Human Resources and Development
COUNTY OF TULARE
AGENDA ITEM

AGENDA DATE: April 10, 2018

Public Hearing Required	Yes	☐	N/A	☒
Scheduled Public Hearing w/Clerk	Yes	☐	N/A	☒
Published Notice Required	Yes	☐	N/A	☒
Advertised Published Notice	Yes	☐	N/A	☒
Meet & Confer Required	Yes	☐	N/A	☒
Electronic file(s) has been sent	Yes	☒	N/A	☐
Budget Transfer (Aud 308) attached	Yes	☐	N/A	☒
Personnel Resolution attached	Yes	☒	N/A	☐
Agreements are attached and signature line for Chairman is marked with tab(s)/flag(s)	Yes	☒	N/A	☐

CONTACT PERSON: Rhonda Sjostrom PHONE: (559) 636-4900

SUBJECT: Approval of the San Joaquin Valley Insurance Authority Participation Agreement

REQUEST(S):

That the Board of Supervisors:

1. Authorize the Chairman to execute the SJVIA Participation Agreement with the San Joaquin Valley Insurance Authority (SJVIA) retroactive to April 1, 2017 through December 31, 2018 for the purpose of participating in the SJVIA health insurance programs (medical, dental, vision and prescription) for eligible employees, retirees, and special districts. The agreement is retroactive due to anticipated updated contract language recently completed by SJVIA counsel.

2. Find that the Board had authority to enter into the proposed agreement as of April 1, 2017 and that it was in the County's best interest to enter into the agreement on that date.

SUMMARY:

In October 2009, your Board approved the execution of a Joint Exercise of Powers Agreement creating the San Joaquin Valley Insurance Authority (SJVIA) with the County of Fresno. The SJVIA offers the County reduced fixed costs and medical health insurance plans, a pharmacy program, as well as dental and vision insurance for eligible employees, retirees, and special districts.

The 2016 SJVIA Participation Agreement was amended through March 31, 2017 to reflect new SJVIA 2017 Plan Year medical, pharmacy, dental and vision rates. It

was originally anticipated that updated contract language and provisions would be completed by April 1, 2017; however, changes to this contract were not completed until recently by SJVIA counsel. As a result, Human Resources & Development is recommending that a new agreement be executed retroactive to April 1, 2017 through December 31, 2018.

The Board should note the following deviations from County contract protocol in this agreement: 1) The forum for any disputes is Fresno County instead of Tulare County and 2) the Dispute Resolution clause contains provisions that would require the County to submit to arbitration.

FISCAL IMPACT/FINANCING:

Adoption of this agreement does not result in increased cost to the County.

LINKAGE TO THE COUNTY OF TULARE STRATEGIC BUSINESS PLAN:

Organizational Performance: Continuously improve organizational effectiveness and fiscal stability. Provide for the stability of county operations through periods of economic fluctuations, changing priorities and service demands.

ADMINISTRATIVE SIGN-OFF:

Rhonda Sjostrom
Human Resources Director

cc: Auditor-Controller
County Counsel
County Administrative Office (2)
San Joaquin Valley Insurance Authority

Attachment(s) SJVIA Participation Agreement
Exhibit A & B – April 1, 2017 – December 31, 2017
Exhibit A & B – January 1, 2018 – December 31, 2018

BEFORE THE BOARD OF SUPERVISORS
COUNTY OF TULARE, STATE OF CALIFORNIA

IN THE MATTER OF APPROVAL OF THE SAN JOAQUIN VALLEY INSURANCE AUTHORITY PARTICIPATION AGREEMENT) **Resolution No. _____**) **Agreement No. _____**)

UPON MOTION OF SUPERVISOR _____, SECONDED BY SUPERVISOR _____, THE FOLLOWING WAS ADOPTED BY THE BOARD OF SUPERVISORS, AT AN OFFICIAL MEETING HELD **APRIL 10, 2018**, BY THE FOLLOWING VOTE:

AYES:
NOES:
ABSTAIN:
ABSENT:

ATTEST: MICHAEL C. SPATA
COUNTY ADMINISTRATIVE OFFICER/
CLERK, BOARD OF SUPERVISORS

BY: _____
Deputy Clerk

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That the Board of Supervisors:

1. Authorized the Chairman to execute the SJVIA Participation Agreement with the San Joaquin Valley Insurance Authority (SJVIA) retroactive to April 1, 2017 through December 31, 2018 for the purpose of participating in the SJVIA health insurance programs (medical, dental, vision and prescription) for eligible employees, retirees, and special districts. The agreement is retroactive due to anticipated updated contract language recently completed by SJVIA counsel.

2. Found that the Board had authority to enter into the proposed agreement as of April 1, 2017 and that it was in the County's best interest to enter into the agreement on that date.

SJVIA PARTICIPATION AGREEMENT

THIS AGREEMENT ("Agreement") is made and entered into this 1st day of April 1, 2017, by and between **COUNTY OF TULARE**, a political subdivision of the State of California, hereinafter referred to as "**COUNTY OF TULARE**", and the SAN JOAQUIN VALLEY INSURANCE AUTHORITY, a joint powers agency, hereinafter referred to as "SJVIA".

W I T N E S S E T H:

WHEREAS, the purpose of the SJVIA is to develop and provide various health insurance programs for health, pharmacy, vision, dental, mental health and life insurance, including related administrative services for such programs to be provided by the insurance provider(s) and the SJVIA and its agents and consultants (collectively, "Various Benefits"), for the benefit of participating entities; and

WHEREAS, the COUNTY OF TULARE wishes to participate in the SJVIA Various Benefits for the purpose of purchasing health insurance programs, and/or other benefits in a cost-effective manner for its participating employees; and

WHEREAS, the COUNTY OF TULARE elects to participate in the selected SJVIA health insurance programs as referenced in Exhibit "A" (collectively, "SELECTED PROGRAMS"), for the benefit of participating entities; and

WHEREAS, the COUNTY OF TULARE and the SJVIA now desire to enter into this Agreement to secure the COUNTY OF TULARE's commitment to remit premium payments to the SJVIA for the Various Benefits to be provided under the Insurance Contract and by the SJVIA and its agents and consultants, as provided herein.

WHEREAS, a true and correct copy of a summary of applicable SJVIA health insurance programs is attached hereto and incorporated herein by reference as Exhibit "A"; and

WHEREAS, the SJVIA represents that it will contract with Insurance Providers which will provide its Various Benefits under the terms and conditions of a written contract between the SJVIA and the Insurance Provider (the "Insurance Contract") for each of the COUNTY OF TULARE's participating employees; and

WHEREAS, the SJVIA represents that the rates for the Various Benefits under the SELECTED PROGRAMS to be provided under the Insurance Contract and by the SJVIA, including the costs of its agents and consultants, are set forth in Exhibit "B" which is attached hereto and incorporated herein by reference; and

WHEREAS, the COUNTY OF TULARE and the SJVIA now desire to enter into this Agreement to secure the COUNTY OF TULARE's commitment to remit premium payments to the SJVIA for the Various Benefits to be provided under the Insurance Contract, and the COUNTY OF TULARE's portion of the costs of the SJVIA's agents and consultants, as provided herein.

NOW THEREFORE, in consideration of their mutual promises, covenants and conditions, the Parties agree as follows:

1. ENTITY COUNTY OF TULARE's OBLIGATIONS: The COUNTY OF TULARE acknowledges that this agreement requires a commitment to participate in SJVIA Various Benefits effective April 1, 2017 through December 31, 2018. Within ten business days of the date that SJVIA is required under the Insurance Contract to pay any insurance premium and/or similar charge to the Insurance Provider, the COUNTY OF TULARE shall remit to SJVIA the amount necessary to pay the required premium payment based on the intervals of such payments under the Insurance Contract.

The COUNTY OF TULARE may also participate in SELECTED PROGRAMS as referenced in Exhibit "A" and shall comply with all applicable terms and provisions of the Insurance Contract and this Agreement, effective April 1, 2017. The attached rates in Exhibit "B" reference only the SELECTED PROGRAMS the COUNTY OF TULARE is electing. Exhibit "B" also references the effective term such rates apply to the COUNTY OF

TULARE which are effective April 1, 2017 through December 31, 2017 and January 1, 2018 through December 31, 2018. The COUNTY OF TULARE agrees that it may only elect to participate in additional health insurance programs, or elect to make changes to the SELECTED PROGRAMS, through subsequent amendment to this agreement or separate agreement. Subsequent renewals are based on the SJVIA underwriting guidelines. The SJVIA is underwritten and renewed as a single risk pool using actuarially based underwriting standards.

2. SJVIA'S OBLIGATIONS: The SJVIA shall approve and execute related Insurance Contracts. Following execution of the Insurance Contracts, (i) SJVIA shall make available the fully-executed copy of the Insurance Contract to COUNTY OF TULARE, (ii) SJVIA shall enforce SJVIA's rights under the Insurance Contract for the benefit of COUNTY OF TULARE, and (iii) SJVIA shall perform SJVIA's obligations under the terms and conditions of the Insurance Contracts, including making timely payment of premium payments, and/or any similar charges, necessary to keep the Insurance Contracts in full force and effect.

3. MODIFICATION: Any matters of this Agreement may be modified from time to time but only by the written consent of all the parties hereto without, in any way, affecting the remainder hereof.

4. NON-ASSIGNMENT: Neither party hereto shall assign, transfer, or subcontract this Agreement nor their rights or duties under this Agreement without the prior written consent of the other party hereto.

5. AUDITS AND INSPECTIONS: The SJVIA shall at any time during usual SJVIA business hours, upon request by the COUNTY OF TULARE, and as often as the COUNTY OF TULARE may deem necessary, make available to the COUNTY OF TULARE for examination all SJVIA records and data for inspection, examination, and audit by the COUNTY OF TULARE with respect to the matters covered by this Agreement. SJVIA shall be subject to the examination and audit of the State Auditor General for a period of three (3) years after final payment under contract (Government Code section 8546.7).

6. NOTICES: The persons having authority to give and receive notices under this Agreement and their addresses include the following:

COUNTY OF TULARE	SJVIA
Rhonda Sjostrom Human Resource Director 2500 West Burrel Ave Visalia, CA 93291 rsjostro@co.tulare.ca.us	Paul Nerland SJVIA Manager 2220 Tulare Street, 14th floor Fresno, CA 93721 pnerland@co.fresno.ca.us

Any and all notices between the COUNTY OF TULARE and the SJVIA provided for or permitted under this Agreement shall be in writing and shall be deemed duly served when personally delivered to one of the parties, or in lieu of such personal service, when deposited in the United States Mail, postage prepaid, addressed to such party.

7. GOVERNING LAW: The parties agree that for the purposes of venue, performance under this Agreement is to be in Fresno County, California. The rights and obligations of the parties and all interpretation and performance of this Agreement shall be governed in all respects by the laws of the State of California.

8. TERM: This Agreement shall become effective beginning at 12:01 a.m. on April 1, 2017 and shall terminate on December 31, 2018.

9. TERMINATION:

a. The terms of this Agreement, and the health insurance programs, Administrative Services, and/or SJVIA Staff Costs to be provided hereunder, are contingent on the approval of funds by the COUNTY OF TULARE. Should sufficient funds not be allocated, the services

provided may be modified, or this Agreement terminated at any time by giving SJVIA 120 days advance written notice.

b. Notwithstanding any other provision of this Article, if the COUNTY OF TULARE fails to make in full any payment when due pursuant to Article 1, the SJVIA shall have the right, in its sole discretion, to terminate this Agreement, without notice, effective at the expiration of the last period for which full premium payment was made. Notwithstanding such termination or suspension, the SJVIA, in its sole discretion, may accept late payment or delinquent amounts and, upon acceptance, this Agreement may be reinstated retroactively to the last date for which full premium payment was made. Any such acceptance of a delinquent payment by the SJVIA shall not be deemed a waiver of this provision for termination of this Agreement in the event of any future failure of the COUNTY OF TULARE to make timely payments of any amounts due under this Agreement.

10. SEVERABILITY: In the event any provisions of this Agreement are held by a court of competent jurisdiction to be invalid, void, or unenforceable, the Parties will use their best efforts to meet and confer to determine how to mutually amend such provisions with valid and enforceable provisions, and the remaining provisions of this Agreement will nevertheless continue in full force and effect without being impaired or invalidated in any way.

11. DISPUTE RESOLUTION: Any controversy or dispute between the parties arising out of this agreement shall be submitted to mediation. The mediator will be selected by mutual agreement. If the matter cannot be resolved through mediation or if the parties cannot agree upon a mediator the matter shall be submitted to arbitration and such arbitration shall comply with and be governed by the provisions of the California Arbitration Act, of the California Code of Civil Procedure.

12. ENTIRE AGREEMENT: This Agreement constitutes the entire agreement between the SJVIA and COUNTY OF TULARE with respect to the subject matter hereof and supersedes all previous agreement negotiations, proposals, commitments, writings, advertisements, publications, and understandings of any nature whatsoever unless expressly included in this Agreement.

13. COUNTERPARTS: This Agreement may be executed in one or more original counterparts, all of which together will constitute one and the same agreement.

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(Go to next page for signatures)

AGREEMENT BETWEEN COUNTY OF TULARE AND THE

SAN JOAQUIN VALLEY INSURANCE AUTHORITY

SAN JOAQUIN VALLEY INSURANCE AUTHORITY:

By _____
Pete Vander Poel
SJVIA Board President

Date: _____

REVIEWED & RECOMMENDED FOR APPROVAL

By _____
Paul Nerland
SJVIA Manager

COUNTY OF TULARE

By _____
Steven Worthley
Chairman, Board of Supervisors

Date: _____

ATTEST:

By _____
Michael C. Spata, County Administrative Officer/Clerk of the Board of Supervisors

APPROVED AS TO LEGAL FORM:

By _____

Anthem Blue Cross

SJVIA PPO Zero
Custom PPO 0/500/20/90/70

Anthem believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that this plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.
Questions regarding which protections of the Affordable Care Act apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Anthem at the telephone number printed on the back of your member identification card, or contact your group benefits administrator if you do not have an identification card. For ERISA plans, you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1–866–444–3272 or www.dol.gov/ebsa/healthreform. This Web site has a table summarizing which protections do and do not apply to grandfathered health plans. For nonfederal governmental plans, you may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.
In addition to dollar and percentage copays, members are responsible for deductibles, as described below. Please review the deductible information to know if a deductible applies to a specific covered service. Certain Covered Services have maximum visit and/or day limits per year. The number of visits and/or days allowed for these services will begin accumulating on the first visit and/or day, regardless of whether your Deductible has been met. Members are also responsible for all costs over the plan maximums. Plan maximums and other important information appear in italics.
Benefits are subject to all terms, conditions, limitations, and exclusions of the Policy.

Explanation of Maximum Allowed Amount

Maximum Allowed Amount is the total reimbursement payable under the plan for covered services received from Participating and Non-Participating Providers. It is the payment towards the services billed by a provider combined with any applicable deductible, copayment or coinsurance.
Participating Providers- The rate the provider has agreed to accept as reimbursement for covered services. Members are not responsible for the difference between the provider's usual charges & the maximum allowed amount.
Non-Participating Providers & Other Health Care Providers-(includes those not represented in the PPO provider network)-Reimbursement amount is based on: an Anthem Blue Cross rate or fee schedule, a rate negotiated with the provider, information from a third party vendor, or billed charges. For Medical Emergency care rendered by a Non-Participating Provider or Non-Contracting Hospital, reimbursement may be based on the reasonable and customary value. Members may be responsible for any amount in excess of the reasonable and customary

When using Non-PPO and Other Health Care Providers, members are responsible for any difference between the covered expense & actual charges, as well as any deductible & percentage copay.

Calendar year deductible		
For PPO Providers & Other Health Providers	None	
For non-PPO Providers	$500/member; $1,000/family	
Deductible for non-Anthem Blue Cross PPO hospital or residential treatment center	None	
Deductible for non-Anthem Blue Cross PPO hospital or residential treatment center if utilization review not obtained	$250/admission *(waived for emergency admission)*	
Deductible for emergency room services	$100/visit *(waived if admitted directly from ER)*	
Annual Out-of-Pocket Maximums (*no cross application*)		
PPO Providers & Other Health Care Providers	$2,000/member/year; $4,000/family/year	
Non-PPO Providers	$5,000/member/year; $10,000/family/year	
The following do not apply to out-of-pocket maximums: non-covered expense. After a member reaches the out-of-pocket maximum, the member remains responsible for non-PPO providers & other health care providers, costs in excess of the covered expense.		
Lifetime Maximum	Unlimited	
Covered Services	**PPO: Per Member Copay**	**Non-PPO: Per Member Copay[1]**
Hospital Medical Services *(subject to utilization review for inpatient services; waived for emergency admissions)*		
➢ Semi-private room, meals & special diets, & ancillary services	10%	30% *(benefit limited to $600/day)*
➢ Outpatient medical care, surgical services & supplies *(hospital care other than emergency room care)*	10%	30% *(benefit limited to $600/day)*
Ambulatory Surgical Centers		
➢ Outpatient surgery, services & supplies	10%	30% *(benefit limited to $350/day)*
Skilled Nursing Facility *(subject to utilization review)*		
➢ Semi-private room, services & supplies *(limited to 100 days/calendar year)*	10%	10%
Hospice Care *(subject to utilization review)*		
➢ Inpatient or outpatient services for member with up to one year life expectancy; family bereavement services	No copay[2]	

[1]The percentage copay for non-emergency services from non-Anthem Blue Cross PPO providers is based on the scheduled amount.

[2]These providers are not represented in the Anthem Blue Cross PPO network.

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay[1]
Home Health Care *(subject to utilization review)*		
➢ Services & supplies from a home health agency *(limited to combined 100 prior authorized visits/calendar year, one visit by a home health aide equals four hours or less; not covered while member receives hospice care)*	10%	10% with authorization
Home Infusion Therapy *(subject to utilization review)*		
➢ Includes medication, ancillary services & supplies; caregiver training & visits by provider to monitor therapy; durable medical equipment; lab services	10%	10%
Physician Medical Services		
➢ Office & home visits	$20/visit[2]	30%
➢ Hospital & skilled nursing facility visits	10%	30%
➢ Surgeon & surgical assistant; anesthesiologist or anesthetist	10%	30%
➢ Drugs administered by a medical provider *(certain drugs are subject to utilization review)*	10%	30%
Diagnostic X-ray & Lab		
➢ MRI, CT scan, PET scan & nuclear cardiac scan *(subject to utilization review)*	10%	30%
➢ Other diagnostic x-ray & lab	No copay	30%
Preventive Care Services Preventive Care Services including*, physical exams, preventive screenings (including screenings for cancer, HPV, diabetes, cholesterol, blood pressure, hearing and vision immunizations, health education, intervention services, HIV testing), and additional preventive care for women provided for in the guidelines supported by the Health Resources and Services Administration. *This list is not exhaustive. This benefit includes all Preventive Care Services required by federal and state law.	No copay	30%
Physical Therapy, Physical Medicine & Occupational Therapy	$25/visit	30%
Chiropractic Services *(up to 12 visits/calendar year; additional visits may be approved, if medically necessary)*	$25/visit	30%
Speech Therapy		
➢ Outpatient speech therapy following injury or organic disease	$20/visit	30%
Acupuncture		
➢ Services for the treatment of disease, illness or injury *(limited to 20 visits/calendar year)*	$25/visit[3]	$25/visit[3]
Temporomandibular Joint Disorders		
➢ Splint therapy & surgical treatment	10%	30%
Pregnancy & Maternity Care		
➢ Physician office visits	$20/visit[2]	30%
➢ Prescription drug for elective abortion *(mifepristone)*	10%	Not covered
Normal delivery, cesarean section, complications of pregnancy & abortion		
➢ Inpatient physician services	10%	30%
➢ Hospital & ancillary services	10%	30% *(benefit limited to $600/day)*
➢ Family planning counseling	$20/visit	Not covered

[1] The percentage copay for non-emergency services from non-Anthem Blue Cross PPO providers is based on the scheduled amount.

[2] The dollar copay applies only to the visit itself. An additional 10% copay applies for any services performed in office (i.e., X-ray, lab, surgery), after any applicable deductible.

[3] Acupuncture services can be performed by a certified acupuncturist (C.A.), a doctor of medicine (M.D.), a doctor of osteopathy (D.O.), a podiatrist (D.P.M.), or a dentist (D.D.S.).

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay[1]
Organ & Tissue Transplants *(subject to utilization review; specified organ transplants covered only when performed at a Center of Expertise [COE])*		
➢ Inpatient services provided in connection with non-investigative organ or tissue transplants	10%	
➢ Transplant travel expense for an authorized, specified transplant at a *COE* *(recipient & companion transportation limited to 6 trips/episode & $250/person/trip for round-trip coach airfare, hotel limited to 1 room double occupancy & $100/day for 21 days/trip, other expenses limited to $25/day/person for 21 days/trip, donor transportation limited to 1 trip/episode & $250 for round-trip coach airfare, hotel limited to $100/day for 7 days, other expenses limited to $25/day for 7 days*	No copay	
Bariatric Surgery *(subject to utilization review; medically necessary surgery for weight loss, only for morbid obesity, covered only when performed at a Center of Expertise [COE])*		
➢ Inpatient services provided in connection with medically necessary surgery for weight loss, only for morbid obesity	10%	
➢ Bariatric travel expense when member's home is 50 miles or more from the nearest Bariatric *CME (member's transportation to & from CME limited to $130/person/trip for 3 trips [pre-surgical visit, initial surgery & one follow-up visit]; one companion's transportation to & from CME limited to $130/person/trip for 2 trips [initial surgery & one follow-up visit]; hotel for member & one companion limited to one room double occupancy & $100/day for 2 days/trip, or as medically necessary, for pre-surgical & follow-up visit; hotel for one companion limited to one room double occupancy & $100/day for duration of member's initial surgery stay for 4 days; other reasonable expenses limited to $25/day/person for 4 days/trip)*	No copay	
Diabetes Education Programs *(requires physician supervision)*		
➢ Teach members & their families about the disease process, the daily management of diabetic therapy & self-management training	$20/visit	30%
Prosthetic Devices		
➢ Coverage for breast prostheses; prosthetic devices to restore a method of speaking; surgical implants; artificial limbs or eyes; the first pair of contact lenses or eyeglasses when required as a result of eye surgery; & therapeutic shoes & inserts	10%	30%
Durable Medical Equipment		
➢ Rental or purchase of DME including , dialysis equipment & supplies, home medical equipment, prosthetic/orthotics *(hearing aids benefit available for one hearing aid per ear every three years; breast pump and supplies are covered under preventive care at no charge for in-network)*	10%	30%
Related Outpatient Medical Services & Supplies		
➢ Ground or air ambulance transportation, services & disposable supplies	10%[2]	
➢ Blood transfusions, blood processing & the cost of unreplaced blood & blood products	10%[2]	
➢ Autologous blood *(self-donated blood collection, testing, processing & storage for planned surgery)*	10%[2]	

[1] The percentage copay for non-emergency services from non-Anthem Blue Cross PPO providers is based on the scheduled amount.

[2] These providers are not represented in the Anthem Blue Cross PPO network.

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay[1]
Emergency Care		
➢ Emergency room services & supplies *($100 deductible waived if admitted)*	10%	10%
➢ Inpatient hospital services & supplies	10%	10%
➢ Physician services	10%	10%
Mental or Nervous Disorders and Substance Abuse		
Inpatient Care		
➢ Facility-based care *(subject to utilization review; waived for emergency admissions)*	10%	30% *(benefit limited to $600/day)*
➢ Inpatient physician visits	10%	30%
Outpatient Care		
➢ Facility-based care *(subject to utilization review; waived for emergency admissions)*	10%	30% *(benefit limited to $600/day)*
➢ Outpatient physician visits *(Behavioral Health treatment for Autism & Pervasive disorder will be subject to pre-service review)*	$20/visit[2]	30%

[1] The percentage copay for non-emergency services from non-Anthem Blue Cross PPO providers is based on the scheduled amount.

[2] The dollar copay applies only to the visit itself. An additional 10% copay applies for any services performed in office (i.e., X-ray, lab, surgery), after any applicable deductible.

This Summary of Benefits is a brief review of benefits. Once enrolled, members will receive a Combined Evidence of Coverage and Disclosure Form, which explains the exclusions and limitations, as well as the full range of covered services of the plan, in detail.

Classic PPO Exclusions and Limitations

Not Medically Necessary. Services or supplies that are not medically necessary, as defined.

Experimental or Investigative. Any experimental or investigative procedure or medication. But, if member is denied benefits because it is determined that the requested treatment is experimental or investigative, the member may request an independent medical review, as described in the Evidence of Coverage (EOC).

Outside the United States. Services or supplies furnished and billed by a provider outside the United States, unless such services or supplies are furnished in connection with urgent care or an emergency.

Crime or Nuclear Energy. Conditions that result from (1) the member's commission of or attempt to commit a felony, as long as any injuries are not a result of a medical condition or an act of domestic violence; or (2) any release of nuclear energy, whether or not the result of war, when government funds are available for the treatment of illness or injury arising from the release of nuclear energy.

Not Covered. Services received before the member's effective date. Services received after the member's coverage ends, except as specified as covered in the EOC.

Excess Amounts. Any amounts in excess of covered expense or the lifetime maximum.

Work-Related. Work-related conditions if benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation, employer's liability law or occupational disease law, whether or not the member claims those benefits. If there is a dispute of substantial uncertainty as to whether benefits may be recovered for those conditions pursuant to workers' compensation, we will provide the benefits of this plan for such conditions, subject to a right of recovery and reimbursement under California Labor Code Section 4903, as specified as covered in the EOC.

Government Treatment. Any services the member actually received that were provided by a local, state or federal government agency, except when payment under this plan is expressly required by federal or state law. We will not cover payment for these services if the member is not required to pay for them or they are given to the member for free.

Services of Relatives. Professional services received from a person living in the member's home or who is related to the member by blood or marriage, except as specified as covered in the EOC.

Voluntary Payment. Services for which the member has no legal obligation to pay, or for which no charge would be made in the absence of insurance coverage or other health plan coverage, except services received at a non-governmental charitable research hospital. Such a hospital must meet the following guidelines:

1. it must be internationally known as being devoted mainly to medical research;
2. at least 10% of its yearly budget must be spent on research not directly related to patient care;
3. at least one-third of its gross income must come from donations or grants other than gifts or payments for patient care;
4. it must accept patients who are unable to pay; and
5. two-thirds of its patients must have conditions directly related to the hospital's research.

Not Specifically Listed. Services not specifically listed in the plan as covered services.

Private Contracts. Services or supplies provided pursuant to a private contract between the member and a provider, for which reimbursement under Medicare program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act.

Inpatient Diagnostic Tests. Inpatient room and board charges in connection with a hospital stay primarily for diagnostic tests which could have been performed safely on an outpatient basis.

Mental or Nervous Disorders. Academic or educational testing, counseling, and remediation. Mental or nervous disorders or substance abuse, including rehabilitative care in relation to these conditions, except as specified as covered in the EOC.

Orthodontia. Braces, other orthodontic appliances or orthodontic services.

Dental Services or Supplies. Dental plates, bridges, crowns, caps or other dental prostheses, dental implants, dental services, extraction of teeth, treatment to the teeth or gums, or treatment to or for any disorders for the temporomandibular (jaw) joint, except as specified as covered in the EOC. Cosmetic dental surgery or other dental services for beautification.

Hearing Aids or Tests

Optometric Services or Supplies. Optometric services, eye exercises including orthoptics. Routine eye exams and routine eye refractions, as specified as covered in the EOC. Eyeglasses or contact lenses, except as specified as covered in the EOC.

Outpatient Occupational Therapy. Outpatient occupational therapy, except by a home health agency, hospice, or home infusion therapy provider, as specified as covered in the EOC.

Outpatient Speech Therapy. Outpatient speech therapy, except as specified as covered in the EOC.

