatient Prescription Drug Rider

Group Rider
PPO

Enhanced Rx $10/30/50 with $0 Pharmacy Deductible Summary of Benefits

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

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

Calendar Year Pharmacy Deductible(CYPD)[1]

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

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

Prescription Drug Benefits[4,5]

	Your payment			
	When using a Participating Pharmacy[2]	**CYPD[1] applies**	**When using a Non-Participating Pharmacy[3]**	**CYPD[1] applies**
Retail pharmacy prescription Drugs				
Per prescription, up to a 30-day supply.				
Contraceptive Drugs and devices	$0		Applicable Tier 1, Tier 2, or Tier 3 Copayment	
Tier 1 Drugs	$10/prescription		25% plus $10/prescription	
Tier 2 Drugs	$30/prescription		25% plus $30/prescription	
Tier 3 Drugs	$50/prescription		25% plus $50/prescription	
Tier 4 Drugs	30% up to $250/prescription		30% up to $250/prescription plus 25% of purchase price	
Retail pharmacy prescription Drugs				
Per prescription, for a 90-day supply.				
Contraceptive Drugs and devices	$0		Not covered	
Tier 1 Drugs	$30/prescription		Not covered	

Prescription Drug Benefits[4,5]	Your payment			
	When using a Participating Pharmacy[2]	CYPD[1] applies	When using a Non-Participating Pharmacy[3]	CYPD[1] applies
Tier 2 Drugs	$90/prescription		Not covered	
Tier 3 Drugs	$150/prescription		Not covered	
Tier 4 Drugs	30% up to $750/prescription		Not covered	
Mail service pharmacy prescription Drugs				
Per prescription, for a 31-90-day supply.				
Contraceptive Drugs and devices	$0		Not covered	
Tier 1 Drugs	$20/prescription		Not covered	
Tier 2 Drugs	$60/prescription		Not covered	
Tier 3 Drugs	$100/prescription		Not covered	
Tier 4 Drugs	30% up to $500/prescription		Not covered	

Notes

1 Calendar Year Pharmacy Deductible (CYPD):

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

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

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

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

2 Using Participating Pharmacies:

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

Participating Pharmacies and Drug Formulary. You can find a Participating Pharmacy and the Drug Formulary by visiting https://www.blueshieldca.com/wellness/drugs/formulary#heading2.

3 Using Non-Participating Pharmacies:

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

Notes

4 Outpatient Prescription Drug Coverage:

Medicare Part D-creditable coverage-

This prescription Drug coverage is on average equivalent to or better than the standard benefit set by the federal government for Medicare Part D (also called creditable coverage). Because this prescription Drug coverage is creditable, you do not have to enroll in Medicare Part D while you maintain this coverage; however, you should be aware that if you do not enroll in Medicare Part D within 63 days following termination of this coverage, you could be subject to Medicare Part D premium penalties.

5 Outpatient Prescription Drug Coverage:

Brand Drug coverage when a Generic or Biosimilar Drug is available. If you, the Physician, or Health Care Provider select a Brand Drug when a Generic Drug equivalent or Biosimilar Drug is available, you are responsible for the difference between the cost to Blue Shield for the Brand Drug and its Generic Drug equivalent or Biosimilar Drug plus the applicable tier Copayment or Coinsurance of the Brand Drug. This difference in cost will not count towards any Calendar Year Pharmacy Deductible, medical Deductible, or the Calendar Year Out-of-Pocket Maximum. If you or your Physician believes a Brand Drug is Medically Necessary, either person may request a Medical Necessity Review. If approved, the Brand Drug will be covered at the applicable Drug tier Copayment or Coinsurance.

See the Obtaining outpatient prescription Drugs at a Participating Pharmacy section for more information about how a brand contraceptive may be covered without a Copayment or Coinsurance.

Short-Cycle Specialty Drug program. This program allows initial prescriptions for select Specialty Drugs to be filled for a 15-day supply with your approval. When this occurs, the Copayment or Coinsurance will be pro-rated.

Specialty Drugs. Specialty Drugs are only available from a Network Specialty Pharmacy, up to a 30-day supply.

Oral Anticancer Drugs. You pay up to $250 for oral Anticancer Drugs from a Participating Pharmacy, up to a 30-day supply. Oral Anticancer Drugs from a Participating Pharmacy are not subject to any Deductible.

Retail pharmacy. You may receive up to a 90-day supply for maintenance Drugs at a Participating Pharmacy when you pay the applicable Copayment or Coinsurance for each 30-day supply.

Mail service Drugs. You pay the applicable 30-day retail pharmacy Copayment or Coinsurance for a 30-day supply or less from the mail service pharmacy.