Cosmetic Surgery. Cosmetic surgery or other services performed solely for beautification or to alter or reshape normal (including aged) structures or tissues of the body to improve appearance. This exclusion does not apply to reconstructive surgery (that is, surgery performed to correct deformities caused by congenital or developmental abnormalities, illness, or injury for the purpose of improving bodily function or symptomatology or to create a normal appearance), including surgery performed to restore symmetry following mastectomy. Cosmetic surgery does not become reconstructive surgery because of psychological or psychiatric reasons.

Commercial Weight Loss Programs. Weight loss programs, whether or not they are pursued under medical or *physician* supervision, unless specifically listed as covered in this *plan*.

This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

This exclusion does not apply to *medically necessary* treatments for morbid obesity or dietary evaluations and counseling, and behavioral modification programs for the treatment of anorexia nervosa or bulimia nervosa. Surgical treatment for morbid obesity is covered as described in the Evidence of Coverage (EOC).

Sterilization Reversal.

Infertility Treatment. Any services or supplies furnished in connection with the diagnosis and treatment of infertility, including, but not limited to diagnostic tests, medication, surgery, artificial insemination, in vitro fertilization, sterilization reversal and gamete intrafallopian transfer.

Surrogate Mother Services. For any services or supplies provided to a person not covered under the plan in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

Orthopedic shoes and shoe inserts. This exclusion does not apply to orthopedic footwear used as an integral part of a brace, shoe inserts that are custom molded to the patient, or therapeutic shoes and inserts designed to treat foot complications due to diabetes, as specifically stated in the EOC.

Air Conditioners. Air purifiers, air conditioners or humidifiers.

Custodial Care or Rest Cures. Inpatient room and board charges in connection with a hospital stay primarily for environmental change or physical therapy. Services provided by a rest home, a home for the aged, a nursing home or any similar facility. Services provided by a skilled nursing facility or custodial care or rest cures, except as specified as covered in the EOC.

Health Club Memberships. Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment or facilities used for developing or maintaining physical fitness, even if ordered by a *physician*. This exclusion also applies to health spas.

Personal Items. Any supplies for comfort, hygiene or beautification.

Education or Counseling. Educational services or nutritional counseling, except as specified as covered in the EOC. This exclusion does not apply to counseling for the treatment of anorexia nervosa or bulimia nervosa.

Food or Dietary Supplements. Nutritional and/or dietary supplements, except as provided in this *plan* or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not requirement either a written prescription or dispensing by a licensed pharmacist.

Telephone and Facsimile Machine Consultations. Consultations provided by telephone or facsimile machine.

Routine Exams or Tests. Routine physical exams or tests which do not directly treat an actual illness, injury or condition, including those required by employment or government authority, except as specified as covered in the EOC.

Acupuncture. Acupuncture treatment, except as specified as covered in the EOC. Acupressure or massage to control pain, treat illness or promote health by applying pressure to one or more specific areas of the body based on dermatomes or acupuncture points.

Eye Surgery for Refractive Defects. Any eye surgery solely or primarily for the purpose of correcting refractive defects of the eye such as nearsightedness (myopia) and/or astigmatism. Contact lenses and eyeglasses required as a result of this surgery.

Physical Therapy or Physical Medicine. Services of a physician for physical therapy or physical medicine, except when provided during a covered inpatient confinement or as specified as covered in the EOC.

Outpatient Prescription Drugs and Medications. Outpatient prescription drugs or medications and insulin, except as specified as covered in the EOC. Any non-prescription, over-the-counter patent or proprietary drug or medicine. Cosmetics, health or beauty aids.

Specialty Pharmacy Drugs. Specialty pharmacy drugs that must be obtained from the specialty pharmacy program, but, which are obtained from a retail pharmacy, are not covered by this plan. **Member will have to pay the full cost of the specialty pharmacy drugs obtained from a retail pharmacy that should have been obtained from the specialty pharmacy program.**

Contraceptive Devices. Contraceptive devices prescribed for birth control except as specified as covered in the EOC.

Diabetic Supplies. Prescription and non-prescription diabetic supplies except as specified as covered in the EOC.

Private Duty Nursing. Inpatient or outpatient services of a private duty nurse.

Lifestyle Programs. Programs to alter one's lifestyle which may include but are not limited to diet, exercise, imagery or nutrition. This exclusion will not apply to cardiac rehabilitation programs approved by us.

Wigs.

Third Party Liability — Anthem Blue Cross is entitled to reimbursement of benefits paid if the member recovers damages from a legally liable third party.

Coordination of Benefits — The benefits of this plan may be reduced if the member has any other group health or dental coverage so that the services received from all group coverages do not exceed 100% of the covered expense.

SJVIA PPO Zero BlueCard Custom PPO 0/500/20/90/70

Anthem believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that this plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.
Questions regarding which protections of the Affordable Care Act apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Anthem at the telephone number printed on the back of your member identification card, or contact your group benefits administrator if you do not have an identification card. For ERISA plans, you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1–866–444–3272 or www.dol.gov/ebsa/healthreform. This Web site has a table summarizing which protections do and do not apply to grandfathered health plans. For nonfederal governmental plans, you may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.
In addition to dollar and percentage copays, members are responsible for deductibles, as described below. Please review the deductible information to know if a deductible applies to a specific covered service. Certain Covered Services have maximum visit and/or day limits per year. The number of visits and/or days allowed for these services will begin accumulating on the first visit and/or day, regardless of whether your Deductible has been met. Members are also responsible for all costs over the plan maximums. Plan maximums and other important information appear in italics.
Benefits are subject to all terms, conditions, limitations, and exclusions of the Policy.

Explanation of Maximum Allowed Amount

Maximum Allowed Amount is the total reimbursement payable under the plan for covered services received from Participating and Non-Participating Providers. It is the payment towards the services billed by a provider combined with any applicable deductible, copayment or coinsurance.
Participating Providers- The rate the provider has agreed to accept as reimbursement for covered services. Members are not responsible for the difference between the provider's usual charges & the maximum allowed amount.
Non-Participating Providers & Other Health Care Providers-(includes those not represented in the PPO provider network)-Reimbursement amount is based on: an Anthem Blue Cross rate or fee schedule, a rate negotiated with the provider, information from a third party vendor, or billed charges. For Medical Emergency care rendered by a Non-Participating Provider or Non-Contracting Hospital, reimbursement may be based on the reasonable and customary value. Members may be responsible for any amount in excess of the reasonable and customary

When using Non-PPO and Other Health Care Providers, members are responsible for any difference between the covered expense & actual charges, as well as any deductible & percentage copay.

Calendar year deductible		
For PPO Providers & Other Health Providers	None	
For non-PPO Providers	$500/member; $1,000/family	
Deductible for non-Anthem Blue Cross PPO hospital or residential treatment center	None	
Deductible for non-Anthem Blue Cross PPO hospital or residential treatment center if utilization review not obtained	$250/admission *(waived for emergency admission)*	
Deductible for emergency room services	$100/visit *(waived if admitted directly from ER)*	
Annual Out-of-Pocket Maximums (*no cross application*)		
PPO Providers & Other Health Care Providers	$2,000/member/year; $4,000/family/year	
Non-PPO Providers	$5,000/member/year; $10,000/family/year	
The following do not apply to out-of-pocket maximums: non-covered expense. After a member reaches the out-of-pocket maximum, the member remains responsible for non-PPO providers & other health care providers, costs in excess of the covered expense.		
Lifetime Maximum	Unlimited	
Covered Services	**PPO: Per Member Copay**	**Non-PPO: Per Member Copay[1]**
Hospital Medical Services *(subject to utilization review for inpatient services; waived for emergency admissions)*		
➢ Semi-private room, meals & special diets, & ancillary services	10%	30% *(benefit limited to $600/day)*
➢ Outpatient medical care, surgical services & supplies *(hospital care other than emergency room care)*	10%	30% *(benefit limited to $600/day)*
Ambulatory Surgical Centers		
➢ Outpatient surgery, services & supplies	10%	30% *(benefit limited to $350/day)*
Skilled Nursing Facility *(subject to utilization review)*		
➢ Semi-private room, services & supplies *(limited to 100 days/calendar year)*	10%	10%
Hospice Care *(subject to utilization review)*		
➢ Inpatient or outpatient services for member with up to one year life expectancy; family bereavement services	No copay[2]	

[1]The percentage copay for non-emergency services from non-Anthem Blue Cross PPO providers is based on the scheduled amount.

[2]These providers are not represented in the Anthem Blue Cross PPO network.

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay[1]
Home Health Care *(subject to utilization review)*		
➢ Services & supplies from a home health agency *(limited to combined 100 prior authorized visits/calendar year, one visit by a home health aide equals four hours or less; not covered while member receives hospice care)*	10%	10% with authorization
Home Infusion Therapy *(subject to utilization review)*		
➢ Includes medication, ancillary services & supplies; caregiver training & visits by provider to monitor therapy; durable medical equipment; lab services	10%	10%
Physician Medical Services		
➢ Office & home visits	$20/visit[2]	30%
➢ Hospital & skilled nursing facility visits	10%	30%
➢ Surgeon & surgical assistant; anesthesiologist or anesthetist	10%	30%
➢ Drugs administered by a medical provider (*certain drugs are subject to utilization review)*	10%	30%
Diagnostic X-ray & Lab		
➢ MRI, CT scan, PET scan & nuclear cardiac scan *(subject to utilization review)*	10%	30%
➢ Other diagnostic x-ray & lab	No copay	30%
Preventive Care Services Preventive Care Services including*, physical exams, preventive screenings (including screenings for cancer, HPV, diabetes, cholesterol, blood pressure, hearing and vision immunizations, health education, intervention services, HIV testing), and additional preventive care for women provided for in the guidelines supported by the Health Resources and Services Administration. *This list is not exhaustive. This benefit includes all Preventive Care Services required by federal and state law.	No copay	30%
Physical Therapy, Physical Medicine & Occupational Therapy	$25/visit	30%
Chiropractic Services *(up to 12 visits/calendar year; additional visits may be approved, if medically necessary)*	$25/visit	30%
Speech Therapy		
➢ Outpatient speech therapy following injury or organic disease	$20/visit	30%
Acupuncture		
➢ Services for the treatment of disease, illness or injury *(limited to 20 visits/calendar year)*	$25/visit[3]	$25/visit[3]
Temporomandibular Joint Disorders		
➢ Splint therapy & surgical treatment	10%	30%
Pregnancy & Maternity Care		
➢ Physician office visits	$20/visit[2]	30%
➢ Prescription drug for elective abortion *(mifepristone)*	10%	Not covered
Normal delivery, cesarean section, complications of pregnancy & abortion		
➢ Inpatient physician services	10%	30%
➢ Hospital & ancillary services	10%	30% *(benefit limited to $600/day)*
➢ Family planning counseling	$20/visit	Not covered

[1] The percentage copay for non-emergency services from non-Anthem Blue Cross PPO providers is based on the scheduled amount.

[2] The dollar copay applies only to the visit itself. An additional 10% copay applies for any services performed in office (i.e., X-ray, lab, surgery), after any applicable deductible.

[3] Acupuncture services can be performed by a certified acupuncturist (C.A.), a doctor of medicine (M.D.), a doctor of osteopathy (D.O.), a podiatrist (D.P.M.), or a dentist (D.D.S.).

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay[1]
Organ & Tissue Transplants *(subject to utilization review; specified organ transplants covered only when performed at a Center of Expertise [COE])*		
➢ Inpatient services provided in connection with non-investigative organ or tissue transplants	10%	
➢ Transplant travel expense for an authorized, specified transplant at a *COE* *(recipient & companion transportation limited to 6 trips/episode & $250/person/trip for round-trip coach airfare, hotel limited to 1 room double occupancy & $100/day for 21 days/trip, other expenses limited to $25/day/person for 21 days/trip, donor transportation limited to 1 trip/episode & $250 for round-trip coach airfare, hotel limited to $100/day for 7 days, other expenses limited to $25/day for 7 days*	No copay	
Bariatric Surgery *(subject to utilization review; medically necessary surgery for weight loss, only for morbid obesity, covered only when performed at a Center of Expertise [COE])*		
➢ Inpatient services provided in connection with medically necessary surgery for weight loss, only for morbid obesity	10%	
➢ Bariatric travel expense when member's home is 50 miles or more from the nearest Bariatric *CME (member's transportation to & from CME limited to $130/person/trip for 3 trips [pre-surgical visit, initial surgery & one follow-up visit]; one companion's transportation to & from CME limited to $130/person/trip for 2 trips [initial surgery & one follow-up visit]; hotel for member & one companion limited to one room double occupancy & $100/day for 2 days/trip, or as medically necessary, for pre-surgical & follow-up visit; hotel for one companion limited to one room double occupancy & $100/day for duration of member's initial surgery stay for 4 days; other reasonable expenses limited to $25/day/person for 4 days/trip)*	No copay	
Diabetes Education Programs *(requires physician supervision)*		
➢ Teach members & their families about the disease process, the daily management of diabetic therapy & self-management training	$20/visit	30%
Prosthetic Devices		
➢ Coverage for breast prostheses; prosthetic devices to restore a method of speaking; surgical implants; artificial limbs or eyes; the first pair of contact lenses or eyeglasses when required as a result of eye surgery; & therapeutic shoes & inserts	10%	30%
Durable Medical Equipment		
➢ Rental or purchase of DME including , dialysis equipment & supplies, home medical equipment, prosthetic/orthotics *(hearing aids benefit available for one hearing aid per ear every three years; breast pump and supplies are covered under preventive care at no charge for in-network)*	10%	30%
Related Outpatient Medical Services & Supplies		
➢ Ground or air ambulance transportation, services & disposable supplies	10%[2]	
➢ Blood transfusions, blood processing & the cost of unreplaced blood & blood products	10%[2]	
➢ Autologous blood *(self-donated blood collection, testing, processing & storage for planned surgery)*	10%[2]	

[1] The percentage copay for non-emergency services from non-Anthem Blue Cross PPO providers is based on the scheduled amount.

[2] These providers are not represented in the Anthem Blue Cross PPO network.

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay[1]
Emergency Care		
➢ Emergency room services & supplies *($100 deductible waived if admitted)*	10%	10%
➢ Inpatient hospital services & supplies	10%	10%
➢ Physician services	10%	10%
Mental or Nervous Disorders and Substance Abuse		
Inpatient Care		
➢ Facility-based care *(subject to utilization review; waived for emergency admissions)*	10%	30% *(benefit limited to $600/day)*
➢ Inpatient physician visits	10%	30%
Outpatient Care		
➢ Facility-based care *(subject to utilization review; waived for emergency admissions)*	10%	30% *(benefit limited to $600/day)*
➢ Outpatient physician visits *(Behavioral Health treatment for Autism & Pervasive disorder will be subject to pre-service review)*	$20/visit[2]	30%

[1] The percentage copay for non-emergency services from non-Anthem Blue Cross PPO providers is based on the scheduled amount.

[2] The dollar copay applies only to the visit itself. An additional 10% copay applies for any services performed in office (i.e., X-ray, lab, surgery), after any applicable deductible.

This Summary of Benefits is a brief review of benefits. Once enrolled, members will receive a Combined Evidence of Coverage and Disclosure Form, which explains the exclusions and limitations, as well as the full range of covered services of the plan, in detail.

Classic PPO Exclusions and Limitations

Not Medically Necessary. Services or supplies that are not medically necessary, as defined.

Experimental or Investigative. Any experimental or investigative procedure or medication. But, if member is denied benefits because it is determined that the requested treatment is experimental or investigative, the member may request an independent medical review, as described in the Evidence of Coverage (EOC).

Outside the United States. Services or supplies furnished and billed by a provider outside the United States, unless such services or supplies are furnished in connection with urgent care or an emergency.

Crime or Nuclear Energy. Conditions that result from (1) the member's commission of or attempt to commit a felony, as long as any injuries are not a result of a medical condition or an act of domestic violence; or (2) any release of nuclear energy, whether or not the result of war, when government funds are available for the treatment of illness or injury arising from the release of nuclear energy.

Not Covered. Services received before the member's effective date. Services received after the member's coverage ends, except as specified as covered in the EOC.

Excess Amounts. Any amounts in excess of covered expense or the lifetime maximum.

Work-Related. Work-related conditions if benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation, employer's liability law or occupational disease law, whether or not the member claims those benefits. If there is a dispute of substantial uncertainty as to whether benefits may be recovered for those conditions pursuant to workers' compensation, we will provide the benefits of this plan for such conditions, subject to a right of recovery and reimbursement under California Labor Code Section 4903, as specified as covered in the EOC.

Government Treatment. Any services the member actually received that were provided by a local, state or federal government agency, except when payment under this plan is expressly required by federal or state law. We will not cover payment for these services if the member is not required to pay for them or they are given to the member for free.

Services of Relatives. Professional services received from a person living in the member's home or who is related to the member by blood or marriage, except as specified as covered in the EOC.

Voluntary Payment. Services for which the member has no legal obligation to pay, or for which no charge would be made in the absence of insurance coverage or other health plan coverage, except services received at a non-governmental charitable research hospital. Such a hospital must meet the following guidelines:

1. it must be internationally known as being devoted mainly to medical research;
2. at least 10% of its yearly budget must be spent on research not directly related to patient care;
3. at least one-third of its gross income must come from donations or grants other than gifts or payments for patient care;
4. it must accept patients who are unable to pay; and
5. two-thirds of its patients must have conditions directly related to the hospital's research.

Not Specifically Listed. Services not specifically listed in the plan as covered services.

Private Contracts. Services or supplies provided pursuant to a private contract between the member and a provider, for which reimbursement under Medicare program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act.

Inpatient Diagnostic Tests. Inpatient room and board charges in connection with a hospital stay primarily for diagnostic tests which could have been performed safely on an outpatient basis.

Mental or Nervous Disorders. Academic or educational testing, counseling, and remediation. Mental or nervous disorders or substance abuse, including rehabilitative care in relation to these conditions, except as specified as covered in the EOC.

Orthodontia. Braces, other orthodontic appliances or orthodontic services.

Dental Services or Supplies. Dental plates, bridges, crowns, caps or other dental prostheses, dental implants, dental services, extraction of teeth, treatment to the teeth or gums, or treatment to or for any disorders for the temporomandibular (jaw) joint, except as specified as covered in the EOC. Cosmetic dental surgery or other dental services for beautification.

Hearing Aids or Tests

Optometric Services or Supplies. Optometric services, eye exercises including orthoptics. Routine eye exams and routine eye refractions, as specified as covered in the EOC. Eyeglasses or contact lenses, except as specified as covered in the EOC.

Outpatient Occupational Therapy. Outpatient occupational therapy, except by a home health agency, hospice, or home infusion therapy provider, as specified as covered in the EOC.

Outpatient Speech Therapy. Outpatient speech therapy, except as specified as covered in the EOC.

Cosmetic Surgery. Cosmetic surgery or other services performed solely for beautification or to alter or reshape normal (including aged) structures or tissues of the body to improve appearance. This exclusion does not apply to reconstructive surgery (that is, surgery performed to correct deformities caused by congenital or developmental abnormalities, illness, or injury for the purpose of improving bodily function or symptomatology or to create a normal appearance), including surgery performed to restore symmetry following mastectomy. Cosmetic surgery does not become reconstructive surgery because of psychological or psychiatric reasons.

Commercial Weight Loss Programs. Weight loss programs, whether or not they are pursued under medical or *physician* supervision, unless specifically listed as covered in this *plan*.

This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

This exclusion does not apply to *medically necessary* treatments for morbid obesity or dietary evaluations and counseling, and behavioral modification programs for the treatment of anorexia nervosa or bulimia nervosa. Surgical treatment for morbid obesity is covered as described in the Evidence of Coverage (EOC).

Sterilization Reversal.

Infertility Treatment. Any services or supplies furnished in connection with the diagnosis and treatment of infertility, including, but not limited to diagnostic tests, medication, surgery, artificial insemination, in vitro fertilization, sterilization reversal and gamete intrafallopian transfer.

Surrogate Mother Services. For any services or supplies provided to a person not covered under the plan in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

Orthopedic shoes and shoe inserts. This exclusion does not apply to orthopedic footwear used as an integral part of a brace, shoe inserts that are custom molded to the patient, or therapeutic shoes and inserts designed to treat foot complications due to diabetes, as specifically stated in the EOC.

Air Conditioners. Air purifiers, air conditioners or humidifiers.

Custodial Care or Rest Cures. Inpatient room and board charges in connection with a hospital stay primarily for environmental change or physical therapy. Services provided by a rest home, a home for the aged, a nursing home or any similar facility. Services provided by a skilled nursing facility or custodial care or rest cures, except as specified as covered in the EOC.

Health Club Memberships. Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment or facilities used for developing or maintaining physical fitness, even if ordered by a *physician*. This exclusion also applies to health spas.

Personal Items. Any supplies for comfort, hygiene or beautification.

Education or Counseling. Educational services or nutritional counseling, except as specified as covered in the EOC. This exclusion does not apply to counseling for the treatment of anorexia nervosa or bulimia nervosa.

Food or Dietary Supplements. Nutritional and/or dietary supplements, except as provided in this *plan* or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not requirement either a written prescription or dispensing by a licensed pharmacist.

Telephone and Facsimile Machine Consultations. Consultations provided by telephone or facsimile machine.

Routine Exams or Tests. Routine physical exams or tests which do not directly treat an actual illness, injury or condition, including those required by employment or government authority, except as specified as covered in the EOC.

Acupuncture. Acupuncture treatment, except as specified as covered in the EOC. Acupressure or massage to control pain, treat illness or promote health by applying pressure to one or more specific areas of the body based on dermatomes or acupuncture points.

Eye Surgery for Refractive Defects. Any eye surgery solely or primarily for the purpose of correcting refractive defects of the eye such as nearsightedness (myopia) and/or astigmatism. Contact lenses and eyeglasses required as a result of this surgery.

Physical Therapy or Physical Medicine. Services of a physician for physical therapy or physical medicine, except when provided during a covered inpatient confinement or as specified as covered in the EOC.

Outpatient Prescription Drugs and Medications. Outpatient prescription drugs or medications and insulin, except as specified as covered in the EOC. Any non-prescription, over-the-counter patent or proprietary drug or medicine. Cosmetics, health or beauty aids.

Specialty Pharmacy Drugs. Specialty pharmacy drugs that must be obtained from the specialty pharmacy program, but, which are obtained from a retail pharmacy, are not covered by this plan. **Member will have to pay the full cost of the specialty pharmacy drugs obtained from a retail pharmacy that should have been obtained from the specialty pharmacy program.**

Contraceptive Devices. Contraceptive devices prescribed for birth control except as specified as covered in the EOC.

Diabetic Supplies. Prescription and non-prescription diabetic supplies except as specified as covered in the EOC.

Private Duty Nursing. Inpatient or outpatient services of a private duty nurse.

Lifestyle Programs. Programs to alter one's lifestyle which may include but are not limited to diet, exercise, imagery or nutrition. This exclusion will not apply to cardiac rehabilitation programs approved by us.

Wigs.

Third Party Liability — Anthem Blue Cross is entitled to reimbursement of benefits paid if the member recovers damages from a legally liable third party.

Coordination of Benefits — The benefits of this plan may be reduced if the member has any other group health or dental coverage so that the services received from all group coverages do not exceed 100% of the covered expense.

Anthem Blue Cross

SJVIA PPO 500
Custom PPO 500/35/80/60

Anthem believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that this plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections of the Affordable Care Act apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Anthem at the telephone number printed on the back of your member identification card, or contact your group benefits administrator if you do not have an identification card. For ERISA plans, you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1–866–444–3272 or www.dol.gov/ebsa/healthreform. This Web site has a table summarizing which protections do and do not apply to grandfathered health plans. For nonfederal governmental plans, you may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

In addition to dollar and percentage copays, members are responsible for deductibles, as described below. Please review the deductible information to know if a deductible applies to a specific covered service. Certain Covered Services have maximum visit and/or day limits per year. The number of visits and/or days allowed for these services will begin accumulating on the first visit and/or day, regardless of whether your Deductible has been met. Members are also responsible for all costs over the plan maximums.
Plan maximums and other important information appear in italics. Benefits are subject to all terms, conditions, limitations, and exclusions of the Policy.

Explanation of Maximum Allowed Amount
Maximum Allowed Amount is the total reimbursement payable under the plan for covered services received from Participating and Non-Participating Providers. It is the payment towards the services billed by a provider combined with any applicable deductible, copayment or coinsurance. Participating Providers- The rate the provider has agreed to accept as reimbursement for covered services. Members are not responsible for the difference between the provider's usual charges & the maximum allowed amount. Non-Participating Providers & Other Health Care Providers- (includes those not represented in the PPO provider network)-Reimbursement amount is based on: an Anthem Blue Cross rate or fee schedule, a rate negotiated with the provider, information from a third party vendor, or billed charges. For Medical Emergency care rendered by a Non-Participating Provider or Non-Contracting Hospital, reimbursement may be based on the reasonable and customary value. Members may be responsible for any amount in excess of the reasonable and customary

When using Non-PPO and Other Health Care Providers, members are responsible for any difference between the covered expense & actual charges, as well as any deductible & percentage copay.

Calendar year deductible for all providers	$500/member; $1,000/family
Deductible for non-Anthem Blue Cross PPO hospital or residential treatment center	$250/admission *(waived for emergency admission)*
Deductible for non-Anthem Blue Cross PPO hospital or residential treatment center if utilization review not obtained	$250/admission *(waived for emergency admission)*
Deductible for emergency room services	$100/visit *(waived if admitted directly from ER)*
Annual Out-of-Pocket Maximums (*no cross application*)	
PPO Providers & Other Health Care Providers	$3,000/member/year; $6,000/family/year
Non-PPO Providers	$10,000/member/year; $20,000/family/year
The following do not apply to out-of-pocket maximums: non-covered expense. After a member reaches the out-of-pocket maximum, the member remains responsible for non-PPO providers & other health care providers, costs in excess of the covered expense	
Lifetime Maximum	Unlimited

Covered Services	**PPO: Per Member Copay**	**Non-PPO: Per Member Copay[1]**
Hospital Medical Services *(subject to utilization review for inpatient services; waived for emergency admissions)*		
➢ Semi-private room, meals & special diets, & ancillary services	$250/admission + 20%	40% *(benefit limited to $600/day)*
➢ Outpatient medical care, surgical services & supplies *(hospital care other than emergency room care)*	20%	40% *(benefit limited to $600/day)*
Ambulatory Surgical Centers		
➢ Outpatient surgery, services & supplies	$125/surgery + 20%	40% *(benefit limited to $350/day)*
Skilled Nursing Facility *(subject to utilization review)*		
➢ Semi-private room, services & supplies *(limited to 100 days/calendar year)*	20%	20%
Hospice Care *(subject to utilization review)*		
➢ Inpatient or outpatient services for members with up to one year life expectancy; family bereavement services	No copay[2]	

[1] The percentage copay for non-emergency services from non-Anthem Blue Cross PPO providers is based on the scheduled amount. [2] These providers are not represented in the Anthem Blue Cross PPO network.

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay[1]
Home Health Care *(subject to utilization review)*		
➢ Services & supplies from a home health agency *(limited to combined 100 prior authorized visits/calendar year, one visit by a home health aide equals four hours or less; not covered while member receives hospice care)*	20%	20% with authorization
Home Infusion Therapy *(subject to utilization review)*		
➢ Includes medication, ancillary services & supplies; caregiver training & visits by provider to monitor therapy; durable medical equipment; lab services	20%	20%
Physician Medical Services		
➢ Office & home visits	$35/visit[2] *(deductible waived)*	40%
➢ Hospital & skilled nursing facility visits	20%	40%
➢ Surgeon & surgical assistant; anesthesiologist or anesthetist	20%	40%
➢ Drugs administered by a medical provider (*certain drugs are subject to utilization review)*	20%	40%
Diagnostic X-ray & Lab		
➢ MRI, CT scan, PET scan & nuclear cardiac scan *(subject to utilization review)*	20%	40%
➢ Other diagnostic x-ray & lab	No copay	40%
Preventive Care Services Preventive Care Services including*, physical exams, preventive screenings (including screenings for cancer, HPV, diabetes, cholesterol, blood pressure, hearing and vision immunizations, health education, intervention services, HIV testing), and additional preventive care for women provided for in the guidelines supported by the Health Resources and Services Administration. *This list is not exhaustive. This benefit includes all Preventive Care Services required by federal and state law.	No copay (deductible waived)	40%
Physical Therapy, Physical Medicine & Occupational Therapy	$25/visit *(deductible waived)*	40%
Chiropractic Services *(up to 12 visits/calendar year; additional visits may be approved, if medically necessary)*	$25/visit *(deductible waived)*	40%
Speech Therapy		
➢ Outpatient speech therapy following injury or organic disease	$35/visit *(deductible waived)*	40%
Acupuncture		
➢ Services for the treatment of disease, illness or injury *(limited to 20 visits/calendar year)*	20%[3]	40%[3]
Temporomandibular Joint Disorders		
➢ Splint therapy & surgical treatment	20%	40%
Pregnancy & Maternity Care		
➢ Physician office visits	$35/visit[2] *(deductible waived)*	40%
➢ Prescription drug for elective abortion *(mifepristone)*	20%	Not covered
Normal delivery, cesarean section, complications of pregnancy & abortion		
➢ Inpatient physician services	20%	40%
➢ Hospital & ancillary services	$250/admission + 20%	40% *(benefit limited to $600/day)*
➢ Female Sterilization (*including tubal ligation and counseling/consultation)*	*No copay*	Not covered
➢ Male Sterilization	20%	Not covered
➢ Family Planning counseling	$35/visit *(deductible waived)*	Not covered

[1]The percentage copay for non-emergency services from non-Anthem Blue Cross PPO providers is based on the scheduled amount.

[2]The dollar copay applies only to the visit itself. An additional 20% copay applies for any services performed in office (i.e., X-ray, lab, surgery), after any applicable deductible.

[3]Acupuncture services can be performed by a certified acupuncturist (C.A.), a doctor of medicine (M.D.), a doctor of osteopathy (D.O.), a podiatrist (D.P.M.), or a dentist (D.D.S.).

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay[1]
Organ & Tissue Transplants *(subject to utilization review; specified organ transplants covered only when performed at a Center of Expertise [COE])*		
➢ Inpatient services provided in connection with non-investigative organ or tissue transplants		$250/admission + 20%
➢ Transplant travel expense for an authorized, specified transplant at a *COE* *(recipient & companion transportation limited to 6 trips/episode & $250/person/trip for round-trip coach airfare, hotel limited to 1 room double occupancy & $100/day for 21 days/trip, other expenses limited to $25/day/person for 21 days/trip, donor transportation limited to 1 trip/episode & $250 for round-trip coach airfare, hotel limited to $100/day for 7 days, other expenses limited to $25/day for 7 days)*		No copay *(deductible waived)*
Bariatric Surgery *(subject to utilization review; medically necessary surgery for weight loss, only for morbid obesity, covered only when performed at a Center of Expertise [COE])*		
➢ Inpatient services provided in connection with medically necessary surgery for weight loss, only for morbid obesity		$250/admission + 20%
➢ Bariatric travel expense when member's home is 50 miles or more from the nearest Bariatric *CME* *(member's transportation to & from CME limited to $130/person/trip for 3 trips [pre-surgical visit, initial surgery & one follow-up visit]; one companion's transportation to & from CME limited to $130/person/trip for 2 trips [initial surgery & one follow-up visit]; hotel for member & one companion limited to one room double occupancy & $100/day for 2 days/trip, or as medically necessary, for pre-surgical & follow-up visit; hotel for one companion limited to one room double occupancy & $100/day for duration of member's initial surgery stay for 4 days; other reasonable expenses limited to $25/day/person for 4 days/trip)*		No copay *(deductible waived)*
Diabetes Education Programs *(requires physician supervision)*		
➢ Teach members & their families about the disease process, the daily management of diabetic therapy & self-management training	$35/visit *(deductible waived)*	40%
Prosthetic Devices		
➢ Coverage for breast prostheses; prosthetic devices to restore a method of speaking; surgical implants; artificial limbs or eyes; the first pair of contact lenses or eyeglasses when required as a result of eye surgery; & therapeutic shoes & inserts	20%	40%
Durable Medical Equipment		
➢ Rental or purchase of DME including , dialysis equipment & supplies, home medical equipment, prosthetic/orthotics *(hearing aids benefit available for one hearing aid per ear every three years; breast pump and supplies are covered under preventive care at no charge for in-network)*	20%	20%
Related Outpatient Medical Services & Supplies		
➢ Ground or air ambulance transportation, services & disposable supplies		20%[2]
➢ Blood transfusions, blood processing & the cost of unreplaced blood & blood products		20%[2]
➢ Autologous blood *(self-donated blood collection, testing, processing & storage for planned surgery)*		20%[2]

[1] The percentage copay for non-emergency services from non-Anthem Blue Cross PPO providers is based on the scheduled amount.

[2] These providers are not represented in the Anthem Blue Cross PPO network.

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay[1]
Emergency Care		
➢ Emergency room services & supplies *($100 deductible waived if admitted)*	20%	20%
➢ Inpatient hospital services & supplies	$250/admission + 20%	$250/admission + 20%
➢ Physician services	20%	20%
Mental or Nervous Disorders and Substance Abuse		
Inpatient Care		
➢ Facility-based care *(subject to utilization review; waived for emergency admissions)*	$250/admission + 20%	40% *(benefit limited to $600/day)*
➢ Inpatient physician visits	20%	40%
Outpatient Care		
➢ Facility-based care *(subject to utilization review; waived for emergency admissions)*	20%	40% *(benefit limited to $600/day)*
➢ Outpatient physician visits *(Behavioral Health treatment for Autism & Pervasive Disorder will be subject to pre-service review)*	$35/visit[3] *(deductible waived)*	40%

[1] The percentage copay for non-emergency services from non-Anthem Blue Cross PPO providers is based on the scheduled amount.

[3] The dollar copay applies only to the visit itself. An additional 20% copay applies for any services performed in office (i.e., X-ray, lab, surgery), after any applicable deductible.

This Summary of Benefits is a brief review of benefits. Once enrolled, members will receive a Combined Evidence of Coverage and Disclosure Form, which explains the exclusions and limitations, as well as the full range of covered services of the plan, in detail.

Classic PPO Plan Exclusions and Limitations

Not Medically Necessary. Services or supplies that are not medically necessary, as defined.

Experimental or Investigative. Any experimental or investigative procedure or medication. But, if member is denied benefits because it is determined that the requested treatment is experimental or investigative, the member may request an independent medical review, as described in the Evidence of Coverage (EOC).

Outside the United States. Services or supplies furnished and billed by a provider outside the United States, unless such services or supplies are furnished in connection with urgent care or an emergency.

Crime or Nuclear Energy. Conditions that result from (1) the member's commission of or attempt to commit a felony, as long as any injuries are not a result of a medical condition or an act of domestic violence; or (2) any release of nuclear energy, whether or not the result of war, when government funds are available for the treatment of illness or injury arising from the release of nuclear energy.

Not Covered. Services received before the member's effective date. Services received after the member's coverage ends, except as specified as covered in the EOC.

Excess Amounts. Any amounts in excess of covered expense or the lifetime maximum.

Work-Related. Work-related conditions if benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation, employer's liability law or occupational disease law, whether or not the member claims those benefits. If there is a dispute of substantial uncertainty as to whether benefits may be recovered for those conditions pursuant to workers' compensation, we will provide the benefits of this plan for such conditions, subject to a right of recovery and reimbursement under California Labor Code Section 4903, as specified as covered in the EOC.

Government Treatment. Any services the member actually received that were provided by a local, state or federal government agency, except when payment under this plan is expressly required by federal or state law. We will not cover payment for these services if the member is not required to pay for them or they are given to the member for free.

Services of Relatives. Professional services received from a person living in the member's home or who is related to the member by blood or marriage, except as specified as covered in the EOC.

Voluntary Payment. Services for which the member has no legal obligation to pay, or for which no charge would be made in the absence of insurance coverage or other health plan coverage, except services received at a non-governmental charitable research hospital. Such a hospital must meet the following guidelines:

1. it must be internationally known as being devoted mainly to medical research;
2. at least 10% of its yearly budget must be spent on research not directly related to patient care;
3. at least one-third of its gross income must come from donations or grants other than gifts or payments for patient care;
4. it must accept patients who are unable to pay; and
5. two-thirds of its patients must have conditions directly related to the hospital's research.

Not Specifically Listed. Services not specifically listed in the plan as covered services.

Private Contracts. Services or supplies provided pursuant to a private contract between the member and a provider, for which reimbursement under Medicare program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act.

Inpatient Diagnostic Tests. Inpatient room and board charges in connection with a hospital stay primarily for diagnostic tests which could have been performed safely on an outpatient basis.

Mental or Nervous Disorders. Academic or educational testing, counseling, and remediation. Mental or nervous disorders or substance abuse, including rehabilitative care in relation to these conditions, except as specified as covered in the EOC.

Orthodontia. Braces, other orthodontic appliances or orthodontic services.

Dental Services or Supplies. Dental plates, bridges, crowns, caps or other dental prostheses, dental implants, dental services, extraction of teeth, treatment to the teeth or gums, or treatment to or for any disorders for the temporomandibular (jaw) joint, except as specified as covered in the EOC. Cosmetic dental surgery or other dental services for beautification.

Hearing Aids or Tests

Optometric Services or Supplies. Optometric services, eye exercises including orthoptics. Routine eye exams and routine eye refractions, as specified as covered in the EOC. Eyeglasses or contact lenses, except as specified as covered in the EOC.

Outpatient Occupational Therapy. Outpatient occupational therapy, except by a home health agency, hospice, or home infusion therapy provider, as specified as covered in the EOC.

Outpatient Speech Therapy. Outpatient speech therapy, except as specified as covered in the EOC.

Cosmetic Surgery. Cosmetic surgery or other services performed solely for beautification or to alter or reshape normal (including aged) structures or tissues of the body to improve appearance. This exclusion does not apply to reconstructive surgery (that is, surgery performed to correct deformities caused by congenital or developmental abnormalities, illness, or injury for the purpose of improving bodily function or symptomatology or to create a normal appearance), including surgery performed to restore symmetry following mastectomy. Cosmetic surgery does not become reconstructive surgery because of psychological or psychiatric reasons.

Commercial Weight Loss Programs. Weight loss programs, whether or not they are pursued under medical or *physician* supervision, unless specifically listed as covered in this *plan*.

This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

This exclusion does not apply to *medically necessary* treatments for morbid obesity or dietary evaluations and counseling, and behavioral modification programs for the treatment of anorexia nervosa or bulimia nervosa. Surgical treatment for morbid obesity is covered as described in the Evidence of Coverage (EOC).

Sterilization Reversal.

Infertility Treatment. Any services or supplies furnished in connection with the diagnosis and treatment of infertility, including, but not limited to diagnostic tests, medication, surgery, artificial insemination, in vitro fertilization, sterilization reversal and gamete intrafallopian transfer.

Surrogate Mother Services. For any services or supplies provided to a person not covered under the plan in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

Orthopedic shoes and shoe inserts. This exclusion does not apply to orthopedic footwear used as an integral part of a brace, shoe inserts that are custom molded to the patient, or therapeutic shoes and inserts designed to treat foot complications due to diabetes, as specifically stated in the EOC.

Air Conditioners. Air purifiers, air conditioners or humidifiers.

Custodial Care or Rest Cures. Inpatient room and board charges in connection with a hospital stay primarily for environmental change or physical therapy. Services provided by a rest home, a home for the aged, a nursing home or any similar facility. Services provided by a skilled nursing facility or custodial care or rest cures, except as specified as covered in the EOC.

Health Club Memberships. Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment or facilities used for developing or maintaining physical fitness, even if ordered by a *physician*. This exclusion also applies to health spas.

Personal Items. Any supplies for comfort, hygiene or beautification.

Education or Counseling. Educational services or nutritional counseling, except as specified as covered in the EOC. This exclusion does not apply to counseling for the treatment of anorexia nervosa or bulimia nervosa.

Food or Dietary Supplements. Nutritional and/or dietary supplements, except as provided in this *plan* or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not requirement either a written prescription or dispensing by a licensed pharmacist.

Telephone and Facsimile Machine Consultations. Consultations provided by telephone or facsimile machine.

Routine Exams or Tests. Routine physical exams or tests which do not directly treat an actual illness, injury or condition, including those required by employment or government authority, except as specified as covered in the EOC.

Acupuncture. Acupuncture treatment, except as specified as covered in the EOC. Acupressure or massage to control pain, treat illness or promote health by applying pressure to one or more specific areas of the body based on dermatomes or acupuncture points.

Eye Surgery for Refractive Defects. Any eye surgery solely or primarily for the purpose of correcting refractive defects of the eye such as nearsightedness (myopia) and/or astigmatism. Contact lenses and eyeglasses required as a result of this surgery.

Physical Therapy or Physical Medicine. Services of a physician for physical therapy or physical medicine, except when provided during a covered inpatient confinement or as specified as covered in the EOC.

Outpatient Prescription Drugs and Medications. Outpatient prescription drugs or medications and insulin, except as specified as covered in the EOC. Any non-prescription, over-the-counter patent or proprietary drug or medicine. Cosmetics, health or beauty aids.

Specialty Pharmacy Drugs. Specialty pharmacy drugs that must be obtained from the specialty pharmacy program, but, which are obtained from a retail pharmacy, are not covered by this plan. **Member will have to pay the full cost of the specialty pharmacy drugs obtained from a retail pharmacy that should have been obtained from the specialty pharmacy program.**

Contraceptive Devices. Contraceptive devices prescribed for birth control except as specified as covered in the EOC.

Diabetic Supplies. Prescription and non-prescription diabetic supplies except as specified as covered in the EOC.

Private Duty Nursing. Inpatient or outpatient services of a private duty nurse.

Lifestyle Programs. Programs to alter one's lifestyle which may include but are not limited to diet, exercise, imagery or nutrition. This exclusion will not apply to cardiac rehabilitation programs approved by us.

Wigs.

Third Party Liability — Anthem Blue Cross is entitled to reimbursement of benefits paid if the member recovers damages from a legally liable third party.

Coordination of Benefits — The benefits of this plan may be reduced if the member has any other group health or dental coverage so that the services received from all group coverages do not exceed 100% of the covered expense.

SJVIA PPO 500 BlueCard
Custom PPO 500/35/80/60

Anthem believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that this plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections of the Affordable Care Act apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Anthem at the telephone number printed on the back of your member identification card, or contact your group benefits administrator if you do not have an identification card. For ERISA plans, you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1–866–444–3272 or www.dol.gov/ebsa/healthreform. This Web site has a table summarizing which protections do and do not apply to grandfathered health plans. For nonfederal governmental plans, you may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

In addition to dollar and percentage copays, members are responsible for deductibles, as described below. Please review the deductible information to know if a deductible applies to a specific covered service. Certain Covered Services have maximum visit and/or day limits per year. The number of visits and/or days allowed for these services will begin accumulating on the first visit and/or day, regardless of whether your Deductible has been met. Members are also responsible for all costs over the plan maximums.
Plan maximums and other important information appear in italics. Benefits are subject to all terms, conditions, limitations, and exclusions of the Policy.

Explanation of Maximum Allowed Amount
Maximum Allowed Amount is the total reimbursement payable under the plan for covered services received from Participating and Non-Participating Providers. It is the payment towards the services billed by a provider combined with any applicable deductible, copayment or coinsurance. Participating Providers- The rate the provider has agreed to accept as reimbursement for covered services. Members are not responsible for the difference between the provider's usual charges & the maximum allowed amount. Non-Participating Providers & Other Health Care Providers- (includes those not represented in the PPO provider network)-Reimbursement amount is based on: an Anthem Blue Cross rate or fee schedule, a rate negotiated with the provider, information from a third party vendor, or billed charges. For Medical Emergency care rendered by a Non-Participating Provider or Non-Contracting Hospital, reimbursement may be based on the reasonable and customary value. Members may be responsible for any amount in excess of the reasonable and customary

When using Non-PPO and Other Health Care Providers, members are responsible for any difference between the covered expense & actual charges, as well as any deductible & percentage copay.

Calendar year deductible for all providers	$500/member; $1,000/family
Deductible for non-Anthem Blue Cross PPO hospital or residential treatment center	$250/admission *(waived for emergency admission)*
Deductible for non-Anthem Blue Cross PPO hospital or residential treatment center if utilization review not obtained	$250/admission *(waived for emergency admission)*
Deductible for emergency room services	$100/visit *(waived if admitted directly from ER)*
Annual Out-of-Pocket Maximums (*no cross application*)	
PPO Providers & Other Health Care Providers	$3,000/member/year; $6,000/family/year
Non-PPO Providers	$10,000/member/year; $20,000/family/year
The following do not apply to out-of-pocket maximums: non-covered expense. After a member reaches the out-of-pocket maximum, the member remains responsible for non-PPO providers & other health care providers, costs in excess of the covered expense	
Lifetime Maximum	Unlimited

Covered Services	**PPO: Per Member Copay**	**Non-PPO: Per Member Copay[1]**
Hospital Medical Services *(subject to utilization review for inpatient services; waived for emergency admissions)*		
➢ Semi-private room, meals & special diets, & ancillary services	$250/admission + 20%	40% *(benefit limited to $600/day)*
➢ Outpatient medical care, surgical services & supplies *(hospital care other than emergency room care)*	20%	40% *(benefit limited to $600/day)*
Ambulatory Surgical Centers		
➢ Outpatient surgery, services & supplies	$125/surgery + 20%	40% *(benefit limited to $350/day)*
Skilled Nursing Facility *(subject to utilization review)*		
➢ Semi-private room, services & supplies *(limited to 100 days/calendar year)*	20%	20%
Hospice Care *(subject to utilization review)*		
➢ Inpatient or outpatient services for members with up to one year life expectancy; family bereavement services	No copay[2]	

[1] The percentage copay for non-emergency services from non-Anthem Blue Cross PPO providers is based on the scheduled amount. [2] These providers are not represented in the Anthem Blue Cross PPO network.

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay[1]
Home Health Care *(subject to utilization review)*		
➢ Services & supplies from a home health agency *(limited to combined 100 prior authorized visits/calendar year, one visit by a home health aide equals four hours or less; not covered while member receives hospice care)*	20%	20% with authorization
Home Infusion Therapy *(subject to utilization review)*		
➢ Includes medication, ancillary services & supplies; caregiver training & visits by provider to monitor therapy; durable medical equipment; lab services	20%	20%
Physician Medical Services		
➢ Office & home visits	$35/visit[2] *(deductible waived)*	40%
➢ Hospital & skilled nursing facility visits	20%	40%
➢ Surgeon & surgical assistant; anesthesiologist or anesthetist	20%	40%
➢ Drugs administered by a medical provider (*certain drugs are subject to utilization review)*	20%	40%
Diagnostic X-ray & Lab		
➢ MRI, CT scan, PET scan & nuclear cardiac scan *(subject to utilization review)*	20%	40%
➢ Other diagnostic x-ray & lab	No copay	40%
Preventive Care Services Preventive Care Services including*, physical exams, preventive screenings (including screenings for cancer, HPV, diabetes, cholesterol, blood pressure, hearing and vision immunizations, health education, intervention services, HIV testing), and additional preventive care for women provided for in the guidelines supported by the Health Resources and Services Administration. *This list is not exhaustive. This benefit includes all Preventive Care Services required by federal and state law.	No copay (deductible waived)	40%
Physical Therapy, Physical Medicine & Occupational Therapy	$25/visit *(deductible waived)*	40%
Chiropractic Services *(up to 12 visits/calendar year; additional visits may be approved, if medically necessary)*	$25/visit *(deductible waived)*	40%
Speech Therapy		
➢ Outpatient speech therapy following injury or organic disease	$35/visit *(deductible waived)*	40%
Acupuncture		
➢ Services for the treatment of disease, illness or injury *(limited to 20 visits/calendar year)*	20%[3]	40%[3]
Temporomandibular Joint Disorders		
➢ Splint therapy & surgical treatment	20%	40%
Pregnancy & Maternity Care		
➢ Physician office visits	$35/visit[2] *(deductible waived)*	40%
➢ Prescription drug for elective abortion *(mifepristone)*	20%	Not covered
Normal delivery, cesarean section, complications of pregnancy & abortion		
➢ Inpatient physician services	20%	40%
➢ Hospital & ancillary services	$250/admission + 20%	40% *(benefit limited to $600/day)*
➢ Female Sterilization (*including tubal ligation and counseling/consultation)*	*No copay*	Not covered
➢ Male Sterilization	20%	Not covered
➢ Family Planning counseling	$35/visit *(deductible waived)*	Not covered

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[2]The dollar copay applies only to the visit itself. An additional 20% copay applies for any services performed in office (i.e., X-ray, lab, surgery), after any applicable deductible.

[3]Acupuncture services can be performed by a certified acupuncturist (C.A.), a doctor of medicine (M.D.), a doctor of osteopathy (D.O.), a podiatrist (D.P.M.), or a dentist (D.D.S.).

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay[1]
Organ & Tissue Transplants *(subject to utilization review; specified organ transplants covered only when performed at a Center of Expertise [COE])*		
➢ Inpatient services provided in connection with non-investigative organ or tissue transplants		$250/admission + 20%
➢ Transplant travel expense for an authorized, specified transplant at a *COE* *(recipient & companion transportation limited to 6 trips/episode & $250/person/trip for round-trip coach airfare, hotel limited to 1 room double occupancy & $100/day for 21 days/trip, other expenses limited to $25/day/person for 21 days/trip, donor transportation limited to 1 trip/episode & $250 for round-trip coach airfare, hotel limited to $100/day for 7 days, other expenses limited to $25/day for 7 days)*		No copay *(deductible waived)*
Bariatric Surgery *(subject to utilization review; medically necessary surgery for weight loss, only for morbid obesity, covered only when performed at a Center of Expertise [COE])*		
➢ Inpatient services provided in connection with medically necessary surgery for weight loss, only for morbid obesity		$250/admission + 20%
➢ Bariatric travel expense when member's home is 50 miles or more from the nearest Bariatric *CME* *(member's transportation to & from CME limited to $130/person/trip for 3 trips [pre-surgical visit, initial surgery & one follow-up visit]; one companion's transportation to & from CME limited to $130/person/trip for 2 trips [initial surgery & one follow-up visit]; hotel for member & one companion limited to one room double occupancy & $100/day for 2 days/trip, or as medically necessary, for pre-surgical & follow-up visit; hotel for one companion limited to one room double occupancy & $100/day for duration of member's initial surgery stay for 4 days; other reasonable expenses limited to $25/day/person for 4 days/trip)*		No copay *(deductible waived)*
Diabetes Education Programs *(requires physician supervision)*		
➢ Teach members & their families about the disease process, the daily management of diabetic therapy & self-management training	$35/visit *(deductible waived)*	40%
Prosthetic Devices		
➢ Coverage for breast prostheses; prosthetic devices to restore a method of speaking; surgical implants; artificial limbs or eyes; the first pair of contact lenses or eyeglasses when required as a result of eye surgery; & therapeutic shoes & inserts	20%	40%
Durable Medical Equipment		
➢ Rental or purchase of DME including , dialysis equipment & supplies, home medical equipment, prosthetic/orthotics *(hearing aids benefit available for one hearing aid per ear every three years; breast pump and supplies are covered under preventive care at no charge for in-network)*	20%	20%
Related Outpatient Medical Services & Supplies		
➢ Ground or air ambulance transportation, services & disposable supplies		20%[2]
➢ Blood transfusions, blood processing & the cost of unreplaced blood & blood products		20%[2]
➢ Autologous blood *(self-donated blood collection, testing, processing & storage for planned surgery)*		20%[2]

[1] The percentage copay for non-emergency services from non-Anthem Blue Cross PPO providers is based on the scheduled amount.

[2] These providers are not represented in the Anthem Blue Cross PPO network.

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay[1]
Emergency Care		
➢ Emergency room services & supplies *($100 deductible waived if admitted)*	20%	20%
➢ Inpatient hospital services & supplies	$250/admission + 20%	$250/admission + 20%
➢ Physician services	20%	20%
Mental or Nervous Disorders and Substance Abuse		
Inpatient Care		
➢ Facility-based care *(subject to utilization review; waived for emergency admissions)*	$250/admission + 20%	40% *(benefit limited to $600/day)*
➢ Inpatient physician visits	20%	40%
Outpatient Care		
➢ Facility-based care *(subject to utilization review; waived for emergency admissions)*	20%	40% *(benefit limited to $600/day)*
➢ Outpatient physician visits *(Behavioral Health treatment for Autism & Pervasive Disorder will be subject to pre-service review)*	$35/visit[3] *(deductible waived)*	40%

[1] The percentage copay for non-emergency services from non-Anthem Blue Cross PPO providers is based on the scheduled amount.

[3] The dollar copay applies only to the visit itself. An additional 20% copay applies for any services performed in office (i.e., X-ray, lab, surgery), after any applicable deductible.

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Outside the United States. Services or supplies furnished and billed by a provider outside the United States, unless such services or supplies are furnished in connection with urgent care or an emergency.

Crime or Nuclear Energy. Conditions that result from (1) the member's commission of or attempt to commit a felony, as long as any injuries are not a result of a medical condition or an act of domestic violence; or (2) any release of nuclear energy, whether or not the result of war, when government funds are available for the treatment of illness or injury arising from the release of nuclear energy.

Not Covered. Services received before the member's effective date. Services received after the member's coverage ends, except as specified as covered in the EOC.

Excess Amounts. Any amounts in excess of covered expense or the lifetime maximum.

Work-Related. Work-related conditions if benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation, employer's liability law or occupational disease law, whether or not the member claims those benefits. If there is a dispute of substantial uncertainty as to whether benefits may be recovered for those conditions pursuant to workers' compensation, we will provide the benefits of this plan for such conditions, subject to a right of recovery and reimbursement under California Labor Code Section 4903, as specified as covered in the EOC.

Government Treatment. Any services the member actually received that were provided by a local, state or federal government agency, except when payment under this plan is expressly required by federal or state law. We will not cover payment for these services if the member is not required to pay for them or they are given to the member for free.

Services of Relatives. Professional services received from a person living in the member's home or who is related to the member by blood or marriage, except as specified as covered in the EOC.

Voluntary Payment. Services for which the member has no legal obligation to pay, or for which no charge would be made in the absence of insurance coverage or other health plan coverage, except services received at a non-governmental charitable research hospital. Such a hospital must meet the following guidelines:

1. it must be internationally known as being devoted mainly to medical research;
2. at least 10% of its yearly budget must be spent on research not directly related to patient care;
3. at least one-third of its gross income must come from donations or grants other than gifts or payments for patient care;
4. it must accept patients who are unable to pay; and
5. two-thirds of its patients must have conditions directly related to the hospital's research.

Not Specifically Listed. Services not specifically listed in the plan as covered services.

Private Contracts. Services or supplies provided pursuant to a private contract between the member and a provider, for which reimbursement under Medicare program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act.

Inpatient Diagnostic Tests. Inpatient room and board charges in connection with a hospital stay primarily for diagnostic tests which could have been performed safely on an outpatient basis.

Mental or Nervous Disorders. Academic or educational testing, counseling, and remediation. Mental or nervous disorders or substance abuse, including rehabilitative care in relation to these conditions, except as specified as covered in the EOC.

Orthodontia. Braces, other orthodontic appliances or orthodontic services.

Dental Services or Supplies. Dental plates, bridges, crowns, caps or other dental prostheses, dental implants, dental services, extraction of teeth, treatment to the teeth or gums, or treatment to or for any disorders for the temporomandibular (jaw) joint, except as specified as covered in the EOC. Cosmetic dental surgery or other dental services for beautification.

Hearing Aids or Tests

Optometric Services or Supplies. Optometric services, eye exercises including orthoptics. Routine eye exams and routine eye refractions, as specified as covered in the EOC. Eyeglasses or contact lenses, except as specified as covered in the EOC.

Outpatient Occupational Therapy. Outpatient occupational therapy, except by a home health agency, hospice, or home infusion therapy provider, as specified as covered in the EOC.

Outpatient Speech Therapy. Outpatient speech therapy, except as specified as covered in the EOC.