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

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Assisted Reproductive Technology Rider

Group Rider
HMO/POS/PPO/EPO

Additional Assisted Reproductive Technology Benefits Rider 50% Summary of Benefits

This Summary of Benefits shows the amount you will pay for Covered Services under this assisted reproductive technology Benefit.

Benefits	Your Payment	
	When using a Level I Provider	**When using a Non-Participating Provider**
Assisted reproductive technology (ART) procedures and associated services	50% of the allowable amount	Not covered

Services are not subject to the Calendar Year Medical Deductible and do not count towards the Calendar Year Out-of-Pocket Maximum.

Assisted Reproductive Technology (ART) Procedures and Associated Services	Lifetime Benefit Maximums
Natural artificial inseminations *Without ovum [oocyte or ovarian tissue (egg)] stimulation*	6/lifetime
Stimulated artificial inseminations *With ovum [oocyte or ovarian tissue] stimulation*	3/lifetime
Gamete intrafallopian transfer (GIFT)	1/lifetime
Zygote intrafallopian transfer (ZIFT)	2/lifetime
In-vitro fertilization (IVF)	2/lifetime
Intracytoplasmic sperm injection (ICSI)	2/lifetime
Cryopreservation of embryos, oocytes, ovarian tissue, sperm *Retrieved from a Member. Includes one retrieval and three years of storage per person*	1/lifetime

Lifetime Benefit Maximum

Lifetime Benefit maximums for the above described procedures apply to all services related to or performed in conjunction with such procedures, such that once the maximums for the above procedures have been reached, no services related to or performed in conjunction with the procedures will be covered.

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

Introduction

Only the Member is entitled to Benefits under this assisted reproductive technology Benefit. Covered Services for Infertility include all professional, Hospital, Ambulatory Surgery Center, ancillary services and injectable drugs when authorized by the Primary Care Physician to a Member for the inducement of fertilization as described herein.

For the purposes of this Benefit, Infertility is:

- a demonstrated condition recognized by a licensed physician and surgeon as a cause for infertility; or
- the inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year of regular sexual relations without contraception.

Benefits

Benefits are provided for a Member who meets the definition of Infertility for a medically appropriate diagnostic work-up and ART procedures.

The Member is responsible for the Copayment or Coinsurance listed for all professional and Hospital services, Ambulatory Surgery Center and ancillary services used in connection with any procedure covered under this Benefit, and injectable drugs administered by the provider to induce fertilization. If your Employer selected the Outpatient Prescription Drug Rider as an optional Benefit, self-administered Drugs prescribed to induce fertilization are covered at the applicable Drug tier Copayment or Coinsurance. Procedures must be consistent with established medical practice for the treatment of Infertility and authorized by the Primary Care Physician.

Benefits are only provided for services received from Level I Providers.

The Calendar Year Medical Deductible does not apply to these Covered Services, and Cost Share for these Covered Services does not apply towards the Out-of-Pocket Maximum responsibility.

Exclusions

No Benefits are provided for:

- Services received from Non-Participating Providers;
- Outpatient Prescription Drugs prescribed for self-administration, if your Employer did not select the Outpatient Prescription Drug Rider;
- Services for or incident to sexual dysfunction and sexual inadequacies, except as provided for treatment of organically based conditions, for which Covered Services are provided only under the medical Benefits portion of the Evidence of Coverage (EOC);
- Services incident to or resulting from procedures for a surrogate mother. However, if the surrogate mother is enrolled in a Blue Shield of California health Plan, Covered Services for pregnancy and maternity care for the surrogate mother will be covered under that health Plan;
- Services for collection, purchase or storage of embryos, oocytes, ovarian tissue, or sperm from donors other than the Member entitled to Benefits under this assisted reproductive technology Benefit;
- Cryopreservation of embryos, oocytes, ovarian tissue, or sperm from donors other than the Member entitled to Benefits under this assisted reproductive technology Benefit;
- Home ovulation prediction testing kits or home pregnancy tests;
- Microsurgical epididymal sperm aspiration (MESA), percutaneous epididymal sperm aspiration (PESA), and testicular sperm aspiration (TESA) if the Member had a previous vasectomy;

- Reversal of surgical sterilization and associated services;
- Any services not specifically listed as a Covered Service, above; or
- Covered Services in excess of the lifetime Benefit maximums.

Benefits are limited to a Member who has diagnosed Infertility as defined at the time services are provided.

See the Grievance Process portion of your EOC for information on filing a grievance, your right to seek assistance from the Department of Managed Health Care, and your rights to independent medical review.

Please be sure to retain this document. It is not a contract but is a part of your EOC.