Cosmetic Surgery. Cosmetic surgery or other services performed solely for beautification or to alter or reshape normal (including aged) structures or tissues of the body to improve appearance. This exclusion does not apply to reconstructive surgery (that is, surgery performed to correct deformities caused by congenital or developmental abnormalities, illness, or injury for the purpose of improving bodily function or symptomatology or to create a normal appearance), including surgery performed to restore symmetry following mastectomy. Cosmetic surgery does not become reconstructive surgery because of psychological or psychiatric reasons.

Commercial Weight Loss Programs. Weight loss programs, whether or not they are pursued under medical or *physician* supervision, unless specifically listed as covered in this *plan*.

This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

This exclusion does not apply to *medically necessary* treatments for morbid obesity or dietary evaluations and counseling, and behavioral modification programs for the treatment of anorexia nervosa or bulimia nervosa. Surgical treatment for morbid obesity is covered as described in the Evidence of Coverage (EOC).

Sterilization Reversal.

Infertility Treatment. Any services or supplies furnished in connection with the diagnosis and treatment of infertility, including, but not limited to diagnostic tests, medication, surgery, artificial insemination, in vitro fertilization, sterilization reversal and gamete intrafallopian transfer.

Surrogate Mother Services. For any services or supplies provided to a person not covered under the plan in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

Orthopedic shoes and shoe inserts. This exclusion does not apply to orthopedic footwear used as an integral part of a brace, shoe inserts that are custom molded to the patient, or therapeutic shoes and inserts designed to treat foot complications due to diabetes, as specifically stated in the EOC.

Air Conditioners. Air purifiers, air conditioners or humidifiers.

Custodial Care or Rest Cures. Inpatient room and board charges in connection with a hospital stay primarily for environmental change or physical therapy. Services provided by a rest home, a home for the aged, a nursing home or any similar facility. Services provided by a skilled nursing facility or custodial care or rest cures, except as specified as covered in the EOC.

Health Club Memberships. Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment or facilities used for developing or maintaining physical fitness, even if ordered by a *physician*. This exclusion also applies to health spas.

Personal Items. Any supplies for comfort, hygiene or beautification.

Education or Counseling. Educational services or nutritional counseling, except as specified as covered in the EOC. This exclusion does not apply to counseling for the treatment of anorexia nervosa or bulimia nervosa.

Food or Dietary Supplements. Nutritional and/or dietary supplements, except as provided in this *plan* or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not requirement either a written prescription or dispensing by a licensed pharmacist.

Telephone and Facsimile Machine Consultations. Consultations provided by telephone or facsimile machine.

Routine Exams or Tests. Routine physical exams or tests which do not directly treat an actual illness, injury or condition, including those required by employment or government authority, except as specified as covered in the EOC.

Acupuncture. Acupuncture treatment, except as specified as covered in the EOC. Acupressure or massage to control pain, treat illness or promote health by applying pressure to one or more specific areas of the body based on dermatomes or acupuncture points.

Eye Surgery for Refractive Defects. Any eye surgery solely or primarily for the purpose of correcting refractive defects of the eye such as nearsightedness (myopia) and/or astigmatism. Contact lenses and eyeglasses required as a result of this surgery.

Physical Therapy or Physical Medicine. Services of a physician for physical therapy or physical medicine, except when provided during a covered inpatient confinement or as specified as covered in the EOC.

Outpatient Prescription Drugs and Medications. Outpatient prescription drugs or medications and insulin, except as specified as covered in the EOC. Any non-prescription, over-the-counter patent or proprietary drug or medicine. Cosmetics, health or beauty aids.

Specialty Pharmacy Drugs. Specialty pharmacy drugs that must be obtained from the specialty pharmacy program, but, which are obtained from a retail pharmacy, are not covered by this plan. **Member will have to pay the full cost of the specialty pharmacy drugs obtained from a retail pharmacy that should have been obtained from the specialty pharmacy program.**

Contraceptive Devices. Contraceptive devices prescribed for birth control except as specified as covered in the EOC.

Diabetic Supplies. Prescription and non-prescription diabetic supplies except as specified as covered in the EOC.

Private Duty Nursing. Inpatient or outpatient services of a private duty nurse.

Lifestyle Programs. Programs to alter one's lifestyle which may include but are not limited to diet, exercise, imagery or nutrition. This exclusion will not apply to cardiac rehabilitation programs approved by us.

Wigs.

Third Party Liability — Anthem Blue Cross is entitled to reimbursement of benefits paid if the member recovers damages from a legally liable third party.

Coordination of Benefits — The benefits of this plan may be reduced if the member has any other group health or dental coverage so that the services received from all group coverages do not exceed 100% of the covered expense.

SJVIA PPO 1000 Custom Classic PPO (1000/45/80/50)

Anthem believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that this plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections of the Affordable Care Act apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Anthem at the telephone number printed on the back of your member identification card, or contact your group benefits administrator if you do not have an identification card. For ERISA plans, you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1–866–444–3272 or www.dol.gov/ebsa/healthreform. This Web site has a table summarizing which protections do and do not apply to grandfathered health plans. For nonfederal governmental plans, you may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

In addition to dollar and percentage copays, members are responsible for deductibles, as described below. Please review the deductible information to know if a deductible applies to a specific covered service. Certain Covered Services have maximum visit and/or day limits per year. The number of visits and/or days allowed for these services will begin accumulating on the first visit and/or day, regardless of whether your Deductible has been met. Members are also responsible for all costs over the plan maximums.

Plan maximums and other important information appear in italics. Benefits are subject to all terms, conditions, limitations, and exclusions of the Policy.

Explanation of Maximum Allowed Amount

Maximum Allowed Amount is the total reimbursement payable under the plan for covered services received from Participating and Non-Participating Providers. It is the payment towards the services billed by a provider combined with any applicable deductible, copayment or coinsurance.

Participating Providers- The rate the provider has agreed to accept as reimbursement for covered services. Members are not responsible for the difference between the provider's usual charges & the maximum allowed amount.

Non-Participating Providers & Other Health Care Providers-(includes those not represented in the PPO provider network)-Reimbursement amount is based on: an Anthem Blue Cross rate or fee schedule, a rate negotiated with the provider, information from a third party vendor, or billed charges. For Medical Emergency care rendered by a Non-Participating Provider or Non-Contracting Hospital, reimbursement may be based on the reasonable and customary value. Members may be responsible for any amount in excess of the reasonable and customary value

When using Non-PPO and Other Health Care Providers, members are responsible for any difference between the covered expense & actual charges, as well as any deductible & percentage copay.

Calendar year deductible for all providers	$1,000/member; $2,000/family	
Deductible for non-Anthem Blue Cross PPO hospital or residential treatment center	None	
Deductible for non-Anthem Blue Cross PPO hospital or residential treatment center if utilization review not obtained	$250/admission *(waived for emergency admission)*	
Deductible for emergency room services	$100/visit *(waived if admitted directly from ER)*	
Annual Out-of-Pocket Maximums ***(no cross application)***		
PPO Providers & Other Health Care Providers	$4,000/member/year; $8,000/family/year	
Non-PPO Providers	$10,000/member/year; $20,000/family/year	
The following do not apply to out-of-pocket maximums: non-covered expense. After a member reaches the out-of-pocket maximum, the member remains responsible for non-PPO providers & other health care providers, costs in excess of the covered expense.		
Lifetime Maximum	Unlimited	
Covered Services	**PPO: Per Member Copay**	**Non-PPO: Per Member Copay[1]**
Hospital Medical Services ***(subject to utilization review*** *for inpatient services; waived for emergency admissions)*		
➢ Semi-private room, meals & special diets, & ancillary services	$1,000/year[2] + 20%	50% *(benefit limited to $600/day)*
➢ Outpatient medical care, surgical services & supplies *(hospital care other than emergency room care)*	20%	50% *(benefit limited to $600/day)*
Ambulatory Surgical Centers		
➢ Outpatient surgery, services & supplies	$250/surgery + 20%	50% *(benefit limited to $350/visit)*
Skilled Nursing Facility *(subject to utilization review)*		
➢ Semi-private room, services & supplies *(limited to 100 days/calendar year)*	20%	20%
Hospice Care *(subject to utilization review)*		
➢ Inpatient or outpatient services; for members with up to one year life expectancy; family Bereavement services	No copay	

[1] The percentage copay for non-emergency services from non-Anthem Blue Cross PPO providers is based on the scheduled amount.

[2] Applicable to the Annual Out-of-Pocket maximums.

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay[1]
Home Health Care *(subject to utilization review)*		
➢ Services & supplies from a home health agency *(limited to 100 prior authorized visits/calendar year, one visit by a home health aide equals four hours or less; not covered while member receives hospice care)*	20%	20% with authorization
Home Infusion Therapy *(subject to utilization review)*		
➢ Includes medication, ancillary services & supplies;) caregiver training & visits by provider to monitor therapy; durable medical equipment; lab services	20%	20%
Physician Medical Services		
➢ Office & home visits	$45/visit[2] *(deductible waived)*	50%
➢ Hospital & skilled nursing facility visits	20%	50%
➢ Surgeon & surgical assistant; anesthesiologist or anesthetist	20%	50%
➢ Drugs administered by a medical provider (*certain drugs are subject to utilization review)*	20%	50%
Diagnostic X-ray & Lab		
➢ MRI, CT scan, PET scan & nuclear cardiac scan *(subject to utilization review)*	20%	50%
➢ Other diagnostic x-ray & lab	No copay	50%
Preventive Care Services Preventive Care Services including*, physical exams, preventive screenings (including screenings for cancer, HPV, diabetes, cholesterol, blood pressure, hearing and vision immunizations, health education, intervention services, HIV testing), and additional preventive care for women provided for in the guidelines supported by the Health Resources and Services Administration. *This list is not exhaustive. This benefit includes all Preventive Care Services required by federal and state law.	No copay (*deductible waived)*	50%
Physical Therapy, Physical Medicine & Occupational Therapy	$25/visit *(deductible waived)*	50%
Chiropractic Services *(up to 12 visits/calendar year; additional visits may be approved, if medically necessary)*	$25/visit *(deductible waived)*	50%
Speech Therapy		
➢ Outpatient speech therapy following injury or organic disease	$45/visit *(deductible waived)*	50%
Acupuncture		
➢ Services for the treatment of disease, illness or injury *(limited to 20 visits/calendar year)*	20%[3]	50%[3]
Temporomandibular Joint Disorders		
➢ Splint therapy & surgical treatment	20%	50%
Pregnancy & Maternity Care		
➢ Physician office visits	$45/visit[2] *(deductible waived)*	50%
➢ Prescription drug for elective abortion *(mifepristone)*	20%	Not covered
Normal delivery, cesarean section, complications of pregnancy & abortion		
➢ Inpatient physician services	20%	50%
➢ Hospital & ancillary services	$1,000/year[4] + 20%	50% *(benefit limited to $600/day)*
➢ Female Sterilization(*including tubal ligation and counseling/consultation)*	No copay	Not covered
➢ Male Sterilization	20%	Not Covered
➢ Family planning counseling	$45/visit *(deductible waived)*	Not covered

[1]The percentage copay for non-emergency services from non-Anthem Blue Cross PPO providers is based on the scheduled amount.

[2]The dollar copay applies only to the visit itself. An additional 20% copay applies for any services performed in office (i.e., X-ray, lab, surgery), after any applicable deductible.

[3]Acupuncture services can be performed by a certified acupuncturist (C.A.), a doctor of medicine (M.D.), a doctor of osteopathy (D.O.), a podiatrist (D.P.M.), or a dentist (D.D.S.).

[4] Applicable to the Annual Out-of-Pocket maximums

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay[1]
Organ & Tissue Transplants *(subject to utilization review; specified organ transplants covered only when performed at a Center of Expertise [COE])*		
➢ Inpatient services provided in connection with non-investigative organ or tissue transplants	$1,000/year[3] + 20%	
➢ Transplant travel expense for an authorized, specified transplant at a *COE* *(recipient & companion transportation limited to 6 trips/episode & $250/person/trip for round-trip coach airfare, hotel limited to 1 room double occupancy & $100/day for 21 days/trip, other expenses limited to $25/day/person for 21 days/trip, donor transportation limited to 1 trip/episode & $250 for round-trip coach airfare, hotel limited to $100/day for 7 days, other expenses limited to $25/day for 7 days)*	No copay *(deductible waived)*	
Bariatric Surgery *(subject to utilization review; medically necessary surgery for weight loss, only for morbid obesity, covered only when performed at a Center of Expertise [COE])*		
➢ Inpatient services provided in connection with medically necessary surgery for weight loss, only for morbid obesity	$1,000/year[3] + 20%	
➢ Bariatric travel expense when member's home is 50 miles or more from the nearest Bariatric *COE* *(member's transportation to & from COE limited to $130/person/trip for 3 trips [pre-surgical visit, initial surgery & one follow-up visit]; one companion's transportation to & from COE limited to $130/person/trip for 2 trips [initial surgery & one follow-up visit]; hotel for member & one companion limited to one room double occupancy & $100/day for 2 days/trip, or as medically necessary, for pre-surgical & follow-up visit; hotel for one companion limited to one room double occupancy & $100/day for duration of member's initial surgery stay for 4 days; other reasonable expenses limited to $25/day/person for 4 days/trip)*	No copay *(deductible waived)*	
Diabetes Education Programs *(requires physician supervision)*		
➢ Teach members & their families about the disease process, the daily management of diabetic therapy & self-management training	$45/visit *(deductible waived)*	50%
Prosthetic Devices		
➢ Coverage for breast prostheses; prosthetic devices to restore a method of speaking; surgical implants; artificial limbs or eyes; the first pair of contact lenses or eyeglasses when required as a result of eye surgery; & therapeutic shoes & inserts	50%	50%
Durable Medical Equipment		
➢ Rental or purchase of DME including dialysis equipment & supplies, home medical equipment, prosthetic/orthotics *(hearing aids benefit available for one hearing aid per ear every three years; breast pump and supplies are covered under preventive care at no charge for in-network)*	50%	50%
Related Outpatient Medical Services & Supplies		
➢ Ground or air ambulance transportation, services & disposable supplies	20%[2]	
➢ Blood transfusions, blood processing & the cost of unreplaced blood & blood products	20%[2]	
➢ Autologous blood *(self-donated blood collection, testing, processing & storage for planned surgery)*	20%[2]	

[1] The percentage copay for non-emergency services from non-Anthem Blue Cross PPO providers is based on the scheduled amount.

[2] These providers are not represented in the Anthem Blue Cross PPO network.

[3] Applicable to the Annual Out-of-Pocket maximums

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay[1]
Emergency Care		
➢ Emergency room services & supplies *($100 deductible waived if admitted)*	20%	20%
➢ Inpatient hospital services & supplies	$1,000/year[3] + 20%	20%
➢ Physician services	20%	20%
Mental or Nervous Disorders and Substance Abuse		
Inpatient Care		
➢ Facility-based care *(subject to utilization review; waived for emergency admissions)*	$1,000/year[3] + 20%	50% *(benefit limited to $600/day)*
➢ Inpatient physician visits	20%	50%
Outpatient Care		
➢ Facility-based care *(subject to utilization review; waived for emergency admissions)*	20%	50% *(benefit limited to $600/day)*
➢ Outpatient physician visits *(Behavioral Health treatment for Autism & Pervasive Disorder will be subject to pre-service review)*	$45/visit[2] *(deductible waived)*	50%

[1] The percentage copay for non-emergency services from non-Anthem Blue Cross PPO providers is based on the scheduled amount.

[2] The dollar copay applies only to the visit itself. An additional 20% copay applies for any services performed in office (i.e., X-ray, lab, surgery), after any applicable deductible.

[3] Applicable to the Annual Out-of-Pocket maximums

This Summary of Benefits is a brief review of benefits. Once enrolled, members will receive a Combined Evidence of Coverage and Disclosure Form, which explains the exclusions and limitations, as well as the full range of covered services of the plan, in detail.

Classic PPO Plan Exclusions and Limitations

Not Medically Necessary. Services or supplies that are not medically necessary, as defined.

Experimental or Investigative. Any experimental or investigative procedure or medication. But, if member is denied benefits because it is determined that the requested treatment is experimental or investigative, the member may request an independent medical review, as described in the Evidence of Coverage (EOC).

Outside the United States. Services or supplies furnished and billed by a provider outside the United States, unless such services or supplies are furnished in connection with urgent care or an emergency.

Crime or Nuclear Energy. Conditions that result from (1) the member's commission of or attempt to commit a felony, as long as any injuries are not a result of a medical condition or an act of domestic violence; or (2) any release of nuclear energy, whether or not the result of war, when government funds are available for the treatment of illness or injury arising from the release of nuclear energy.

Not Covered. Services received before the member's effective date. Services received after the member's coverage ends, except as specified as covered in the EOC.

Excess Amounts. Any amounts in excess of covered expense or any Medical Benefit Maximum.

Work-Related. Work-related conditions if benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation, employer's liability law or occupational disease law, whether or not the member claims those benefits. If there is a dispute of substantial uncertainty as to whether benefits may be recovered for those conditions pursuant to workers' compensation, we will provide the benefits of this plan for such conditions, subject to a right of recovery and reimbursement under California Labor Code Section 4903, as specified as covered in the EOC.

Government Treatment. Any services the member actually received that were provided by a local, state or federal government agency, except when payment under this plan is expressly required by federal or state law. We will not cover payment for these services if the member is not required to pay for them or they are given to the member for free.

Services of Relatives. Professional services received from a person living in the member's home or who is related to the member by blood or marriage, except as specified as covered in the EOC.

Voluntary Payment. Services for which the member has no legal obligation to pay, or for which no charge would be made in the absence of insurance coverage or other health plan coverage, except services received at a non-governmental charitable research hospital. Such a hospital must meet the following guidelines:

1. it must be internationally known as being devoted mainly to medical research;
2. at least 10% of its yearly budget must be spent on research not directly related to patient care;
3. at least one-third of its gross income must come from donations or grants other than gifts or payments for patient care;
4. it must accept patients who are unable to pay; and
5. two-thirds of its patients must have conditions directly related to the hospital's research.

Not Specifically Listed. Services not specifically listed in the plan as covered services.

Private Contracts. Services or supplies provided pursuant to a private contract between the member and a provider, for which reimbursement under Medicare program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act.

Inpatient Diagnostic Tests. Inpatient room and board charges in connection with a hospital stay primarily for diagnostic tests which could have been performed safely on an outpatient basis.

Mental or Nervous Disorders. Academic or educational testing, counseling, and remediation. Mental or nervous disorders or substance abuse, including rehabilitative care in relation to these conditions, except as specified as covered in the EOC.

Orthodontia. Braces, other orthodontic appliances or orthodontic services.

Dental Services or Supplies. Dental plates, bridges, crowns, caps or other dental prostheses, dental implants, dental services, extraction of teeth, treatment to the teeth or gums, or treatment to or for any disorders for the temporomandibular (jaw) joint, except as specified as covered in the EOC. Cosmetic dental surgery or other dental services for beautification.

Hearing Aids or Tests. .

Optometric Services or Supplies. Optometric services, eye exercises including orthoptics. Routine eye exams and routine eye refractions, as specified as covered in the EOC. Eyeglasses or contact lenses, except as specified as covered in the EOC.

Outpatient Occupational Therapy. Outpatient occupational therapy, except by a home health agency, hospice, or home infusion therapy provider, as specified as covered in the EOC.

Outpatient Speech Therapy. Outpatient speech therapy, except as specified as covered in the EOC.

Cosmetic Surgery. Cosmetic surgery or other services performed solely for beautification or to alter or reshape normal (including aged) structures or tissues of the body to improve appearance. This exclusion does not apply to reconstructive surgery (that is, surgery performed to correct deformities caused by congenital or developmental abnormalities, illness, or injury for the purpose of improving bodily function or symptomatology or to create a normal appearance), including surgery performed to restore symmetry following mastectomy. Cosmetic surgery does not become reconstructive surgery because of psychological or psychiatric reasons.

Commercial Weight Loss Programs. Weight loss programs, whether or not they are pursued under medical or *physician* supervision, unless specifically listed as covered in this *plan*.

This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

This exclusion does not apply to *medically necessary* treatments for morbid obesity or dietary evaluations and counseling, and behavioral modification programs for the treatment of anorexia nervosa or bulimia nervosa. Surgical treatment for morbid obesity is covered as described in the Evidence of Coverage (EOC).

Sterilization Reversal.

Infertility Treatment. Any services or supplies furnished in connection with the diagnosis and treatment of infertility, including, but not limited to diagnostic tests, medication, surgery, artificial insemination, in vitro fertilization, sterilization reversal and gamete intrafallopian transfer.

Surrogate Mother Services. For any services or supplies provided to a person not covered under the plan in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

Orthopedic shoes and shoe inserts. This exclusion does not apply to orthopedic footwear used as an integral part of a brace, shoe inserts that are custom molded to the patient, or therapeutic shoes and inserts designed to treat foot complications due to diabetes, as specifically stated in the EOC.

Air Conditioners. Air purifiers, air conditioners or humidifiers.

Custodial Care or Rest Cures. Inpatient room and board charges in connection with a hospital stay primarily for environmental change or physical therapy. Services provided by a rest home, a home for the aged, a nursing home or any similar facility. Services provided by a skilled nursing facility or custodial care or rest cures, except as specified as covered in the EOC.

Health Club Memberships. Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment or facilities used for developing or maintaining physical fitness, even if ordered by a *physician*. This exclusion also applies to health spas.

Personal Items. Any supplies for comfort, hygiene or beautification.

Education or Counseling. Educational services or nutritional counseling, except as specified as covered in the EOC. This exclusion does not apply to counseling for the treatment of anorexia nervosa or bulimia nervosa.

Food or Dietary Supplements. Nutritional and/or dietary supplements, except as provided in this *plan* or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not requirement either a written prescription or dispensing by a licensed pharmacist.

Telephone and Facsimile Machine Consultations. Consultations provided by telephone or facsimile machine.

Routine Exams or Tests. Routine physical exams or tests which do not directly treat an actual illness, injury or condition, including those required by employment or government authority, except as specified as covered in the EOC.

Acupuncture. Acupuncture treatment, except as specified as covered in the EOC. Acupressure or massage to control pain, treat illness or promote health by applying pressure to one or more specific areas of the body based on dermatomes or acupuncture points.

Eye Surgery for Refractive Defects. Any eye surgery solely or primarily for the purpose of correcting refractive defects of the eye such as nearsightedness (myopia) and/or astigmatism. Contact lenses and eyeglasses required as a result of this surgery.

Physical Therapy or Physical Medicine. Services of a physician for physical therapy or physical medicine, except when provided during a covered inpatient confinement or as specified as covered in the EOC.

Outpatient Prescription Drugs and Medications. Outpatient prescription drugs or medications and insulin, except as specified as covered in the EOC. Any non-prescription, over-the-counter patent or proprietary drug or medicine. Cosmetics, health or beauty aids.

Specialty Pharmacy Drugs. Specialty pharmacy drugs that must be obtained from the specialty pharmacy program, but, which are obtained from a retail pharmacy, are not covered by this plan. **Member will have to pay the full cost of the specialty pharmacy drugs obtained from a retail pharmacy that should have been obtained from the specialty pharmacy program.**

Contraceptive Devices. Contraceptive devices prescribed for birth control except as specified as covered in the EOC.

Diabetic Supplies. Prescription and non-prescription diabetic supplies except as specified as covered in the EOC.

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SJVIA PPO 1000 BlueCard Modified PPO (1000/45/80/50)

Anthem believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that this plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections of the Affordable Care Act apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Anthem at the telephone number printed on the back of your member identification card, or contact your group benefits administrator if you do not have an identification card. For ERISA plans, you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1–866–444–3272 or www.dol.gov/ebsa/healthreform. This Web site has a table summarizing which protections do and do not apply to grandfathered health plans. For nonfederal governmental plans, you may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

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Maximum Allowed Amount is the total reimbursement payable under the plan for covered services received from Participating and Non-Participating Providers. It is the payment towards the services billed by a provider combined with any applicable deductible, copayment or coinsurance.

Participating Providers- The rate the provider has agreed to accept as reimbursement for covered services. Members are not responsible for the difference between the provider's usual charges & the maximum allowed amount.

Non-Participating Providers & Other Health Care Providers-(includes those not represented in the PPO provider network)-Reimbursement amount is based on: an Anthem Blue Cross rate or fee schedule, a rate negotiated with the provider, information from a third party vendor, or billed charges. For Medical Emergency care rendered by a Non-Participating Provider or Non-Contracting Hospital, reimbursement may be based on the reasonable and customary value. Members may be responsible for any amount in excess of the reasonable and customary value

When using Non-PPO and Other Health Care Providers, members are responsible for any difference between the covered expense & actual charges, as well as any deductible & percentage copay.

Calendar year deductible for all providers	$1,000/member; $2,000/family	
Deductible for non-Anthem Blue Cross PPO hospital or residential treatment center	None	
Deductible for non-Anthem Blue Cross PPO hospital or residential treatment center if utilization review not obtained	$250/admission *(waived for emergency admission)*	
Deductible for emergency room services	$100/visit *(waived if admitted directly from ER)*	
Annual Out-of-Pocket Maximums ***(no cross application)***		
PPO Providers & Other Health Care Providers	$4,000/member/year; $8,000/family/year	
Non-PPO Providers	$10,000/member/year; $20,000/family/year	
The following do not apply to out-of-pocket maximums: non-covered expense. After a member reaches the out-of-pocket maximum, the member remains responsible for non-PPO providers & other health care providers, costs in excess of the covered expense.		
Lifetime Maximum	Unlimited	
Covered Services	**PPO: Per Member Copay**	**Non-PPO: Per Member Copay[1]**
Hospital Medical Services ***(subject to utilization review*** *for inpatient services; waived for emergency admissions)*		
➢ Semi-private room, meals & special diets, & ancillary services	$1,000/year[2] + 20%	50% *(benefit limited to $600/day)*
➢ Outpatient medical care, surgical services & supplies *(hospital care other than emergency room care)*	20%	50% *(benefit limited to $600/day)*
Ambulatory Surgical Centers		
➢ Outpatient surgery, services & supplies	$250/surgery + 20%	50% *(benefit limited to $350/visit)*
Skilled Nursing Facility *(subject to utilization review)*		
➢ Semi-private room, services & supplies *(limited to 100 days/calendar year)*	20%	20%
Hospice Care *(subject to utilization review)*		
➢ Inpatient or outpatient services; for members with up to one year life expectancy; family Bereavement services	No copay	

[1]The percentage copay for non-emergency services from non-Anthem Blue Cross PPO providers is based on the scheduled amount.

[2] Applicable to the Annual Out-of-Pocket maximums.

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay[1]
Home Health Care *(subject to utilization review)*		
➢ Services & supplies from a home health agency *(limited to 100 prior authorized visits/calendar year, one visit by a home health aide equals four hours or less; not covered while member receives hospice care)*	20%	20% with authorization
Home Infusion Therapy *(subject to utilization review)*		
➢ Includes medication, ancillary services & supplies;) caregiver training & visits by provider to monitor therapy; durable medical equipment; lab services	20%	20%
Physician Medical Services		
➢ Office & home visits	$45/visit[2] *(deductible waived)*	50%
➢ Hospital & skilled nursing facility visits	20%	50%
➢ Surgeon & surgical assistant; anesthesiologist or anesthetist	20%	50%
➢ Drugs administered by a medical provider (*certain drugs are subject to utilization review)*	20%	50%
Diagnostic X-ray & Lab		
➢ MRI, CT scan, PET scan & nuclear cardiac scan *(subject to utilization review)*	20%	50%
➢ Other diagnostic x-ray & lab	No copay	50%
Preventive Care Services Preventive Care Services including*, physical exams, preventive screenings (including screenings for cancer, HPV, diabetes, cholesterol, blood pressure, hearing and vision immunizations, health education, intervention services, HIV testing), and additional preventive care for women provided for in the guidelines supported by the Health Resources and Services Administration. *This list is not exhaustive. This benefit includes all Preventive Care Services required by federal and state law.	No copay (*deductible waived)*	50%
Physical Therapy, Physical Medicine & Occupational Therapy	$25/visit *(deductible waived)*	50%
Chiropractic Services *(up to 12 visits/calendar year; additional visits may be approved, if medically necessary)*	$25/visit *(deductible waived)*	50%
Speech Therapy		
➢ Outpatient speech therapy following injury or organic disease	$45/visit *(deductible waived)*	50%
Acupuncture		
➢ Services for the treatment of disease, illness or injury *(limited to 20 visits/calendar year)*	20%[3]	50%[3]
Temporomandibular Joint Disorders		
➢ Splint therapy & surgical treatment	20%	50%
Pregnancy & Maternity Care		
➢ Physician office visits	$45/visit[2] *(deductible waived)*	50%
➢ Prescription drug for elective abortion *(mifepristone)*	20%	Not covered
Normal delivery, cesarean section, complications of pregnancy & abortion		
➢ Inpatient physician services	20%	50%
➢ Hospital & ancillary services	$1,000/year[4] + 20%	50% *(benefit limited to $600/day)*
➢ Female Sterilization(*including tubal ligation and counseling/consultation)*	No copay	Not covered
➢ Male Sterilization	20%	Not Covered
➢ Family planning counseling	$45/visit *(deductible waived)*	Not covered

[1]The percentage copay for non-emergency services from non-Anthem Blue Cross PPO providers is based on the scheduled amount.

[2]The dollar copay applies only to the visit itself. An additional 20% copay applies for any services performed in office (i.e., X-ray, lab, surgery), after any applicable deductible.

[3]Acupuncture services can be performed by a certified acupuncturist (C.A.), a doctor of medicine (M.D.), a doctor of osteopathy (D.O.), a podiatrist (D.P.M.), or a dentist (D.D.S.).

[4] Applicable to the Annual Out-of-Pocket maximums

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay[1]
Organ & Tissue Transplants *(subject to utilization review; specified organ transplants covered only when performed at a Center of Expertise [COE])*		
➢ Inpatient services provided in connection with non-investigative organ or tissue transplants		$1,000/year[3] + 20%
➢ Transplant travel expense for an authorized, specified transplant at a *COE* *(recipient & companion transportation limited to 6 trips/episode & $250/person/trip for round-trip coach airfare, hotel limited to 1 room double occupancy & $100/day for 21 days/trip, other expenses limited to $25/day/person for 21 days/trip, donor transportation limited to 1 trip/episode & $250 for round-trip coach airfare, hotel limited to $100/day for 7 days, other expenses limited to $25/day for 7 days)*		No copay *(deductible waived)*
Bariatric Surgery *(subject to utilization review; medically necessary surgery for weight loss, only for morbid obesity, covered only when performed at a Center of Expertise [COE])*		
➢ Inpatient services provided in connection with medically necessary surgery for weight loss, only for morbid obesity		$1,000/year[3] + 20%
➢ Bariatric travel expense when member's home is 50 miles or more from the nearest Bariatric *COE* *(member's transportation to & from COE limited to $130/person/trip for 3 trips [pre-surgical visit, initial surgery & one follow-up visit]; one companion's transportation to & from COE limited to $130/person/trip for 2 trips [initial surgery & one follow-up visit]; hotel for member & one companion limited to one room double occupancy & $100/day for 2 days/trip, or as medically necessary, for pre-surgical & follow-up visit; hotel for one companion limited to one room double occupancy & $100/day for duration of member's initial surgery stay for 4 days; other reasonable expenses limited to $25/day/person for 4 days/trip)*		No copay *(deductible waived)*
Diabetes Education Programs *(requires physician supervision)*		
➢ Teach members & their families about the disease process, the daily management of diabetic therapy & self-management training	$45/visit *(deductible waived)*	50%
Prosthetic Devices		
➢ Coverage for breast prostheses; prosthetic devices to restore a method of speaking; surgical implants; artificial limbs or eyes; the first pair of contact lenses or eyeglasses when required as a result of eye surgery; & therapeutic shoes & inserts	50%	50%
Durable Medical Equipment		
➢ Rental or purchase of DME including dialysis equipment & supplies, home medical equipment, prosthetic/orthotics *(hearing aids benefit available for one hearing aid per ear every three years; breast pump and supplies are covered under preventive care at no charge for in-network)*	50%	50%
Related Outpatient Medical Services & Supplies		
➢ Ground or air ambulance transportation, services & disposable supplies		20%[2]
➢ Blood transfusions, blood processing & the cost of unreplaced blood & blood products		20%[2]
➢ Autologous blood *(self-donated blood collection, testing, processing & storage for planned surgery)*		20%[2]

[1] The percentage copay for non-emergency services from non-Anthem Blue Cross PPO providers is based on the scheduled amount.

[2] These providers are not represented in the Anthem Blue Cross PPO network.

[3] Applicable to the Annual Out-of-Pocket maximums

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay[1]
Emergency Care		
➢ Emergency room services & supplies *($100 deductible waived if admitted)*	20%	20%
➢ Inpatient hospital services & supplies	$1,000/year[3] + 20%	20%
➢ Physician services	20%	20%
Mental or Nervous Disorders and Substance Abuse		
Inpatient Care		
➢ Facility-based care *(subject to utilization review; waived for emergency admissions)*	$1,000/year[3] + 20%	50% *(benefit limited to $600/day)*
➢ Inpatient physician visits	20%	50%
Outpatient Care		
➢ Facility-based care *(subject to utilization review; waived for emergency admissions)*	20%	50% *(benefit limited to $600/day)*
➢ Outpatient physician visits *(Behavioral Health treatment for Autism & Pervasive Disorder will be subject to pre-service review)*	$45/visit[2] *(deductible waived)*	50%

[1] The percentage copay for non-emergency services from non-Anthem Blue Cross PPO providers is based on the scheduled amount.

[2] The dollar copay applies only to the visit itself. An additional 20% copay applies for any services performed in office (i.e., X-ray, lab, surgery), after any applicable deductible.

[3] Applicable to the Annual Out-of-Pocket maximums

This Summary of Benefits is a brief review of benefits. Once enrolled, members will receive a Combined Evidence of Coverage and Disclosure Form, which explains the exclusions and limitations, as well as the full range of covered services of the plan, in detail.

Classic PPO Plan Exclusions and Limitations

Not Medically Necessary. Services or supplies that are not medically necessary, as defined.

Experimental or Investigative. Any experimental or investigative procedure or medication. But, if member is denied benefits because it is determined that the requested treatment is experimental or investigative, the member may request an independent medical review, as described in the Evidence of Coverage (EOC).

Outside the United States. Services or supplies furnished and billed by a provider outside the United States, unless such services or supplies are furnished in connection with urgent care or an emergency.

Crime or Nuclear Energy. Conditions that result from (1) the member's commission of or attempt to commit a felony, as long as any injuries are not a result of a medical condition or an act of domestic violence; or (2) any release of nuclear energy, whether or not the result of war, when government funds are available for the treatment of illness or injury arising from the release of nuclear energy.

Not Covered. Services received before the member's effective date. Services received after the member's coverage ends, except as specified as covered in the EOC.

Excess Amounts. Any amounts in excess of covered expense or any Medical Benefit Maximum.

Work-Related. Work-related conditions if benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation, employer's liability law or occupational disease law, whether or not the member claims those benefits. If there is a dispute of substantial uncertainty as to whether benefits may be recovered for those conditions pursuant to workers' compensation, we will provide the benefits of this plan for such conditions, subject to a right of recovery and reimbursement under California Labor Code Section 4903, as specified as covered in the EOC.

Government Treatment. Any services the member actually received that were provided by a local, state or federal government agency, except when payment under this plan is expressly required by federal or state law. We will not cover payment for these services if the member is not required to pay for them or they are given to the member for free.

Services of Relatives. Professional services received from a person living in the member's home or who is related to the member by blood or marriage, except as specified as covered in the EOC.

Voluntary Payment. Services for which the member has no legal obligation to pay, or for which no charge would be made in the absence of insurance coverage or other health plan coverage, except services received at a non-governmental charitable research hospital. Such a hospital must meet the following guidelines:

1. it must be internationally known as being devoted mainly to medical research;
2. at least 10% of its yearly budget must be spent on research not directly related to patient care;
3. at least one-third of its gross income must come from donations or grants other than gifts or payments for patient care;
4. it must accept patients who are unable to pay; and
5. two-thirds of its patients must have conditions directly related to the hospital's research.

Not Specifically Listed. Services not specifically listed in the plan as covered services.

Private Contracts. Services or supplies provided pursuant to a private contract between the member and a provider, for which reimbursement under Medicare program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act.

Inpatient Diagnostic Tests. Inpatient room and board charges in connection with a hospital stay primarily for diagnostic tests which could have been performed safely on an outpatient basis.

Mental or Nervous Disorders. Academic or educational testing, counseling, and remediation. Mental or nervous disorders or substance abuse, including rehabilitative care in relation to these conditions, except as specified as covered in the EOC.

Orthodontia. Braces, other orthodontic appliances or orthodontic services.

Dental Services or Supplies. Dental plates, bridges, crowns, caps or other dental prostheses, dental implants, dental services, extraction of teeth, treatment to the teeth or gums, or treatment to or for any disorders for the temporomandibular (jaw) joint, except as specified as covered in the EOC. Cosmetic dental surgery or other dental services for beautification.

Hearing Aids or Tests. .

Optometric Services or Supplies. Optometric services, eye exercises including orthoptics. Routine eye exams and routine eye refractions, as specified as covered in the EOC. Eyeglasses or contact lenses, except as specified as covered in the EOC.

Outpatient Occupational Therapy. Outpatient occupational therapy, except by a home health agency, hospice, or home infusion therapy provider, as specified as covered in the EOC.

Outpatient Speech Therapy. Outpatient speech therapy, except as specified as covered in the EOC.

Cosmetic Surgery. Cosmetic surgery or other services performed solely for beautification or to alter or reshape normal (including aged) structures or tissues of the body to improve appearance. This exclusion does not apply to reconstructive surgery (that is, surgery performed to correct deformities caused by congenital or developmental abnormalities, illness, or injury for the purpose of improving bodily function or symptomatology or to create a normal appearance), including surgery performed to restore symmetry following mastectomy. Cosmetic surgery does not become reconstructive surgery because of psychological or psychiatric reasons.

Commercial Weight Loss Programs. Weight loss programs, whether or not they are pursued under medical or *physician* supervision, unless specifically listed as covered in this *plan*.

This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

This exclusion does not apply to *medically necessary* treatments for morbid obesity or dietary evaluations and counseling, and behavioral modification programs for the treatment of anorexia nervosa or bulimia nervosa. Surgical treatment for morbid obesity is covered as described in the Evidence of Coverage (EOC).

Sterilization Reversal.

Infertility Treatment. Any services or supplies furnished in connection with the diagnosis and treatment of infertility, including, but not limited to diagnostic tests, medication, surgery, artificial insemination, in vitro fertilization, sterilization reversal and gamete intrafallopian transfer.

Surrogate Mother Services. For any services or supplies provided to a person not covered under the plan in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

Orthopedic shoes and shoe inserts. This exclusion does not apply to orthopedic footwear used as an integral part of a brace, shoe inserts that are custom molded to the patient, or therapeutic shoes and inserts designed to treat foot complications due to diabetes, as specifically stated in the EOC.

Air Conditioners. Air purifiers, air conditioners or humidifiers.

Custodial Care or Rest Cures. Inpatient room and board charges in connection with a hospital stay primarily for environmental change or physical therapy. Services provided by a rest home, a home for the aged, a nursing home or any similar facility. Services provided by a skilled nursing facility or custodial care or rest cures, except as specified as covered in the EOC.

Health Club Memberships. Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment or facilities used for developing or maintaining physical fitness, even if ordered by a *physician*. This exclusion also applies to health spas.

Personal Items. Any supplies for comfort, hygiene or beautification.

Education or Counseling. Educational services or nutritional counseling, except as specified as covered in the EOC. This exclusion does not apply to counseling for the treatment of anorexia nervosa or bulimia nervosa.

Food or Dietary Supplements. Nutritional and/or dietary supplements, except as provided in this *plan* or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not requirement either a written prescription or dispensing by a licensed pharmacist.

Telephone and Facsimile Machine Consultations. Consultations provided by telephone or facsimile machine.

Routine Exams or Tests. Routine physical exams or tests which do not directly treat an actual illness, injury or condition, including those required by employment or government authority, except as specified as covered in the EOC.

Acupuncture. Acupuncture treatment, except as specified as covered in the EOC. Acupressure or massage to control pain, treat illness or promote health by applying pressure to one or more specific areas of the body based on dermatomes or acupuncture points.

Eye Surgery for Refractive Defects. Any eye surgery solely or primarily for the purpose of correcting refractive defects of the eye such as nearsightedness (myopia) and/or astigmatism. Contact lenses and eyeglasses required as a result of this surgery.

Physical Therapy or Physical Medicine. Services of a physician for physical therapy or physical medicine, except when provided during a covered inpatient confinement or as specified as covered in the EOC.

Outpatient Prescription Drugs and Medications. Outpatient prescription drugs or medications and insulin, except as specified as covered in the EOC. Any non-prescription, over-the-counter patent or proprietary drug or medicine. Cosmetics, health or beauty aids.

Specialty Pharmacy Drugs. Specialty pharmacy drugs that must be obtained from the specialty pharmacy program, but, which are obtained from a retail pharmacy, are not covered by this plan. **Member will have to pay the full cost of the specialty pharmacy drugs obtained from a retail pharmacy that should have been obtained from the specialty pharmacy program.**

Contraceptive Devices. Contraceptive devices prescribed for birth control except as specified as covered in the EOC.

Diabetic Supplies. Prescription and non-prescription diabetic supplies except as specified as covered in the EOC.

Private Duty Nursing. Inpatient or outpatient services of a private duty nurse.

Lifestyle Programs. Programs to alter one's lifestyle which may include but are not limited to diet, exercise, imagery or nutrition. This exclusion will not apply to cardiac rehabilitation programs approved by us.

Wigs.

Third Party Liability — Anthem Blue Cross is entitled to reimbursement of benefits paid if the member recovers damages from a legally liable third party.

Coordination of Benefits — The benefits of this plan may be reduced if the member has any other group health or dental coverage so that the services received from all group coverages do not exceed 100% of the covered expense.

Anthem Blue Cross

SJVIA
Lumenos® Health Savings Account (HSA)
Custom LHSA 289 (2500/90/50)
Rx Copay after Deductible

Anthem believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that this plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.
Questions regarding which protections of the Affordable Care Act apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Anthem at the telephone number printed on the back of your member identification card, or contact your group benefits administrator if you do not have an identification card. For ERISA plans, you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1–866–444–3272 or www.dol.gov/ebsa/healthreform. This Web site has a table summarizing which protections do and do not apply to grandfathered health plans. For nonfederal governmental plans, you may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

This Lumenos plan is an innovative type of coverage that allows an insured person to use a Health Savings Account to pay for routine medical care. The program also includes traditional health coverage, similar to a typical health plan, that protects the insured person against large medical expenses.
The insured person can spend the money in the HSA account the way the insured person wants on routine medical care, prescription drugs and other qualified medical expenses. There are no copays or deductibles to satisfy first. Unused dollars can be saved from year to year to reduce the amount the insured person may have to pay in the future. If covered expenses exceed the insured person's available HSA dollars, the traditional health coverage is available after a limited out-of-pocket amount is paid by the insured person.
Certain Covered Services have maximum visit and/or day limits per year. The number of visits and/or days allowed for these services will begin accumulating on the first visit and/or day, regardless of whether your Deductible has been met.
The insured person is responsible for all costs over the plan maximums. Plan maximums and other important information appear in *italics*. Benefits are subject to all terms, conditions, limitations, and exclusions of the Policy.

Explanation of Maximum Allowed Amount

Maximum Allowed Amount is the total reimbursement payable under the plan for covered services received from Participating and Non-Participating Providers. It is the payment towards the services billed by a provider combined with any applicable deductible, copayment or coinsurance.
Participating Providers- The rate the provider has agreed to accept as reimbursement for covered services. Members are not responsible for the difference between the provider's usual charges & the maximum allowed amount.
Non-Participating Providers & Other Health Care Providers-(includes those not represented in the PPO provider network)-Reimbursement amount is based on: an Anthem Blue Cross rate or fee schedule, a rate negotiated with the provider, information from a third party vendor, or billed charges. For Medical Emergency care rendered by a Non-Participating Provider or Non-Contracting Hospital, reimbursement may be based on the reasonable and customary value. Members may be responsible for any amount in excess of the reasonable and customary value.
Participating Pharmacies & Mail Service Program-members are not responsible for any amount in excess of the prescription drug maximum allowed amount.
Non-Participating Pharmacies-members are responsible for any expense not covered under this plan & any amount in excess of the prescription drug maximum allowed amount. When using non-participating providers, the insured person is responsible for any difference between the covered expense & actual charges, as well as any deductible & percentage copay.
When using the outpatient prescription drug benefits, the insured person is always responsible for drug expenses which are not covered under this plan, as well as any deductible, percentage or dollar copay.

Calendar year deductible for all providers *(applicable to medical care & prescription drug benefits)*	
➢ Individual insured person	$2,500/individual insured person
➢ Insured family *(includes insured employee & one or more members of the employee's family; no coverage may be paid for any member of a family unless this $5,000 deductible is met)*	$5,000/insured family
Deductible for hospital if utilization review not obtained	$250/admission *(waived for emergency admission)*
Annual Out-of-Pocket Maximums *(in-network/out-of-network out-of-pocket maximums are exclusive of each other; includes calendar year deductible & prescription drug covered expense)*	
➢ For all Providers & Other Health Care Providers & all Participating Pharmacies	$5,000/individual insured person; $10,000/insured family/year

The following do not apply to out-of-pocket maximums: costs in excess of the covered expense & non-covered expense. After an individual insured person or insured family *(includes insured employee & one or more members of the employee's family)* reaches the out-of-pocket maximum for all medical and prescription drug covered expense the individual insured person or insured family incurs during that calendar year, the individual insured person or insured family will no longer be required to pay a copay for the remainder of that year. The individual insured person or insured family remains responsible for costs in excess of the covered expense when provided by non-participating providers and other health care providers; non-covered expense.

Lifetime Maximum	Unlimited

Covered Services	Traditional Health Coverage Insured Person Copay In-Network	 Out-of-Network *(Insured is also responsible for charges in excess of covered expense.)*
Hospital Medical Services *(subject to utilization review for inpatient services; waived for emergency admissions)*		
➢ Semi-private room, meals & special diets, & ancillary services	10%	50% up to $580 plan payment per day
➢ Outpatient medical care, surgical services & supplies *(hospital care other than emergency room care)*	10%	50% *(benefit limited to $350/day)*
Ambulatory Surgical Centers		
➢ Outpatient surgery, services & supplies	10%	50% *(benefit limited to $350/day)*
Skilled Nursing Facility *(subject to utilization review)*		
➢ Semi-private room, services & supplies *(limited to 100 days/calendar year)*	10%	10%
Hospice Care *(subject to utilization review) ($10,000 combined maximum per member per lifetime)*		
➢ Inpatient or outpatient services for insured persons with up to one year life expectancy; family bereavement services	10%	10%
Home Health Care *(subject to utilization review)*		
➢ Services & supplies from a home health agency *(limited to 100 visits/calendar year, one visit by a home health aide equals four hours or less; not covered while insured person receives hospice care)*	10%	10%
Home Infusion Therapy		
➢ Includes medication, ancillary services & supplies; caregiver training & visits by provider to monitor therapy; durable medical equipment; lab services	10%	10%
Physician Medical Services		
➢ Office & home visits	10%	50%
➢ Hospital & skilled nursing facility visits	10%	50%
➢ Surgeon & surgical assistant; anesthesiologist or anesthetist	10%	50%
➢ Drugs administered by a medical provider *(certain drugs are subject to utilization review)*	10%	50%
Diagnostic X-ray & Lab		
➢ MRI, CT scan, PET scan & nuclear cardiac scan *(subject to utilization review)*	10%	50%
➢ Other diagnostic x-ray & lab	10%	50%
Preventive Care Services Preventive Care Services including*, physical exams, preventive screenings (including screenings for cancer, HPV, diabetes, cholesterol, blood pressure, hearing and vision immunizations, health education, intervention services, HIV testing), and additional preventive care for women provided for in the guidelines supported by the Health Resources and Services Administration. *This list is not exhaustive. This benefit includes all Preventive Care Services required by federal and state law.	No copay (deductible waived)	50%
Physical Therapy, Physical Medicine & Occupational Therapy, including Chiropractic Services *(limited to 12 visits/calendar year; additional visits may be approved; if medically necessary)*	10%	50%
Speech Therapy		
➢ Outpatient speech therapy following injury or organic disease	10%	50%

Covered Services	Traditional Health Coverage Insured Person Copay In-Network	Out-of-Network *(Insured is also responsible for charges in excess of covered expense.)*
Acupuncture		
➢ Services for the treatment of disease, illness or injury *(limited to 20 visits/calendar year)*	10%[1]	50%[1]
Temporomandibular Joint Disorders		
➢ Splint therapy & surgical treatment	10%	50%
Pregnancy & Maternity Care		
➢ Physician office visits	10%	50%
➢ Prescription drug for elective abortion *(mifepristone)*	10%	50%
Normal delivery, cesarean section, complications of pregnancy & abortion		
➢ Inpatient physician services	10%	50%
➢ Hospital & ancillary services	10%	50% *(benefit limited to $580/day)*
Organ & Tissue Transplants *(subject to utilization review; specified organ transplants covered only when performed at a Center of Expertise [COE])*		
➢ Inpatient services provided in connection with non-investigative organ or tissue transplants	10%	
➢ Transplant travel expense for an authorized, specified transplant at a *COE (recipient & companion transportation limited to 6 trips/episode & $250/person/trip for round-trip coach airfare hotel limited to 1 room double occupancy & $100/day for 21 days/trip, other expenses limited to $25/day/person for 21 days/trip; donor transportation limited to 1 trip/episode & $250 for round-trip coach airfare, hotel limited to $100/day for 7 days, other expenses limited to $25/day for 7 days)*	No copay	
Bariatric Surgery *(subject to utilization review; medically necessary surgery for weight loss, only for morbid obesity, covered only when performed at a Center of Expertise [COE])*		
➢ Inpatient services provided in connection with medically necessary surgery for weight loss, only for morbid obesity	10%	
➢ Bariatric travel expense when insured person's home is 50 miles or more from the nearest bariatric *COE (insured person's transportation to & from COE limited to $130/person/trip for 3 trips [pre-surgical visit, initial surgery & one follow-up visit]; one companion's transportation to & from COE limited to $130/person/trip for 2 trips [initial surgery & one follow-up visit]; hotel for insured person & one companion limited to one room double occupancy & $100/day for 2 days/trip, or as medically necessary, for pre-surgical & follow-up visit; hotel for one companion limited to one room double occupancy & $100/day for duration of insured person's initial surgery stay for 4 days; other reasonable expenses limited to $25/day/person for 4 days/trip)*	No copay	
Diabetes Education Programs *(requires physician supervision)*		
➢ Teach insured persons & their families about the disease process, the daily management of diabetic therapy & self-management training	10%	50%

[1] Acupuncture services can be performed by a certified acupuncturist (C.A.), a doctor of medicine (M.D.), a doctor of osteopathy (D.O.), a podiatrist (D.P.M.), or a dentist (D.D.S.).

Covered Services	Traditional Health Coverage Insured Person Copay In-Network	Out-of-Network *(Insured is also responsible for charges in excess of covered expense.)*
Prosthetic Devices		
➢ Coverage for breast prostheses; prosthetic devices to restore a method of speaking; surgical implants; artificial limbs or eyes; the first pair of contact lenses or eyeglasses when required as a result of eye surgery; wigs for alopecia resulting from chemotherapy or radiation therapy; & therapeutic shoes & inserts for insured persons with diabetes	10%	10%
Durable Medical Equipment		
Rental or purchase of DME including dialysis equipment & supplies, home medical equipment, prosthetics/orthotics *(hearing aids benefit available for one hearing aid per ear every three years; breast pump and supplies are covered under preventive care at no charge for in-network)*	10%	10%
Related Outpatient Medical Services & Supplies		
➢ Ground or air ambulance transportation, services & disposable supplies	10%[1]	
➢ Blood transfusions, blood processing & the cost of unreplaced blood & blood products	10%[1]	
➢ Autologous blood *(self-donated blood collection, testing, processing & storage for planned surgery)*	10%[1]	
Emergency Care		
➢ Emergency room services & supplies	10%	10%
➢ Inpatient hospital services & supplies	10%	10%
➢ Physician services	10%	10%
Mental or Nervous Disorders and Substance Abuse		
Inpatient Care		
➢ Facility-based care *(subject to utilization review; waived for emergency admissions)*	10%	50% *(benefit limited to $580/day)*
➢ Inpatient physician visits	10%	50%
Outpatient Care		
➢ Facility-based care *(subject to utilization review; waived for emergency admissions)*	10%	50% *(benefit limited to $350/day)*
➢ Outpatient physician visits *(Behavioral Health treatment for Autism & Pervasive Disorder will be subject to pre-service review)*	10%	50%

[1] These providers are not represented in the Anthem Blue Cross PPO Network.

Covered Services (For Outpatient Prescription Drugs)	Traditional Health Coverage Per Insured Person Copay for Each Prescription or Refill
Outpatient Prescription Drug Benefits *(Until the calendar year deductible is satisfied, the insured person pays the prescription drug ,maximum allowed amount and not the copays listed below.)*	
➢ **Retail Pharmacy**	
➢ Preventive immunizations administered by a retail pharmacy -	No copay (*deductible waived)*
➢ Female oral contraceptives generic and single source brand	No copay (*deductible waived)*
➢ Generic drugs	$7
➢ Brand name formulary drugs[1,2]	$25
➢ Self-administered injectable drugs, except insulin	$25
Home Delivery	
➢ Female oral contraceptives generic and single source brand	No copay
➢ Generic drugs	$14
➢ Brand name formulary drugs[1,2]	$50
➢ Self-administered injectable drugs, except insulin	$25
Specialty pharmacy drugs *(may only be obtained through the specialty pharmacy program)*	
➢ Generic drugs	$7
➢ Brand name formulary drugs[1]	$25
➢ Self-administered injectable drugs, except insulin	$25
Non-participating Pharmacies *(compound drugs & specialty pharmacy drugs not covered at retail participating pharmacies)*	*Insured person pays the above retail pharmacy copay plus:* 30% of the remaining prescription drug maximum allowed amount & costs in excess of the maximum amount allowed
Supply Limits[3]	
➢ Retail Pharmacy *(participating and non-participating)*	30-day supply; 60-day supply for federally classified Schedule II attention deficit disorder drugs that require a triplicate prescription form, but require a double copay; 6 tablets or units/30-day period for impotence and/or sexual dysfunction drugs (available only at retail pharmacies)
➢ Home Delivery	90-day supply
➢ Specialty Pharmacy	30-day supply

[1] **Mandatory Generic Substitution:** If an insured person requests a brand name drug when a generic drug substitution exists, the insured person pays the generic drug copay plus the difference in cost between the negotiated rate for the generic drug and the brand name drug, but not more than 50% of our cost of the prescription drug. Mandatory generic substitution does not apply when it has been determined that the brand name drug is medically necessary for the insured person.

[2] When the member's physician has specified "dispense as written" (DAW) for formulary brand drugs, the copay for brand name formulary drugs will apply. When the member's physician has not specified DAW for formulary brand drugs, the member pays the generic drug copay plus the difference in cost between the drug negotiated rate for the generic drug and the brand name formulary drug, but not more than 50% of the drug negotiated rate. Some drugs may also be subject to a review for Medical Necessity by Anthem Blue Cross Life and Health Insurance Company.

[3] Supply limits for certain drugs may be different. Please refer to the Certificate of Insurance for complete information

The Outpatient Prescription Drug Benefit covers the following:

- Outpatient prescription drugs and medications which the law restricts to sale by prescription. Formulas prescribed by a physician for the treatment of phenylketonuria.
- Insulin
- Syringes when dispensed for use with insulin and other self-injectable drugs or medications
- Prescription oral contraceptives; contraceptive diaphragms. Contraceptive diaphragms are limited to one per year.
- Injectable drugs which are self-administered by the subcutaneous route (under the skin) by the patient or insured person. Drugs that have Food and Drug Administration (FDA) labeling for self-administration
- All compound prescription drugs that contain at least one covered prescription ingredient
- Diabetic supplies (i.e., test strips and lancets)
- Prescription drugs for treatment of impotence and/or sexual dysfunction are limited to organic (non-psychological) causes.
- Inhaler spacers and peak flow meters for the treatment of pediatric asthma.
- Smoking cessation products requiring a physician's prescription.
- Certain over-the-counter drugs approved by the Pharmacy and Therapeutics Committee to be included in the prescription drug formulary.

This Summary of Benefits is a brief review of benefits. Once enrolled, insured persons will receive a Certificate of Insurance, which explains the exclusions and limitations, as well as the full range of covered services of the plan in detail.

Lumenos HSA Plan — Exclusions and Limitations

Benefits are not provided for expenses incurred for or in connection with the following items:

Not Medically Necessary. Services or supplies that are not medically necessary, as defined.

Experimental or Investigative. Any experimental or investigative procedure or medication. But, if insured person is denied benefits because it is determined that the requested treatment is experimental or investigative, the insured person may request an independent medical review, as described in the Certificate.

Outside the United States. Services or supplies furnished and billed by a provider outside the United States, unless such services or supplies are furnished in connection with urgent care or an emergency.

Crime or Nuclear Energy. Conditions that result from (1) the insured person's commission of or attempt to commit a felony, as long as any injuries are not a result of a medical condition or an act of domestic violence; or (2) any release of nuclear energy, whether or not the result of war, when government funds are available for the treatment of illness or injury arising from the release of nuclear energy.

Not Covered. Services received before the insured person's effective date. Services received after the insured person's coverage ends, except as specified as covered in the Certificate.

Excess Amounts. Any amounts in excess of covered expense or the lifetime maximum.

Work-Related. Work-related conditions if benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation, employer's liability law or occupational disease law, whether or not the insured person claims those benefits. If there is a dispute of substantial uncertainty as to whether benefits may be recovered for those conditions pursuant to workers' compensation, we will provide the benefits of this plan for such conditions, subject to a right of recovery and reimbursement under California Labor Code Section 4903, as specified as covered in the Certificate.

Government Treatment. Any services the insured person actually received that were provided by a local, state or federal government agency, except when payment under this plan is expressly required by federal or state law. We will not cover payment for these services if the insured person is not required to pay for them or they are given to the insured person for free.

Services of Relatives. Professional services received from a person living in the insured person's home or who is related to the insured person by blood or marriage, except as specified as covered in the Certificate.

Voluntary Payment. Services for which the insured person has no legal obligation to pay, or for which no charge would be made in the absence of insurance coverage or other health plan coverage, except services received at a non-governmental charitable research hospital. Such a hospital must meet the following guidelines:

1. it must be internationally known as being devoted mainly to medical research;
2. at least 10% of its yearly budget must be spent on research not directly related to patient care;
3. at least one-third of its gross income must come from donations or grants other than gifts or payments for patient care;
4. it must accept patients who are unable to pay; and
5. two-thirds of its patients must have conditions directly related to the hospital's research.

Not Specifically Listed. Services not specifically listed in the plan as covered services.

Private Contracts. Services or supplies provided pursuant to a private contract between the insured person and a provider, for which reimbursement under Medicare program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act.

Inpatient Diagnostic Tests. Inpatient room and board charges in connection with a hospital stay primarily for diagnostic tests which could have been performed safely on an outpatient basis.

Mental or Nervous Disorders. Academic or educational testing, counseling, and remediation. Mental or nervous disorders or substance abuse, including rehabilitative care in relation to these conditions, except as specified as covered in the Certificate.

Orthodontia. Braces, other orthodontic appliances or orthodontic services.

Dental Services or Supplies. Dental plates, bridges, crowns, caps or other dental prostheses, dental implants, dental services, extraction of teeth, treatment to the teeth or gums, or treatment to or for any disorders for the temporomandibular (jaw) joint, except as specified as covered in the Certificate. Cosmetic dental surgery or other dental services for beautification.

Hearing Aids or Tests unless otherwise noted

Optometric Services or Supplies. Optometric services, eye exercises including orthoptics. Routine eye exams and routine eye refractions, as specified as covered in the Certificate. Eyeglasses or contact lenses, except as specified as covered in the Certificate.

Outpatient Occupational Therapy. Outpatient occupational therapy, except by a home health agency, hospice, or home infusion therapy provider, as specified as covered in the Certificate.

Outpatient Speech Therapy. Outpatient speech therapy, except as specified as covered in the Certificate.

Cosmetic Surgery. Cosmetic surgery or other services performed solely for beautification or to alter or reshape normal (including aged) structures or tissues of the body to improve appearance. This exclusion does not apply to reconstructive surgery (that is, surgery performed to correct deformities caused by congenital or developmental abnormalities, illness, or injury for the purpose of improving bodily function or symptomatology or to create a normal appearance), including surgery performed to restore symmetry following mastectomy. Cosmetic surgery does not become reconstructive surgery because of psychological or psychiatric reasons.

Scalp Hair Prostheses. Scalp hair prostheses, including wigs or any form of hair replacement, except as specified as covered in the Certificate.

Commercial Weight Loss Programs. Weight loss programs, whether or not they are pursued under medical or *physician* supervision, unless specifically listed as covered in this *plan*.

This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

This exclusion does not apply to *medically necessary* treatments for morbid obesity or dietary evaluations and counseling, and behavioral modification programs for the treatment of anorexia nervosa or bulimia nervosa. Surgical treatment for morbid obesity is covered as described in the Certificate.

Sterilization Reversal.

Infertility Treatment. Any services or supplies furnished in connection with the diagnosis and treatment of infertility, including, but not limited to diagnostic tests, medication, surgery, artificial insemination, in vitro fertilization, sterilization reversal and gamete intrafallopian transfer.

Surrogate Mother Services. For any services or supplies provided to a person not covered under the plan in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

Orthopedic shoes and shoe inserts. This exclusion does not apply to orthopedic footwear used as an integral part of a brace, shoe inserts that are custom molded to the patient, or therapeutic shoes and inserts designed to treat foot complications due to diabetes, as specifically stated in the EOC..

Air Conditioners. Air purifiers, air conditioners or humidifiers.

Custodial Care or Rest Cures. Inpatient room and board charges in connection with a hospital stay primarily for environmental change or physical therapy. Custodial care or rest cures, except as specified as covered in the Certificate. Services provided by a rest home, a home for the aged, a nursing home or any similar facility. Services provided by a skilled nursing facility, except as specified as covered in the Certificate.

Health Club Memberships. Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment or facilities used for developing or maintaining physical fitness, even if ordered by a *physician*. This exclusion also applies to health spas.

Personal Items. Any supplies for comfort, hygiene or beautification.

Education or Counseling. Educational services or nutritional counseling, except as specified as covered in the Certificate. This exclusion does not apply to counseling for the treatment of anorexia nervosa or bulimia nervosa.

Food or Dietary Supplements. Nutritional and/or dietary supplements, except as provided in this *plan* or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not requirement either a written prescription or dispensing by a licensed pharmacist.

Telephone and Facsimile Machine Consultations. Consultations provided by telephone, except as specified as covered in the Certificate, or facsimile machine.

Routine Exams or Tests. Routine physical exams or tests which do not directly treat an actual illness, injury or condition, including those required by employment or government authority, except as specified as covered in the Certificate.

Acupuncture. Acupuncture treatment, except as specified as covered in the Certificate. Acupressure or massage to control pain, treat illness or promote health by applying pressure to one or more specific areas of the body based on dermatomes or acupuncture points.

Eye Surgery for Refractive Defects. Any eye surgery solely or primarily for the purpose of correcting refractive defects of the eye such as nearsightedness (myopia) and/or astigmatism. Contact lenses and eyeglasses required as a result of this surgery.

Physical Therapy or Physical Medicine. Services of a physician for physical therapy or physical medicine, except when provided during a covered inpatient confinement or as specified as covered in the Certificate.

Outpatient Prescription Drugs and Medications. Outpatient prescription drugs or medications and insulin, except as specified as covered in the Certificate. Non-prescription, over-the-counter patent or proprietary drug or medicines. except as specified as covered in the Certificate. Cosmetics, health or beauty aids.

Specialty Pharmacy Drugs. Specialty pharmacy drugs that must be obtained from the specialty pharmacy program, but, which are obtained from a retail pharmacy, are not covered by this plan. **Insured person will have to pay the full cost of the specialty pharmacy drugs obtained from a retail pharmacy that should have been obtained from the specialty pharmacy program.**

Contraceptive Devices. Contraceptive devices prescribed for birth control except as specified as covered in the Certificate.

Diabetic Supplies. Prescription and non-prescription diabetic supplies except as specified as covered in the Certificate.

Private Duty Nursing. Inpatient or outpatient services of a private duty nurse.

Lifestyle Programs. Programs to alter one's lifestyle which may include but are not limited to diet, exercise, imagery or nutrition, except as specified as covered in the Certificate. This exclusion will not apply to cardiac rehabilitation programs approved by us.

Clinical Trials. Services and supplies in connection with clinical trials, except as specified as covered in the Certificate.

Lumenos HSA Rx Copay after Deductible Plan — Exclusions and Limitations (Continued)

Outpatient prescription drug services and supplies are not provided for or in connection with the following:

Immunizing agents, biological sera, blood, blood products or blood plasma

Hypodermic syringes &/or needles, except when dispensed for use with insulin & other self-injectable drugs or medications

Drugs & medications used to induce spontaneous & non-spontaneous abortions

Drugs & medications dispensed or administered in an outpatient setting, including outpatient hospital facilities and physicians' offices

Professional charges in connection with administering, injecting or dispensing drugs

Drugs & medications that may be obtained without a physician's written prescription, except insulin or niacin for cholesterol lowering and certain over-the-counter drugs approved by the Pharmacy and Therapeutics Committee to be included in the prescription drug formulary.

Drugs & medications dispensed by or while confined in a hospital, skilled nursing facility, rest home, sanatorium, convalescent hospital or similar facility

Durable medical equipment, devices, appliances & supplies, even if prescribed by a physician, except contraceptive diaphragms, as specified as covered in the Certificate

Services or supplies for which the insured person is not charged

Oxygen

Cosmetics & health or beauty aids.

Drugs labeled "Caution, Limited by Federal Law to Investigational Use," or Non-FDA approved investigational drugs. Any drugs or medications prescribed for experimental indications

Any expense for a drug or medication incurred in excess of the prescription drug maximum allowed amount

Drugs which have not been approved for general use by the State of California Department of Health Services or the Food and Drug Administration. This does not apply to drugs that are medically necessary for a covered condition.

Drugs to eliminate or reduce dependency on, or addiction to, tobacco and tobacco products. This does not apply to medically necessary drugs that the insured person can only get with a prescription under state and federal law.

Drugs used primarily for cosmetic purposes (e.g., Retin-A for wrinkles). However, this will not apply to the use of this type of drug for medically necessary treatment of a medical condition other than one that is cosmetic.

Drugs used primarily to treat infertility (including, but not limited to, Clomid, Pergonal and Metrodin), unless medically necessary for another covered condition.

Anorexiants and drugs used for weight loss, except when used to treat morbid obesity (e.g., diet pills & appetite suppressants)

Drugs obtained outside the U.S. unless they are furnished in connection with urgent care or an emergency.

Allergy desensitization products or allergy serum

Infusion drugs, except drugs that are self-administered subcutaneously

Herbal supplements, nutritional and dietary supplements except for formulas for the treatment of phenylketonuria.

Prescription drugs with a non-prescription (over-the-counter) chemical and dose equivalent except insulin. This does not apply if an over-the-counter equivalent was tried and was in effective.

Compound medications unless:

a. There is at least one component in it that is a prescription drug; and
b. It is obtained from other than a participating pharmacy. **Insured person will have to pay the full cost of the compound medications if insured person obtains drug at a non-participating pharmacy.**

Specialty pharmacy drugs that must be obtained from the specialty pharmacy program, but, which are obtained from a retail pharmacy are not covered by this plan. **Insured person will have to pay the full cost of the specialty pharmacy drugs obtained from a retail pharmacy that insured person should have obtained from the specialty pharmacy program.**

Third Party Liability – Anthem Blue Cross Life and Health Insurance Company is entitled to reimbursement of benefits paid if the insured person recovers damages from a legally liable third party.

Coordination of Benefits – The benefits of this plan may be reduced if the insured person has any other group health or dental coverage so that the services received from all group coverages do not exceed 100% of the covered expense.

SJVIA HDPPO 2500 BlueCard Lumenos® Health Savings Account (HSA) Custom LHSA 289 (2500/90/50)

Rx Copay after Deductible

Anthem believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that this plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.
Questions regarding which protections of the Affordable Care Act apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Anthem at the telephone number printed on the back of your member identification card, or contact your group benefits administrator if you do not have an identification card. For ERISA plans, you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1–866–444–3272 or www.dol.gov/ebsa/healthreform. This Web site has a table summarizing which protections do and do not apply to grandfathered health plans. For nonfederal governmental plans, you may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

This Lumenos plan is an innovative type of coverage that allows an insured person to use a Health Savings Account to pay for routine medical care. The program also includes traditional health coverage, similar to a typical health plan, which protects the insured person against large medical expenses.
The insured person can spend the money in the HSA account the way the insured person wants on routine medical care, prescription drugs and other qualified medical expenses. There are no copays or deductibles to satisfy first. Unused dollars can be saved from year to year to reduce the amount the insured person may have to pay in the future. If covered expenses exceed the insured person's available HSA dollars, the traditional health coverage is available after a limited out-of-pocket amount is paid by the insured person.
Certain Covered Services have maximum visit and/or day limits per year. The number of visits and/or days allowed for these services will begin accumulating on the first visit and/or day, regardless of whether your deductible has been met.
The insured person is responsible for all costs over the plan maximums. Plan maximums and other important information appear in *italics*. Benefits are subject to all terms, conditions, limitations, and exclusions of the Policy.

Explanation of Maximum Allowed Amount

Maximum Allowed Amount is the total reimbursement payable under the plan for covered services received from Participating and Non-Participating Providers. It is the payment towards the services billed by a provider combined with any applicable deductible, copayment or coinsurance.
Participating Providers- The rate the provider has agreed to accept as reimbursement for covered services. Members are not responsible for the difference between the provider's usual charges & the maximum allowed amount.
Non-Participating Providers & Other Health Care Providers-(includes those not represented in the PPO provider network)-Reimbursement amount is based on: an Anthem Blue Cross rate or fee schedule, a rate negotiated with the provider, information from a third party vendor, or billed charges. For Medical Emergency care rendered by a Non-Participating Provider or Non-Contracting Hospital, reimbursement may be based on the reasonable and customary value. Members may be responsible for any amount in excess of the reasonable and customary value.
Participating Pharmacies & Mail Service Program-members are not responsible for any amount in excess of the prescription drug maximum allowed amount.
Non-Participating Pharmacies-members are responsible for any expense not covered under this plan & any amount in excess of the prescription drug maximum allowed amount. When using non-participating providers, the insured person is responsible for any difference between the covered expense & actual charges, as well as any deductible & percentage copay.
When using the outpatient prescription drug benefits, the insured person is always responsible for drug expenses which are not covered under this plan, as well as any deductible, percentage or dollar copay.

Calendar year deductible for all providers *(applicable to medical care & prescription drug benefits)*	
➢ Individual insured person	$2,500/individual insured person
➢ Insured family *(includes insured employee & one or more members of the employee's family; no coverage may be paid for any member of a family unless this $5,000 deductible is met)*	$5,000/insured family
Deductible for hospital if utilization review not obtained	$250/admission *(waived for emergency admission)*
Annual Out-of-Pocket Maximums *(in-network/out-of-network out-of-pocket maximums are exclusive of each other; includes calendar year deductible & prescription drug covered expense)*	
➢ For all Providers & Other Health Care Providers & all Participating Pharmacies	$5,000/individual insured person; $10,000/insured family/year

The following do not apply to out-of-pocket maximums: costs in excess of the covered expense & non-covered expense. After an individual insured person or insured family *(includes insured employee & one or more members of the employee's family)* reaches the out-of-pocket maximum for all medical and prescription drug covered expense the individual insured person or insured family incurs during that calendar year, the individual insured person or insured family will no longer be required to pay a copay for the remainder of that year. The individual insured person or insured family remains responsible for costs in excess of the covered expense when provided by non-participating providers and other health care providers; non-covered expense.

Lifetime Maximum	Unlimited

Covered Services	Traditional Health Coverage Insured Person Copay In-Network	 Out-of-Network *(Insured is also responsible for charges in excess of covered expense.)*
Hospital Medical Services *(subject to utilization review for inpatient services; waived for emergency admissions)*		
➢ Semi-private room, meals & special diets, & ancillary services	10%	50% up to $580 plan payment per day
➢ Outpatient medical care, surgical services & supplies *(hospital care other than emergency room care)*	10%	50% *(benefit limited to $350/day)*
Ambulatory Surgical Centers		
➢ Outpatient surgery, services & supplies	10%	50% *(benefit limited to $350/day)*
Skilled Nursing Facility *(subject to utilization review)*		
➢ Semi-private room, services & supplies *(limited to 100 days/calendar year)*	10%	10%
Hospice Care *(subject to utilization review) ($10,000 combined maximum per member per lifetime)*		
➢ Inpatient or outpatient services for insured persons with up to one year life expectancy; family bereavement services	10%	10%
Home Health Care *(subject to utilization review)*		
➢ Services & supplies from a home health agency *(limited to 100 visits/calendar year, one visit by a home health aide equals four hours or less; not covered while insured person receives hospice care)*	10%	10%
Home Infusion Therapy		
➢ Includes medication, ancillary services & supplies; caregiver training & visits by provider to monitor therapy; durable medical equipment; lab services	10%	10%
Physician Medical Services		
➢ Office & home visits	10%	50%
➢ Hospital & skilled nursing facility visits	10%	50%
➢ Surgeon & surgical assistant; anesthesiologist or anesthetist	10%	50%
➢ Drugs administered by a medical provider *(certain drugs are subject to utilization review)*	10%	50%
Diagnostic X-ray & Lab		
➢ MRI, CT scan, PET scan & nuclear cardiac scan *(subject to utilization review)*	10%	50%
➢ Other diagnostic x-ray & lab	10%	50%
Preventive Care Services Preventive Care Services including*, physical exams, preventive screenings (including screenings for cancer, HPV, diabetes, cholesterol, blood pressure, hearing and vision immunizations, health education, intervention services, HIV testing), and additional preventive care for women provided for in the guidelines supported by the Health Resources and Services Administration. *This list is not exhaustive. This benefit includes all Preventive Care Services required by federal and state law.	No copay (deductible waived)	50%
Physical Therapy, Physical Medicine & Occupational Therapy, including Chiropractic Services *(limited to 12 visits/calendar year; additional visits may be approved; if medically necessary)*	10%	50%
Speech Therapy		
➢ Outpatient speech therapy following injury or organic disease	10%	50%

Covered Services	Traditional Health Coverage Insured Person Copay In-Network	Out-of-Network *(Insured is also responsible for charges in excess of covered expense.)*
Acupuncture		
➢ Services for the treatment of disease, illness or injury *(limited to 20 visits/calendar year)*	10%[1]	50%[1]
Temporomandibular Joint Disorders		
➢ Splint therapy & surgical treatment	10%	50%
Pregnancy & Maternity Care		
➢ Physician office visits	10%	50%
➢ Prescription drug for elective abortion *(mifepristone)*	10%	50%
Normal delivery, cesarean section, complications of pregnancy & abortion		
➢ Inpatient physician services	10%	50%
➢ Hospital & ancillary services	10%	50% *(benefit limited to $580/day)*
Organ & Tissue Transplants *(subject to utilization review; specified organ transplants covered only when performed at a Center of Expertise [COE])*		
➢ Inpatient services provided in connection with non-investigative organ or tissue transplants	10%	
➢ Transplant travel expense for an authorized, specified transplant at a *COE (recipient & companion transportation limited to 6 trips/episode & $250/person/trip for round-trip coach airfare hotel limited to 1 room double occupancy & $100/day for 21 days/trip, other expenses limited to $25/day/person for 21 days/trip; donor transportation limited to 1 trip/episode & $250 for round-trip coach airfare, hotel limited to $100/day for 7 days, other expenses limited to $25/day for 7 days)*	No copay	
Bariatric Surgery *(subject to utilization review; medically necessary surgery for weight loss, only for morbid obesity, covered only when performed at a Center of Expertise [COE])*		
➢ Inpatient services provided in connection with medically necessary surgery for weight loss, only for morbid obesity	10%	
➢ Bariatric travel expense when insured person's home is 50 miles or more from the nearest bariatric *COE (insured person's transportation to & from COE limited to $130/person/trip for 3 trips [pre-surgical visit, initial surgery & one follow-up visit]; one companion's transportation to & from COE limited to $130/person/trip for 2 trips [initial surgery & one follow-up visit]; hotel for insured person & one companion limited to one room double occupancy & $100/day for 2 days/trip, or as medically necessary, for pre-surgical & follow-up visit; hotel for one companion limited to one room double occupancy & $100/day for duration of insured person's initial surgery stay for 4 days; other reasonable expenses limited to $25/day/person for 4 days/trip)*	No copay	
Diabetes Education Programs *(requires physician supervision)*		
➢ Teach insured persons & their families about the disease process, the daily management of diabetic therapy & self-management training	10%	50%

[1] Acupuncture services can be performed by a certified acupuncturist (C.A.), a doctor of medicine (M.D.), a doctor of osteopathy (D.O.), a podiatrist (D.P.M.), or a dentist (D.D.S.).

Covered Services	Traditional Health Coverage Insured Person Copay In-Network	Out-of-Network *(Insured is also responsible for charges in excess of covered expense.)*
Prosthetic Devices		
➢ Coverage for breast prostheses; prosthetic devices to restore a method of speaking; surgical implants; artificial limbs or eyes; the first pair of contact lenses or eyeglasses when required as a result of eye surgery; wigs for alopecia resulting from chemotherapy or radiation therapy; & therapeutic shoes & inserts for insured persons with diabetes	10%	10%
Durable Medical Equipment		
Rental or purchase of DME including dialysis equipment & supplies, home medical equipment, prosthetics/orthotics *(hearing aids benefit available for one hearing aid per ear every three years; breast pump and supplies are covered under preventive care at no charge for in-network)*	10%	10%
Related Outpatient Medical Services & Supplies		
➢ Ground or air ambulance transportation, services & disposable supplies	10%[1]	
➢ Blood transfusions, blood processing & the cost of unreplaced blood & blood products	10%[1]	
➢ Autologous blood *(self-donated blood collection, testing, processing & storage for planned surgery)*	10%[1]	
Emergency Care		
➢ Emergency room services & supplies	10%	10%
➢ Inpatient hospital services & supplies	10%	10%
➢ Physician services	10%	10%
Mental or Nervous Disorders and Substance Abuse		
Inpatient Care		
➢ Facility-based care *(subject to utilization review; waived for emergency admissions)*	10%	50% *(benefit limited to $580/day)*
➢ Inpatient physician visits	10%	50%
Outpatient Care		
➢ Facility-based care *(subject to utilization review; waived for emergency admissions)*	10%	50% *(benefit limited to $350/day)*
➢ Outpatient physician visits *(Behavioral Health treatment for Autism & Pervasive Disorder will be subject to pre-service review)*	10%	50%

[1] These providers are not represented in the Anthem Blue Cross PPO Network.

Covered Services (For Outpatient Prescription Drugs)	Traditional Health Coverage Per Insured Person Copay for Each Prescription or Refill
Outpatient Prescription Drug Benefits *(Until the calendar year deductible is satisfied, the insured person pays the prescription drug ,maximum allowed amount and not the copays listed below.)*	
➢ **Retail Pharmacy**	
➢ Preventive immunizations administered by a retail pharmacy -	No copay (*deductible waived)*
➢ Female oral contraceptives generic and single source brand	No copay (*deductible waived)*
➢ Generic drugs	$7
➢ Brand name formulary drugs[1,2]	$25
➢ Self-administered injectable drugs, except insulin	$25
Home Delivery	
➢ Female oral contraceptives generic and single source brand	No copay
➢ Generic drugs	$14
➢ Brand name formulary drugs[1,2]	$50
➢ Self-administered injectable drugs, except insulin	$25
Specialty pharmacy drugs *(may only be obtained through the specialty pharmacy program)*	
➢ Generic drugs	$7
➢ Brand name formulary drugs[1]	$25
➢ Self-administered injectable drugs, except insulin	$25
Non-participating Pharmacies *(compound drugs & specialty pharmacy drugs not covered at retail participating pharmacies)*	*Insured person pays the above retail pharmacy copay plus:* 30% of the remaining prescription drug maximum allowed amount & costs in excess of the maximum amount allowed
Supply Limits[3]	
➢ Retail Pharmacy *(participating and non-participating)*	30-day supply; 60-day supply for federally classified Schedule II attention deficit disorder drugs that require a triplicate prescription form, but require a double copay; 6 tablets or units/30-day period for impotence and/or sexual dysfunction drugs (available only at retail pharmacies)
➢ Home Delivery	90-day supply
➢ Specialty Pharmacy	30-day supply

[1] **Mandatory Generic Substitution:** If an insured person requests a brand name drug when a generic drug substitution exists, the insured person pays the generic drug copay plus the difference in cost between the negotiated rate for the generic drug and the brand name drug, but not more than 50% of our cost of the prescription drug. Mandatory generic substitution does not apply when it has been determined that the brand name drug is medically necessary for the insured person.

[2] When the member's physician has specified "dispense as written" (DAW) for formulary brand drugs, the copay for brand name formulary drugs will apply. When the member's physician has not specified DAW for formulary brand drugs, the member pays the generic drug copay plus the difference in cost between the drug negotiated rate for the generic drug and the brand name formulary drug, but not more than 50% of the drug negotiated rate. Some drugs may also be subject to a review for Medical Necessity by Anthem Blue Cross Life and Health Insurance Company.

[3] Supply limits for certain drugs may be different. Please refer to the Certificate of Insurance for complete information

The Outpatient Prescription Drug Benefit covers the following:

- Outpatient prescription drugs and medications which the law restricts to sale by prescription. Formulas prescribed by a physician for the treatment of phenylketonuria.
- Insulin
- Syringes when dispensed for use with insulin and other self-injectable drugs or medications
- Prescription oral contraceptives; contraceptive diaphragms. Contraceptive diaphragms are limited to one per year.
- Injectable drugs which are self-administered by the subcutaneous route (under the skin) by the patient or insured person. Drugs that have Food and Drug Administration (FDA) labeling for self-administration
- All compound prescription drugs that contain at least one covered prescription ingredient
- Diabetic supplies (i.e., test strips and lancets)
- Prescription drugs for treatment of impotence and/or sexual dysfunction are limited to organic (non-psychological) causes.
- Inhaler spacers and peak flow meters for the treatment of pediatric asthma.
- Smoking cessation products requiring a physician's prescription.
- Certain over-the-counter drugs approved by the Pharmacy and Therapeutics Committee to be included in the prescription drug formulary.

This Summary of Benefits is a brief review of benefits. Once enrolled, insured persons will receive a Certificate of Insurance, which explains the exclusions and limitations, as well as the full range of covered services of the plan in detail.

Lumenos HSA Plan — Exclusions and Limitations

Benefits are not provided for expenses incurred for or in connection with the following items:

Not Medically Necessary. Services or supplies that are not medically necessary, as defined.

Experimental or Investigative. Any experimental or investigative procedure or medication. But, if insured person is denied benefits because it is determined that the requested treatment is experimental or investigative, the insured person may request an independent medical review, as described in the Certificate.

Outside the United States. Services or supplies furnished and billed by a provider outside the United States, unless such services or supplies are furnished in connection with urgent care or an emergency.

Crime or Nuclear Energy. Conditions that result from (1) the insured person's commission of or attempt to commit a felony, as long as any injuries are not a result of a medical condition or an act of domestic violence; or (2) any release of nuclear energy, whether or not the result of war, when government funds are available for the treatment of illness or injury arising from the release of nuclear energy.

Not Covered. Services received before the insured person's effective date. Services received after the insured person's coverage ends, except as specified as covered in the Certificate.

Excess Amounts. Any amounts in excess of covered expense or the lifetime maximum.

Work-Related. Work-related conditions if benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation, employer's liability law or occupational disease law, whether or not the insured person claims those benefits. If there is a dispute of substantial uncertainty as to whether benefits may be recovered for those conditions pursuant to workers' compensation, we will provide the benefits of this plan for such conditions, subject to a right of recovery and reimbursement under California Labor Code Section 4903, as specified as covered in the Certificate.

Government Treatment. Any services the insured person actually received that were provided by a local, state or federal government agency, except when payment under this plan is expressly required by federal or state law. We will not cover payment for these services if the insured person is not required to pay for them or they are given to the insured person for free.

Services of Relatives. Professional services received from a person living in the insured person's home or who is related to the insured person by blood or marriage, except as specified as covered in the Certificate.

Voluntary Payment. Services for which the insured person has no legal obligation to pay, or for which no charge would be made in the absence of insurance coverage or other health plan coverage, except services received at a non-governmental charitable research hospital. Such a hospital must meet the following guidelines:

1. it must be internationally known as being devoted mainly to medical research;
2. at least 10% of its yearly budget must be spent on research not directly related to patient care;
3. at least one-third of its gross income must come from donations or grants other than gifts or payments for patient care;
4. it must accept patients who are unable to pay; and
5. two-thirds of its patients must have conditions directly related to the hospital's research.

Not Specifically Listed. Services not specifically listed in the plan as covered services.

Private Contracts. Services or supplies provided pursuant to a private contract between the insured person and a provider, for which reimbursement under Medicare program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act.

Inpatient Diagnostic Tests. Inpatient room and board charges in connection with a hospital stay primarily for diagnostic tests which could have been performed safely on an outpatient basis.

Mental or Nervous Disorders. Academic or educational testing, counseling, and remediation. Mental or nervous disorders or substance abuse, including rehabilitative care in relation to these conditions, except as specified as covered in the Certificate.

Orthodontia. Braces, other orthodontic appliances or orthodontic services.

Dental Services or Supplies. Dental plates, bridges, crowns, caps or other dental prostheses, dental implants, dental services, extraction of teeth, treatment to the teeth or gums, or treatment to or for any disorders for the temporomandibular (jaw) joint, except as specified as covered in the Certificate. Cosmetic dental surgery or other dental services for beautification.

Hearing Aids or Tests unless otherwise noted

Optometric Services or Supplies. Optometric services, eye exercises including orthoptics. Routine eye exams and routine eye refractions, as specified as covered in the Certificate. Eyeglasses or contact lenses, except as specified as covered in the Certificate.

Outpatient Occupational Therapy. Outpatient occupational therapy, except by a home health agency, hospice, or home infusion therapy provider, as specified as covered in the Certificate.

Outpatient Speech Therapy. Outpatient speech therapy, except as specified as covered in the Certificate.

Cosmetic Surgery. Cosmetic surgery or other services performed solely for beautification or to alter or reshape normal (including aged) structures or tissues of the body to improve appearance. This exclusion does not apply to reconstructive surgery (that is, surgery performed to correct deformities caused by congenital or developmental abnormalities, illness, or injury for the purpose of improving bodily function or symptomatology or to create a normal appearance), including surgery performed to restore symmetry following mastectomy. Cosmetic surgery does not become reconstructive surgery because of psychological or psychiatric reasons.

Scalp Hair Prostheses. Scalp hair prostheses, including wigs or any form of hair replacement, except as specified as covered in the Certificate.

Commercial Weight Loss Programs. Weight loss programs, whether or not they are pursued under medical or *physician* supervision, unless specifically listed as covered in this *plan*.

This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

This exclusion does not apply to *medically necessary* treatments for morbid obesity or dietary evaluations and counseling, and behavioral modification programs for the treatment of anorexia nervosa or bulimia nervosa. Surgical treatment for morbid obesity is covered as described in the Certificate.

Sterilization Reversal.

Infertility Treatment. Any services or supplies furnished in connection with the diagnosis and treatment of infertility, including, but not limited to diagnostic tests, medication, surgery, artificial insemination, in vitro fertilization, sterilization reversal and gamete intrafallopian transfer.

Surrogate Mother Services. For any services or supplies provided to a person not covered under the plan in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

Orthopedic shoes and shoe inserts. This exclusion does not apply to orthopedic footwear used as an integral part of a brace, shoe inserts that are custom molded to the patient, or therapeutic shoes and inserts designed to treat foot complications due to diabetes, as specifically stated in the EOC..

Air Conditioners. Air purifiers, air conditioners or humidifiers.

Custodial Care or Rest Cures. Inpatient room and board charges in connection with a hospital stay primarily for environmental change or physical therapy. Custodial care or rest cures, except as specified as covered in the Certificate. Services provided by a rest home, a home for the aged, a nursing home or any similar facility. Services provided by a skilled nursing facility, except as specified as covered in the Certificate.

Health Club Memberships. Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment or facilities used for developing or maintaining physical fitness, even if ordered by a *physician*. This exclusion also applies to health spas.

Personal Items. Any supplies for comfort, hygiene or beautification.

Education or Counseling. Educational services or nutritional counseling, except as specified as covered in the Certificate. This exclusion does not apply to counseling for the treatment of anorexia nervosa or bulimia nervosa.

Food or Dietary Supplements. Nutritional and/or dietary supplements, except as provided in this *plan* or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not requirement either a written prescription or dispensing by a licensed pharmacist.

Telephone and Facsimile Machine Consultations. Consultations provided by telephone, except as specified as covered in the Certificate, or facsimile machine.

Routine Exams or Tests. Routine physical exams or tests which do not directly treat an actual illness, injury or condition, including those required by employment or government authority, except as specified as covered in the Certificate.

Acupuncture. Acupuncture treatment, except as specified as covered in the Certificate. Acupressure or massage to control pain, treat illness or promote health by applying pressure to one or more specific areas of the body based on dermatomes or acupuncture points.

Eye Surgery for Refractive Defects. Any eye surgery solely or primarily for the purpose of correcting refractive defects of the eye such as nearsightedness (myopia) and/or astigmatism. Contact lenses and eyeglasses required as a result of this surgery.

Physical Therapy or Physical Medicine. Services of a physician for physical therapy or physical medicine, except when provided during a covered inpatient confinement or as specified as covered in the Certificate.

Outpatient Prescription Drugs and Medications. Outpatient prescription drugs or medications and insulin, except as specified as covered in the Certificate. Non-prescription, over-the-counter patent or proprietary drug or medicines. except as specified as covered in the Certificate. Cosmetics, health or beauty aids.

Specialty Pharmacy Drugs. Specialty pharmacy drugs that must be obtained from the specialty pharmacy program, but, which are obtained from a retail pharmacy, are not covered by this plan. **Insured person will have to pay the full cost of the specialty pharmacy drugs obtained from a retail pharmacy that should have been obtained from the specialty pharmacy program.**

Contraceptive Devices. Contraceptive devices prescribed for birth control except as specified as covered in the Certificate.

Diabetic Supplies. Prescription and non-prescription diabetic supplies except as specified as covered in the Certificate.

Private Duty Nursing. Inpatient or outpatient services of a private duty nurse.

Lifestyle Programs. Programs to alter one's lifestyle which may include but are not limited to diet, exercise, imagery or nutrition, except as specified as covered in the Certificate. This exclusion will not apply to cardiac rehabilitation programs approved by us.

Clinical Trials. Services and supplies in connection with clinical trials, except as specified as covered in the Certificate.

Lumenos HSA Rx Copay after Deductible Plan — Exclusions and Limitations (Continued)

Outpatient prescription drug services and supplies are not provided for or in connection with the following:

Immunizing agents, biological sera, blood, blood products or blood plasma

Hypodermic syringes &/or needles, except when dispensed for use with insulin & other self-injectable drugs or medications

Drugs & medications used to induce spontaneous & non-spontaneous abortions

Drugs & medications dispensed or administered in an outpatient setting, including outpatient hospital facilities and physicians' offices

Professional charges in connection with administering, injecting or dispensing drugs

Drugs & medications that may be obtained without a physician's written prescription, except insulin or niacin for cholesterol lowering and certain over-the-counter drugs approved by the Pharmacy and Therapeutics Committee to be included in the prescription drug formulary.

Drugs & medications dispensed by or while confined in a hospital, skilled nursing facility, rest home, sanatorium, convalescent hospital or similar facility

Durable medical equipment, devices, appliances & supplies, even if prescribed by a physician, except contraceptive diaphragms, as specified as covered in the Certificate

Services or supplies for which the insured person is not charged

Oxygen

Cosmetics & health or beauty aids.

Drugs labeled "Caution, Limited by Federal Law to Investigational Use," or Non-FDA approved investigational drugs. Any drugs or medications prescribed for experimental indications

Any expense for a drug or medication incurred in excess of the prescription drug maximum allowed amount

Drugs which have not been approved for general use by the State of California Department of Health Services or the Food and Drug Administration. This does not apply to drugs that are medically necessary for a covered condition.

Drugs to eliminate or reduce dependency on, or addiction to, tobacco and tobacco products. This does not apply to medically necessary drugs that the insured person can only get with a prescription under state and federal law.

Drugs used primarily for cosmetic purposes (e.g., Retin-A for wrinkles). However, this will not apply to the use of this type of drug for medically necessary treatment of a medical condition other than one that is cosmetic.

Drugs used primarily to treat infertility (including, but not limited to, Clomid, Pergonal and Metrodin), unless medically necessary for another covered condition.

Anorexiants and drugs used for weight loss, except when used to treat morbid obesity (e.g., diet pills & appetite suppressants)

Drugs obtained outside the U.S. unless they are furnished in connection with urgent care or an emergency.

Allergy desensitization products or allergy serum

Infusion drugs, except drugs that are self-administered subcutaneously

Herbal supplements, nutritional and dietary supplements except for formulas for the treatment of phenylketonuria.

Prescription drugs with a non-prescription (over-the-counter) chemical and dose equivalent except insulin. This does not apply if an over-the-counter equivalent was tried and was in effective.

Compound medications unless:

a. There is at least one component in it that is a prescription drug; and
b. It is obtained from other than a participating pharmacy. **Insured person will have to pay the full cost of the compound medications if insured person obtains drug at a non-participating pharmacy.**

Specialty pharmacy drugs that must be obtained from the specialty pharmacy program, but, which are obtained from a retail pharmacy are not covered by this plan. **Insured person will have to pay the full cost of the specialty pharmacy drugs obtained from a retail pharmacy that insured person should have obtained from the specialty pharmacy program.**

Third Party Liability – Anthem Blue Cross Life and Health Insurance Company is entitled to reimbursement of benefits paid if the insured person recovers damages from a legally liable third party.

Coordination of Benefits – The benefits of this plan may be reduced if the insured person has any other group health or dental coverage so that the services received from all group coverages do not exceed 100% of the covered expense.

SJVIA
San Joaquin Valley Insurance Authority

usscript.

Prescription Drug Copays

30 Day Supply:		Mail	
Generic	$10	Generic	$20
Formulary	$20	Formulary	$40
Non-Formulary	$35	Non-Formulary	$60
DAW 1 - No Cost Differential		DAW 1 - No Cost Differential	
DAW 2 - Non-Formulary + Cost Difference		DAW 2 - Non-Formulary + Cost Difference	
90 Day Supply:		**Specialty Medication Copay:**	
Generic	$20	30% ($100.00 max.)	
Formulary	$40		
Non-Formulary	$60	** Specialty medications are covered at a 30-day	
DAW 1 - No Cost Differential		supply only.**	
DAW 2 - Non-Formulary + Cost Difference			
Annual Out-of-Pocket Maximum			
Individual	$2,000		
Family	$4,000		

Exclusions

Hair Treatments
Pigmenting/Depigmenting
Anti-wrinkle
Fluoride Preps
Misc. Medical Supplies
OTC Medications
Miscellaneous Injectables
Toradol (excluded at mail)
Zyvox (excluded at mail)

This is not a complete summary of benefits. Additional limitations and exclusions may apply.

Disclosure Form

SJVIA - County of Tulare
Customer ID 39189
Member Services 1-800-464-4000
Home Region: Northern California

Principal benefits for Kaiser Permanente Traditional Plan

(1/1/17—12/31/17)

Health Plan believes this coverage is a "grandfathered health plan" under the Patient Protection and Affordable Care Act. If you have questions about grandfathered health plans, please call our Member Service Contact Center.

Accumulation Period

The Accumulation Period for this plan is 1/1/17 through 12/31/17 (calendar year).

Out-of-Pocket Maximum(s) and Deductible(s)

For Services that apply to the Plan Out-of-Pocket Maximum, you will not pay any more Cost Share for the rest of the Accumulation Period once you have reached the amounts listed below.

Amounts Per Accumulation Period	Self-Only Coverage (a Family of one Member)	Family Coverage Each Member in a Family of two or more Members	Family Coverage Entire Family of two or more Members
Plan Out-of-Pocket Maximum	$1,500	$1,500	$3,000
Plan Deductible	None	None	None
Drug Deductible	None	None	None

Professional Services (Plan Provider office visits)	You Pay
Most Primary Care Visits and most Non-Physician Specialist Visits	$25 per visit
Most Physician Specialist Visits	$25 per visit
Routine physical maintenance exams, including well-woman exams	No charge
Well-child preventive exams (through age 23 months)	No charge
Family planning counseling and consultations	No charge
Scheduled prenatal care exams	No charge
Routine eye exams with a Plan Optometrist	No charge
Urgent care consultations, evaluations, and treatment	$25 per visit
Most physical, occupational, and speech therapy	$25 per visit

Outpatient Services	You Pay
Outpatient surgery and certain other outpatient procedures	$25 per procedure
Allergy injections (including allergy serum)	$3 per visit
Most immunizations (including the vaccine)	No charge
Most X-rays and laboratory tests	No charge
Covered individual health education counseling	No charge
Covered health education programs	No charge

Hospitalization Services	You Pay
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	$250 per admission

Emergency Health Coverage	You Pay
Emergency Department visits	$100 per visit

Note: This Cost Share does not apply if you are admitted directly to the hospital as an inpatient for covered Services (see "Hospitalization Services" for inpatient Cost Share).

Ambulance Services	You Pay
Ambulance Services	$50 per trip

Prescription Drug Coverage	You Pay
Covered outpatient items in accord with our drug formulary guidelines:	
Most generic items at a Plan Pharmacy or through our mail-order service	$10 for up to a 100-day supply
Most brand-name items at a Plan Pharmacy or through our mail-order service	$20 for up to a 100-day supply
Most specialty items at a Plan Pharmacy	$20 for up to a 30-day supply

Durable Medical Equipment (DME)	You Pay
DME items in accord with our DME formulary guidelines	20% Coinsurance

Mental Health Services	You Pay
Inpatient psychiatric hospitalization	$250 per admission
Individual outpatient mental health evaluation and treatment	$25 per visit
Group outpatient mental health treatment	$12 per visit

(continues)

Disclosure Form *(continued)*

Chemical Dependency Services	You Pay
Inpatient detoxification	$250 per admission
Individual outpatient chemical dependency evaluation and treatment	$25 per visit
Group outpatient chemical dependency treatment	$5 per visit

Home Health Services	You Pay
Home health care (up to 100 visits per Accumulation Period)	No charge

Other	You Pay
Eyeglasses or contact lenses every 24 months	Amount in excess of $150 Allowance
Skilled nursing facility care (up to 100 days per benefit period)	No charge
Prosthetic and orthotic devices	No charge
All Services related to covered infertility treatment	50% Coinsurance
Hospice care	No charge

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Share, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Share amounts. For a complete explanation, please refer to the *EOC*. Please note that we provide all benefits required by law (for example, diabetes testing supplies).

Disclosure Form

SJVIA - County of Tulare
Customer ID 39189
Member Services 1-800-464-4000
Home Region: Northern California

Principal benefits for Kaiser Permanente Deductible HMO Plan

(1/1/17—12/31/17)

Accumulation Period

The Accumulation Period for this plan is 1/1/17 through 12/31/17 (calendar year).

Out-of-Pocket Maximum(s) and Deductible(s)

For Services that apply to the Plan Out-of-Pocket Maximum, you will not pay any more Cost Share for the rest of the Accumulation Period once you have reached the amounts listed below.
For Services that are subject to the Plan Deductible or the Drug Deductible, you must pay Charges for covered Services you receive during the Accumulation Period until you reach the deductible amounts listed below. All payments you make toward your deductible(s) apply to the Plan Out-of-Pocket Maximum amounts listed below.

Amounts Per Accumulation Period	Self-Only Coverage (a Family of one Member)	Family Coverage Each Member in a Family of two or more Members	Family Coverage Entire Family of two or more Members
Plan Out-of-Pocket Maximum	$3,000	$3,000	$6,000
Plan Deductible	$1,000	$1,000	$2,000
Drug Deductible	None	None	None

Professional Services (Plan Provider office visits)	You Pay
Most Primary Care Visits and most Non-Physician Specialist Visits	$20 per visit (Plan Deductible doesn't apply)
Most Physician Specialist Visits	$20 per visit (Plan Deductible doesn't apply)
Routine physical maintenance exams, including well-woman exams	No charge (Plan Deductible doesn't apply)
Well-child preventive exams (through age 23 months)	No charge (Plan Deductible doesn't apply)
Family planning counseling and consultations	No charge (Plan Deductible doesn't apply)
Scheduled prenatal care exams	No charge (Plan Deductible doesn't apply)
Routine eye exams with a Plan Optometrist	No charge (Plan Deductible doesn't apply)
Urgent care consultations, evaluations, and treatment	$20 per visit (Plan Deductible doesn't apply)
Most physical, occupational, and speech therapy	$20 per visit after Plan Deductible

Outpatient Services	You Pay
Outpatient surgery and certain other outpatient procedures	20% Coinsurance after Plan Deductible
Allergy injections (including allergy serum)	No charge after Plan Deductible
Most immunizations (including the vaccine)	No charge (Plan Deductible doesn't apply)
Most X-rays and laboratory tests	$10 per encounter after Plan Deductible
Preventive X-rays, screenings, and laboratory tests as described in the *EOC*	No charge (Plan Deductible doesn't apply)
MRI, most CT, and PET scans	$50 per procedure after Plan Deductible
Covered individual health education counseling	No charge (Plan Deductible doesn't apply)
Covered health education programs	No charge (Plan Deductible doesn't apply)

Hospitalization Services	You Pay
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	20% Coinsurance after Plan Deductible

Emergency Health Coverage	You Pay
Emergency Department visits	20% Coinsurance after Plan Deductible

Note: This Cost Share does not apply if you are admitted directly to the hospital as an inpatient for covered Services (see "Hospitalization Services" for inpatient Cost Share).

Ambulance Services	You Pay
Ambulance Services	$150 per trip after Plan Deductible

Prescription Drug Coverage	You Pay
Covered outpatient items in accord with our drug formulary guidelines:	
Most generic items at a Plan Pharmacy	$10 for up to a 30-day supply (Plan Deductible doesn't apply)
Most generic refills through our mail-order service	$20 for up to a 100-day supply (Plan Deductible doesn't apply)
Most brand-name items at a Plan Pharmacy	$30 for up to a 30-day supply (Plan Deductible doesn't apply)
Most brand-name refills through our mail-order service	$60 for up to a 100-day supply (Plan Deductible doesn't apply)

(continues)

Disclosure Form

(continued)

Most specialty items at a Plan Pharmacy	$30 for up to a 30-day supply (Plan Deductible doesn't apply)

Durable Medical Equipment (DME)	**You Pay**
DME items in accord with our DME formulary guidelines	20% Coinsurance (Plan Deductible doesn't apply)

Mental Health Services	**You Pay**
Inpatient psychiatric hospitalization	20% Coinsurance after Plan Deductible
Individual outpatient mental health evaluation and treatment	$20 per visit (Plan Deductible doesn't apply)
Group outpatient mental health treatment	$10 per visit (Plan Deductible doesn't apply)

Chemical Dependency Services	**You Pay**
Inpatient detoxification	20% Coinsurance after Plan Deductible
Individual outpatient chemical dependency evaluation and treatment	$20 per visit (Plan Deductible doesn't apply)
Group outpatient chemical dependency treatment	$5 per visit (Plan Deductible doesn't apply)

Home Health Services	**You Pay**
Home health care (up to 100 visits per Accumulation Period)	No charge (Plan Deductible doesn't apply)

Other	**You Pay**
Skilled nursing facility care (up to 100 days per benefit period)	20% Coinsurance after Plan Deductible
Prosthetic and orthotic devices	No charge (Plan Deductible doesn't apply)
All Services related to covered infertility treatment	50% Coinsurance (Plan Deductible doesn't apply)
Hospice care	No charge (Plan Deductible doesn't apply)

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Share, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Share amounts. For a complete explanation, please refer to the *EOC*. Please note that we provide all benefits required by law (for example, diabetes testing supplies).

Provided by American Specialty Health Plans of California, Inc. (ASH Plans)

Your Kaiser Permanente CHIROPRACTIC benefits

When you need chiropractic care, follow these simple steps:

1. Find an ASH Plans Participating Provider near you:
   - Go to **ashlink.com/ash/kp**, or
   - Call **1-800-678-9133** (TTY **711**), Monday through Friday, from 5 a.m. to 6 p.m. Pacific time
2. Schedule an appointment.
3. Pay for your office visit when you arrive for your appointment.

(See the reverse for more details.)

American Specialty Health Plans of California

KAISER PERMANENTE®

YOUR KAISER PERMANENTE

CHIROPRACTIC BENEFIT

Services	Cost Sharing and Office Visit Maximums
Chiropractic Services are covered when provided by a Participating Provider and medically necessary to treat or diagnose Neuromusculoskeletal Disorders. You can obtain services from any ASH Plans Participating Provider without a referral from a Plan Physician.	**Office visit cost share:** $10 copay per visit **Office visit limit:** 30 visits per year **Chiropractic appliance benefit:** If the amount of the appliance in the ASH Plans fee schedule exceeds $50, you will pay the amount in excess of $50, and that payment will not apply toward any applicable deductible or out-of-pocket maximum. Covered chiropractic appliances are limited to: elbow supports, back supports, cervical collars, cervical pillows, heel lifts, hot or cold packs, lumbar braces and supports, lumbar cushions, orthotics, wrist supports, rib belts, home traction units, ankle braces, knee braces, rib supports, and wrist braces.

Office visits: Covered Services are limited to Medically Necessary Chiropractic Services authorized and provided by ASH Plans Participating Providers except for Emergency Chiropractic Services and Services that are not available from Participating Providers or other licensed providers with which ASH contracts to provide covered care. Each office visit counts toward any visit limit, if applicable, even if an adjustment is not provided during the visit.

X-rays and laboratory tests: Medically necessary X-rays and laboratory tests are covered at no charge when prescribed as part of covered chiropractic care and a Participating Provider provides the Services or refers you to another licensed provider with which ASH contracts for the Services.

Participating Providers

ASH Plans contracts with Participating Providers and other licensed providers to provide covered Chiropractic Services, including laboratory tests, X-rays, and chiropractic appliances. You must receive covered services from a Participating Provider or another licensed provider with which ASH contracts, except for Emergency Chiropractic Services, Urgent Chiropractic Services, and services that are not available from Participating Providers or other licensed providers with which ASH contracts to provide covered Services that are authorized in advance by ASH Plans. The list of Participating Providers is available on the ASH Plans website at ashlink.com/ash/kp or from the ASH Plans Customer Service Department toll free at **1-800-678-9133** (TTY users call **711**), weekdays from 5 a.m. to 6 p.m. The list of Participating Providers is subject to change at any time without notice.

How to obtain services

To obtain covered services, call a Participating Provider to schedule an initial examination. If additional services are required, verification that the Services are Medically Necessary may be required. Your Participating Provider will request any medical necessity determinations. An ASH Plans clinician in the same or similar specialty as the provider of Services under review will decide whether the Services are or were Medically Necessary Services. ASH Plans will disclose to you, upon request, the process that it uses to authorize, modify, delay, or deny a request for authorization. If you have questions or concerns, please contact the ASH Plans Customer Service Department.

Second Opinions

You may request a second opinion in regard to covered Services by contacting another Participating Provider. A Participating Provider may also request a second opinion in regard to covered Services by referring you to another Participating Provider in the same or similar specialty.

Your Costs

When you receive covered Services, you must pay your Cost Share amount as described in the *Chiropractic Services Amendment* of your Health Plan *Evidence of Coverage*. The Cost Share does not apply toward the Plan Out-of-Pocket Maximum described in the Health Plan *Evidence of Coverage*.

Emergency and Urgent Chiropractic Services

We cover Emergency Chiropractic Services and Urgent Chiropractic Services provided by both Participating Providers and Non–Participating Providers. We do not cover follow-up or continuing care from a Non–Participating Provider unless ASH Plans has authorized the services in advance. Also, we do not cover services from a Non–Participating Provider that ASH Plans determines are not Emergency Chiropractic Services or Urgent Chiropractic Services.

Getting Assistance

If you have a question or concern regarding the services you received from an ASH Plans Participating Provider or another licensed provider with which ASH contracts, you may call ASH Plans Customer Service Department toll free at **1-800-678-9133** (TTY users call **711**), weekdays from 5 a.m. to 6 p.m. Pacific time.

Grievances

You can file a grievance with Kaiser Permanente regarding any issue. Your grievance must explain your issue, such as the reasons why you believe a decision was in error or why you are dissatisfied with Services you received. You may submit your grievance orally or in writing to Kaiser Permanente as described in your Health Plan *Evidence of Coverage*.

Exclusions and Limitations

- Services for asthma or addiction, such as nicotine addiction
- Hypnotherapy, behavior training, sleep therapy, and weight programs
- Thermography
- Experimental or investigational services
- CT scans, MRIs, PET scans, bone scans, nuclear medicine, and any other types of diagnostic imaging or radiology other than X-rays covered under the "Covered Services" section of your *Chiropractic Services Amendment*
- Ambulance and other transportation
- Education programs, nonmedical self-care or self-help, any self-help physical exercise training, and any related diagnostic testing
- Services for pre-employment physicals or vocational rehabilitation
- Air conditioners, air purifiers, therapeutic mattresses, chiropractic appliances, durable medical equipment, supplies, devices, appliances, and any other item except those listed as covered in your *Chiropractic Services Amendment*
- Drugs and medicines, including non-legend or proprietary drugs and medicines
- Services you receive outside the state of California except for Emergency Chiropractic Services and Urgent Chiropractic Services
- Hospital services, anesthesia, manipulation under anesthesia, and related services
- For Chiropractic Services, adjunctive therapy not associated with spinal, muscle, or joint manipulations
- Dietary and nutritional supplements, such as vitamins, minerals, herbs, herbal products, injectable supplements, and similar products
- Massage therapy
- Services provided by a chiropractor that are not within the scope of licensure for a chiropractor licensed in California
- Maintenance care (services provided to members whose treatment records indicate that they have reached maximum therapeutic benefit)

Definitions

ASH Plans: American Specialty Health Plans of California, Inc., a California corporation.

Chiropractic Services: Services provided or prescribed by a chiropractor (including laboratory tests, X-rays, and chiropractic appliances) for the treatment of your Neuromusculoskeletal Disorder.

Emergency Chiropractic Services: Covered Chiropractic Services provided for the treatment of a Neuromusculoskeletal Disorder which manifests itself by acute symptoms of sufficient severity (including severe pain) such that a reasonable person could expect the absence of immediate Chiropractic Services to result in serious jeopardy to your health or body functions or organs.

Neuromusculoskeletal Disorders: Conditions with associated signs and symptoms related to the nervous, muscular, or skeletal systems. Neuromusculoskeletal Disorders are conditions typically categorized as structural, degenerative, or inflammatory disorders, or biomechanical dysfunction of the joints of the body or related components of the motor unit (muscles, tendons, fascia, nerves, ligaments/capsules, discs, and synovial structures), and related neurological manifestations or conditions.

Participating Provider: A chiropractor who is licensed to provide chiropractic services in California and who has a contract with ASH Plans to provide Medically Necessary Chiropractic Services to you.

Urgent Chiropractic Services: Chiropractic Services that meet all of the following requirements:

- They are necessary to prevent serious deterioration of your health, resulting from an unforeseen illness, injury, or complication of an existing condition, including pregnancy.
- They cannot be delayed until you return to the Service Area.

This is only a summary and is intended to highlight only the most frequently asked questions about the benefit, including cost shares. Please refer to the *Chiropractic Services Amendment of the Kaiser Foundation Health Plan, Inc., Evidence of Coverage* for a detailed description of the chiropractic benefits, including exclusions and limitations, Emergency Chiropractic Services, and Urgent Chiropractic Services.

Kaiser Foundation Health Plan, Inc. (Health Plan), contracts with American Specialty Health Plans of California, Inc. (ASH Plans), to make the ASH Plans network of Participating Providers available to you. You can obtain covered Services from any Participating Provider without a referral from a Plan Physician. Your Cost Share is due when you receive covered Services. Please see the definitions section of your *Chiropractic Services Amendment of the Kaiser Foundation Health Plan, Inc., Evidence of Coverage* for terms you should know.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-678-9133 (TTY: 1-877-257-2746).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-678-9133 (رقم هاتف الصم والبكم: 1-877-257-2746).

ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա Ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-800-678-9133 (TTY (հեռատիպ)՝ 1-877-257-2746):

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-678-9133 (TTY: 1-877-257-2746) تماس بگیرید.

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-678-9133 (TTY: 1-877-257-2746) पर कॉल करें।

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-678-9133 (TTY: 1-877-257-2746).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-678-9133（TTY:1-877-257-2746）まで、お電話にてご連絡ください。

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា មានជូនចំពោះអ្នកដោយឥតគិតថ្លៃ។ ទូរស័ព្ទ 1-800-678-9133 (TTY: 1-877-257-2746)។

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-678-9133 (TTY: 1-877-257-2746)번으로 전화해 주십시오.

Dii baa akó nínízin: Dii saad bee yáníłti'go Diné Bizaad, saad bee áká'anída'awo'dęę', t'áá jiik'eh, éí ná hóló, koji' hódíilnih 1-800-678-9133 (TTY: 1-877-257-2746).

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫ਼ਤ ਉਪਲਬਧ ਹੈ। 1-800-678-9133 (TTY: 1-877-257-2746) 'ਤੇ ਕਾਲ ਕਰੋ।

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-678-9133 (телетайп: 1-877-257-2746).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-678-9133 (TTY: 1-877-257-2746).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-678-9133 (TTY: 1-877-257-2746).

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-678-9133 (TTY: 1-877-257-2746)

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-678-9133（TTY：1-877-257-2746）。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-678-9133 (TTY: 1-877-257-2746).

County of Tulare

Your Two Delta Dental Plan Options

The choice is yours. When it comes to dental health, you want benefits that provide you with the best balance of value and coverage. **Delta Dental PPO℠*** and **DeltaCare® USA** both offer comprehensive dental coverage, quality care and excellent customer service. Each plan has its own advantages.**

The PPO plan gives you the freedom to choose any dentist, and the opportunity for meaningful savings on your treatment costs when you visit a PPO dentist. With a DeltaCare USA plan, when you receive treatment from your assigned dentist you have the convenience of knowing what your copayment is for covered procedures before your visit.

You have the option to select either one of these two outstanding dental benefits plans, both administered by one of the foremost dental benefits organizations in the United States. Select either Delta Dental PPO or DeltaCare USA. Whichever plan you choose, we look forward to providing you with the excellent dentist access, great coverage and friendly service that so many enrollees have come to expect.

* In Texas, Delta Dental offers a Dental Provider Organization (DPO) Plan.

** See back page for the underwriters of these plans in your state.

This booklet provides highlights about both dental plans to help you select the coverage option that best fits your needs. It is not intended or designed to serve as an Evidence of Coverage or benefit booklet. For complete information about your coverage, processing policies, limitations and exclusions, please refer to your Evidence of Coverage or benefit booklet. If you still have questions about your coverage, please contact your group's benefits administrator.

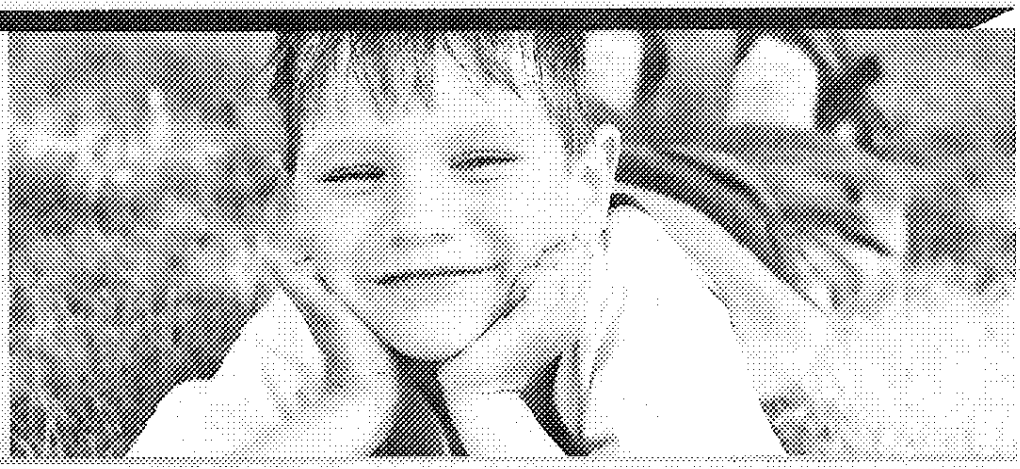
Compare Program Features

Plan Features	Delta Dental PPO	DeltaCare USA
Copayments/coinsurance	• Covered services paid at applicable percentage — for example, fillings are covered at 80% of allowed amount — you pay the remaining 20%	• Covered procedures have predetermined dollar copayments for services provided by network dentists (this means out-of-pocket costs are predictable)
Coverage	• Wide range of covered services • No exclusions for most pre-existing conditions	• Plan covers nearly 300 procedures • No copayments or low copayments for most diagnostic and preventive services • No exclusions for pre-existing conditions or missing teeth
Dentist network	• Freedom to choose any licensed dentist • No referral required for specialty care	• You must select a dentist from a list of network dental facilities and you must visit this dentist to receive benefits • Easy referrals to a large specialty care network
Changing your dentist	• Change dentists any time without contacting Delta Dental	• Ability to change selected or assigned network dentists via telephone or Internet
Transitions from previous plan	• Coverage is provided only for treatment started and completed after your effective date of coverage under the Delta Dental plan	• Coverage is provided only for treatment started and completed after your effective date of coverage under the plan
Orthodontic treatment in progress (when covered under prior plan)	• Plan will pay the remaining amount of the total case fee not paid by your former dental plan (when plan includes orthodontic coverage)	• Covers new enrollees who, on the effective date of their coverage, are in active treatment started under their previous employer-sponsored dental plan • Enrollees are responsible for all copayments and fees subject to the provisions of their prior dental plan
Authorization for specialty care treatment	• Preauthorization is not required	• Preauthorization is required for treatment provided by a specialist • Your DeltaCare USA dentist will coordinate your specialty care treatment authorization
Out-of-area coverage	• Visit any licensed dentist	• Limited to emergency care provision
Deductibles and maximums	• Deductibles and annual maximums apply to most plan designs	• No annual deductible or annual dollar maximums
Claims	• Delta Dental dentists file claim forms and accept payment directly from Delta Dental • Non-Delta Dental dentists may require payment up front, and require you to file a claim for reimbursement	• No claim forms required • You only need to pay the specified copayment at the time of your visit

Delta Dental PPO℠ — Benefit highlights

DELTA DENTAL PPO℠

Easy
Friendly
Accessible



Greatest potential savings when you visit a Delta Dental PPO dentist

OUT-OF-POCKET COSTS

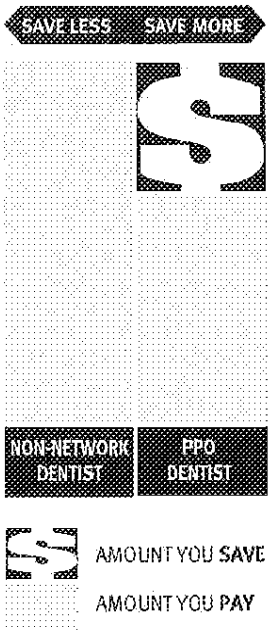


Illustration showing sample enrollee share of cost for information purposes only. Actual dentist fees and contract allowances will vary by region, procedure and by group contract.

We're pleased to be your partner in maintaining great oral health. The Delta Dental PPO* plan makes it easy for you to find a dentist, and easy to control your costs when you visit a network dentist. Here are some of the great things you'll need to know about enrolling with Delta Dental:

- **Save money with a Delta Dental PPO dentist.** Our PPO network dentists accept reduced fees for covered services they provide you, so you'll usually pay the least when you visit a PPO network dentist. This also ensures Delta Dental dentists won't balance bill you the difference between the contracted amount and their usual fee.
- **Visit the dentist of your choice.** Want to visit a non-Delta Dental dentist? No problem. You can visit any licensed dentist, but your costs are usually lowest when you see a PPO dentist.
- **Many network dentists to choose from.** Since Delta Dental offers access to some of the largest dentist networks in the U.S., chances are there's a wide choice of network dentists near your home or office. Four out of five dentists nationwide are contracted Delta Dental dentists, giving more enrollees convenient access to more dentists. Visit us at deltadentalins.com to search our dentist directory by location or specialty.
- **Easy to use your benefits.** When you visit a Delta Dental dentist, pay only your portion for services. Delta Dental dentists will file claim forms for you and receive payment directly from us. Many non-Delta Dental dentists ask that you pay the entire cost up front and wait for reimbursement.
- **Delta Dental's Online Services make getting information quick and easy.** Access your benefits and eligibility, print ID cards and get information about your claims. And check out Delta Dental's oral health resources for tips and information that can help keep your smile healthy.

** In Texas, Delta Dental Insurance Company offers a Dental Provider Organization (DPO) plan.*

Plan Benefit Highlights for: COUNTY OF TULARE
Group No: 16128

DELTA DENTAL PPO℠

BENEFIT HIGHLIGHTS

Eligibility	Primary enrollee, spouse and eligible dependent children to the end of the month dependent turns age 26			
Deductibles	Delta Dental PPO dentists: None Non-Delta Dental PPO dentists: $25 per person / $75 per family each calendar year			
Deductibles waived for Diagnostic & Preventive (D & P)?	Delta Dental PPO dentists: None Non-Delta Dental PPO dentists: Yes			
Maximums	$1,000 per person each calendar year			
Waiting Period(s)	Basic Benefits None	Major Benefits None	Prosthodontics None	Orthodontics None

Diagnostic and General Services*	Delta Dental PPO dentists**	Non-Delta Dental PPO dentists**
Diagnostic & Preventive Services (D & P) Exams, cleaning and x-rays	100 %	100 %
Basic Services Fillings and simple tooth extractions	80 %	80 %
Endodontics (root canals) Covered Under Basic Services	80 %	80 %
Periodontics (gum treatment) Covered Under Basic Services	80 %	80 %
Oral Surgery Covered Under Basic Services	80 %	80 %
Major Services Crowns, inlays, onlays and cast restorations	50 %	50 %
Prosthodontics Bridges, dentures and implants	50 %	50 %
Orthodontic Benefits Adults and dependent children	50 %	50 %
Orthodontic Maximums	$1,500 Lifetime	$1,500 Lifetime
Dental Accident Benefits	100 % (separate $1,000 maximum per person per calendar year)	100 % (separate $1,000 maximum per person per calendar year)

* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.

** Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and program allowance for non-Delta Dental dentists.

Delta Dental of California
100 First St.
San Francisco, CA 94105

Customer Service
800-765-6003

Claims Address
P.O. Box 997330
Sacramento, CA 95899-7330

deltadentalins.com

This benefit information is not intended or designed to replace or serve as the plan's Evidence of Coverage or Summary Plan Description. If you have specific questions regarding the benefits, limitations or exclusions for your plan, please consult your company's benefits representative

Getting the most from your plan

DELTA DENTAL PPO℠

Easy
Friendly
Accessible

With PPO there are no claim forms to submit.


Select a PPO dentist


Schedule an appointment


Receive dental care


Pay only patient's share to dentist

No paperwork.
No hassle.

Save money with a Delta Dental PPO℠ dentist

Although you can visit any dentist, you'll usually pay less when you visit a Delta Dental PPO dentist.

- PPO dentists agree to accept Delta Dental contracted fees as full payment.
- Your share of the bill will likely be lower than when you visit a non-Delta Dental dentist.

Find a Delta Dental PPO dentist

Delta Dental PPO, our preferred provider organization (PPO) plan,* provides access to the largest network of its kind nationwide.

Your out-of-pocket costs are usually lowest when you visit a PPO dentist.

To find the most current listing of our network dental offices:

- Visit our website and click on "Find a Dentist" on our home page.
- Select "Delta Dental PPO" as your plan network.

Is your dentist a Delta Dental PPO dentist?

We recommend that you verify your current dentist's participation in the Delta Dental PPO network. Simply asking if a dentist "accepts Delta Dental" does not guarantee he or she is a PPO dentist.

- Ask specifically if he or she is a contracted Delta Dental PPO dentist.
- You should verify your dentist's participation before each dental appointment.

Maximum choice

The Delta Dental Premier® network — our larger network consisting of nearly 80 percent of dentists nationwide — provides cost-saving features and is the next best option if you can't find a PPO dentist. You can find a Premier dentist using our online dentist directory.

- Premier dentists' contracted fees are usually somewhat higher than PPO dentists' contracted fees.
- Premier dentists will not bill you above their contracted fees, so you still receive cost protections not available with a non-Delta Dental dentist.**

Easy to use

- No ID card is required to receive services; simply provide the dental office with your name, date of birth and social security or enrollee ID number.
- No claim forms to file — Delta Dental dentists file claim forms for you and accept payment directly from Delta Dental.
- After a claim has been processed, you will receive a dental benefits statement from Delta Dental. This document lists the services provided, the costs of the dental treatment and the amount of any fees you owe your dentist.

* In Texas, Delta Dental Insurance Company offers a Dental Provider Organization (DPO) plan.

** Please review your Evidence of Coverage, Summary Plan Description or Group Dental Service Contract for specific details about your plan's dentist network.

Dual coverage/Coordination of benefits

If your spouse has coverage with another dental plan, you or your family members may be covered by both dental plans.*

- The two plans will likely coordinate benefits to potentially lower your out-of-pocket costs.
- Ask your dentist to submit the other plan's Explanation of Benefits with the Delta Dental claim form and we'll take it from there.

Orthodontic treatment in progress

If your Delta Dental plan includes orthodontic benefits, payment for orthodontic treatment in progress depends on the specific provisions of your plan. Typically, treatment in progress is covered and Delta Dental begins paying during the first eligible month. Under some plans, however, you may not be eligible for work in progress or you may lose eligibility if your coverage has lapsed for more than 30 or 60 days.

Transitioning from another plan?

Delta Dental covers treatment started and completed after your plan's effective date of coverage. If you have any dental treatment in progress when your coverage begins — such as root canals, crowns and bridgework — those expenses are not covered by Delta Dental. Those costs may either be your responsibility or that of your previous dental carrier.

Visit our website: deltadentalins.com

On our website, you can:

- Find a dentist in our online directory
- Review benefits
- Check claim status
- Print an ID card and much more

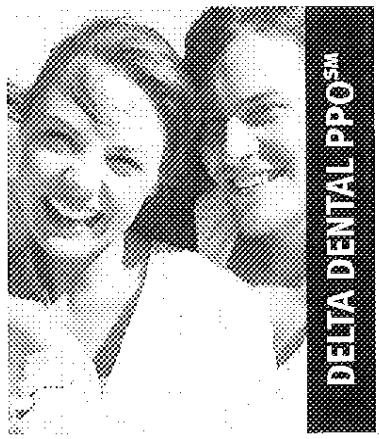
To access some services, you'll need to log in: simply enter your user name and password in the designated boxes and submit. If you are visiting our website for the first time, you'll need to complete a quick one-time registration process by clicking the "Register Today" link.

Talk to your dentist about your health and treatment options

When you visit the dentist, be sure to share your dental and medical history and any prior complications. Dentists can identify signs of more serious health conditions and should be made aware of health information that may be critical to your dental care.

Questions about your plan?

If you have questions, you can check your benefits, eligibility and claims information on our website or on our interactive voice response telephone line. For more information, you may also contact us through our website or call one of our helpful multilingual Customer Service representatives toll-free during business hours.



SmileWay®
Your smile. Your health. Your way.
Wellness Program

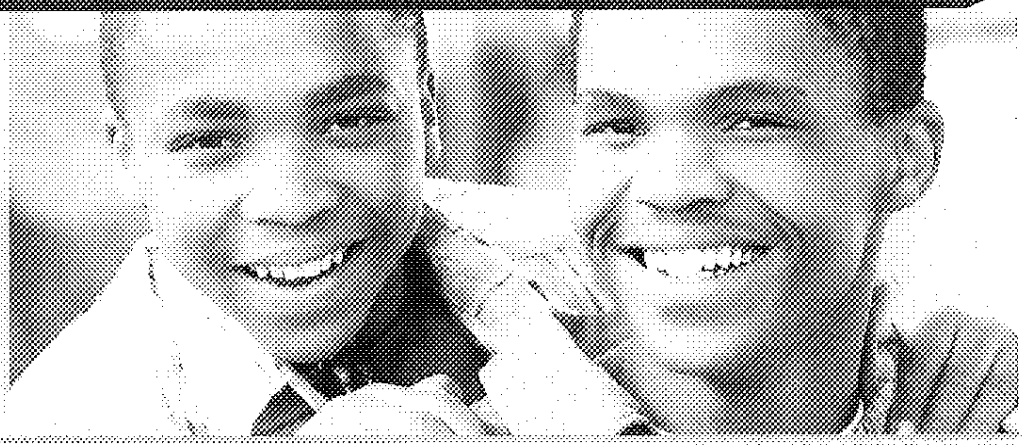
Find all of our dental health resources, including risk assessment quizzes, articles, videos and a free newsletter subscription at: **mysmileway.com.**

*Group-specific exceptions may apply. Please review your Evidence of Coverage, Summary Plan Description or Group Dental Service Contract for specific details about your plan's coordination of benefits, including rules for determining primary and secondary coverage.

DeltaCare® USA – provided by Delta Dental of California

DELTACARE® USA

Quality
Convenience
Predictable
Costs



We'll do **whatever it takes and then some.**

Find a DeltaCare USA dentist

Select from among the many conveniently located DeltaCare USA contracted general dentists. To find the most current listing of DeltaCare USA dental offices:

Visit our website and click on "Find a Dentist" on our home page. Select "DeltaCare USA" as your plan network.

OR

Call Customer Service for help in finding a DeltaCare USA dentist.

Welcome to DeltaCare USA - quality, convenience, predictable costs

DeltaCare USA (administered by Delta Dental Insurance Company) provides you and your family with quality dental benefits at an affordable cost. The DeltaCare USA program is designed to encourage you and your family to visit the dentist regularly to maintain your dental health.

When you enroll, you select a contract dentist to provide services. The DeltaCare USA network consists of private practice dental facilities that have been carefully screened for quality.

Enroll in DeltaCare USA and you'll enjoy these features:

Quality

- Extensive benefits for you and your family
- No restrictions on pre-existing conditions, except for work in progress
- Large, stable network of dentists, so you can enjoy a long-term relationship with your dentist

Convenience

- No claim forms to complete
- Easy access to specialty care
- Expanded business hours for toll-free customer service, from 5 a.m. to 6 p.m., Pacific time

Predictable costs

- No deductibles
- Out-of-pocket costs are clearly defined
- Out-of-area dental emergency coverage up to $100 per emergency
- No annual or lifetime dollar maximums

Administered by Delta Dental Insurance Company

SCHEDULE A

Description of Benefits and Copayments

The Benefits shown below are performed as deemed appropriate by the attending Contract Dentist subject to the limitations and exclusions of the Program. Please refer to *Schedule B* for further clarification of Benefits. **Enrollees should discuss all treatment options with their Contract Dentist prior to services being rendered.**

Text that appears in italics below is specifically intended to clarify the delivery of Benefits under the DeltaCare USA Program and is not to be interpreted as CDT-2016 procedure codes, descriptors or nomenclature that are under copyright by the American Dental Association. The American Dental Association may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.

CODE	DESCRIPTION	ENROLLEE PAYS
D0100-D0999	**I. DIAGNOSTIC**	
D0120	Periodic oral evaluation - established patient	No Cost
D0140	Limited oral evaluation - problem focused	No Cost
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No Cost
D0150	Comprehensive oral evaluation - new or established patient	No Cost
D0160	Detailed and extensive oral evaluation - problem focused, by report	No Cost
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	No Cost
D0171	Re-evaluation - post-operative office visit	No Cost
D0180	Comprehensive periodontal evaluation - new or established patient	No Cost
D0190	Screening of a patient	No Cost
D0191	Assessment of a patient	No Cost
D0210	Intraoral - complete series of radiographic images - *limited to 1 series every 24 months*	No Cost
D0220	Intraoral - periapical first radiographic image	No Cost
D0230	Intraoral - periapical each additional radiographic image	No Cost
D0240	Intraoral - occlusal radiographic image	No Cost
D0250	Extraoral - 2D projection radiographic image created using a stationary radiation source, and detector	No Cost
D0251	Extraoral posterior dental radiographic image	No Cost
D0270	Bitewing - single radiographic image	No Cost
D0272	Bitewings - two radiographic images	No Cost
D0273	Bitewings three radiographic images	No Cost
D0274	Bitewings - four radiographic images - *limited to 1 series every 6 months*	No Cost
D0277	Vertical bitewings - 7 to 8 radiographic images	No Cost
D0330	Panoramic radiographic image	No Cost
D0415	Collection of microorganisms for culture and sensitivity	No Cost
D0425	Caries susceptibility tests	No Cost
D0460	Pulp vitality tests	No Cost
D0470	Diagnostic casts	No Cost
D0472	Accession of tissue, gross examination, preparation and transmission of written report - *available only when performed in conjunction with a covered biopsy*	No Cost
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report - *available only when performed in conjunction with a covered biopsy*	No Cost
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report - *available only when performed in conjunction with a covered biopsy*	No Cost
D0601	Caries risk assessment and documentation, with a finding of low risk - *limited to children age 3 to 19, 1 every 3 years*	No Cost
D0602	Caries risk assessment and documentation, with a finding of moderate risk - *limited to children age 3 to 19, 1 every 3 years*	No Cost
D0603	Caries risk assessment and documentation, with a finding of high risk - *limited to children age 3 to 19, 1 every 3 years*	No Cost
D0999	Unspecified diagnostic procedure, by report - *includes office visit, per visit (in addition to other services)*	No Cost
D1000-D1999	**II. PREVENTIVE**	
D1110	Prophylaxis *cleaning* - adult - *1 per 6 month period*	No Cost
D1110	*Additional prophylaxis cleaning - adult (within the 6 month period)*	$45.00

D1120	Prophylaxis *cleaning* - child - *1 per 6 month period*	No Cost
D1120	*Additional prophylaxis cleaning - child (within the 6 month period)*	$35.00
D1206	Topical application of fluoride varnish - *1 D1206 or D1208 per 6 month period*	No Cost
D1208	Topical application of fluoride - excluding varnish - *1 D1206 or D1208 per 6 month period*	No Cost
D1310	Nutritional counseling for control of dental disease	No Cost
D1320	Tobacco counseling for the control and prevention of oral disease	No Cost
D1330	Oral hygiene instructions	No Cost
D1351	Sealant - per tooth - *limited to permanent molars through age 15*	No Cost
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth - *limited to permanent molars through age 15*	No Cost
D1353	Sealant repair - per tooth - *limited to permanent molars through age 15*	No Cost
D1354	Interim caries arresting medicament application - *1 per 6 month period*	No Cost
D1510	Space maintainer - fixed - unilateral	No Cost
D1515	Space maintainer - fixed - bilateral	No Cost
D1520	Space maintainer - removable - unilateral	No Cost
D1525	Space maintainer - removable - bilateral	No Cost
D1550	Re-cement or re-bond space maintainer	No Cost
D1555	Removal of fixed space maintainer	No Cost

D2000-D2999 III. RESTORATIVE

- Includes polishing, all adhesives and bonding agents, indirect pulp capping, bases, liners and acid etch procedures.
- When there are more than six crowns in the same treatment plan, an Enrollee may be charged an additional $125.00 per crown, beyond the 6th unit.
- Replacement of crowns, inlays and onlays requires the existing restoration to be 5+ years old.
** Name brand, laboratory processed or in-office processed crowns/pontics produced through specialized technique or materials are material upgrades. The Contract Dentist may charge an additional fee not to exceed $325.00 in addition to the listed Copayment. Refer to Limitation of Benefits #4 for additional information.*

D2140	Amalgam - one surface, primary or permanent	No Cost
D2150	Amalgam - two surfaces, primary or permanent	No Cost
D2160	Amalgam - three surfaces, primary or permanent	No Cost
D2161	Amalgam - four or more surfaces, primary or permanent	No Cost
D2330	Resin-based composite - one surface, anterior	No Cost
D2331	Resin-based composite - two surfaces, anterior	No Cost
D2332	Resin-based composite - three surfaces, anterior	No Cost
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	No Cost
D2390	Resin-based composite crown, anterior	No Cost
D2391	Resin-based composite - one surface, posterior	$25.00
D2392	Resin-based composite - two surfaces, posterior	$30.00
D2393	Resin-based composite - three surfaces, posterior	$35.00
D2394	Resin-based composite - four or more surfaces, posterior	$40.00
D2510	Inlay - metallic - one surface	No Cost
D2520	Inlay - metallic - two surfaces	No Cost
D2530	Inlay - metallic - three or more surfaces	No Cost
D2542	Onlay - metallic - two surfaces	No Cost
D2543	Onlay - metallic - three surfaces	No Cost
D2544	Onlay - metallic - four or more surfaces	No Cost
D2610	Inlay - porcelain/ceramic - one surface*	$50.00
D2620	Inlay - porcelain/ceramic - two surfaces*	$60.00
D2630	Inlay - porcelain/ceramic - three or more surfaces*	$65.00
D2642	Onlay - porcelain/ceramic - two surfaces*	$55.00
D2643	Onlay - porcelain/ceramic - three surfaces*	$65.00
D2644	Onlay - porcelain/ceramic - four or more surfaces*	$70.00
D2650	Inlay - resin-based composite - one surface	$15.00
D2651	Inlay - resin-based composite - two surfaces	$20.00
D2652	Inlay - resin-based composite - three or more surfaces	$30.00
D2662	Onlay - resin-based composite - two surfaces	$25.00
D2663	Onlay - resin-based composite - three surfaces	$35.00
D2664	Onlay - resin-based composite - four or more surfaces	$50.00
D2710	Crown - resin-based composite (indirect)	No Cost

D2712	Crown - ¾ resin-based composite (indirect)	No Cost
D2720	Crown - resin with high noble metal	$30.00
D2721	Crown - resin with predominantly base metal	$15.00
D2722	Crown - resin with noble metal	$20.00
D2740	Crown - porcelain/ceramic substrate*	$85.00
D2750	Crown - porcelain fused to high noble metal*	$70.00
D2751	Crown - porcelain fused to predominantly base metal	$55.00
D2752	Crown - porcelain fused to noble metal	$60.00
D2780	Crown - ¾ cast high noble metal	$70.00
D2781	Crown - ¾ cast predominantly base metal	$55.00
D2782	Crown - ¾ cast noble metal	$60.00
D2783	Crown - ¾ porcelain/ceramic*	$70.00
D2790	Crown - full cast high noble metal	$70.00
D2791	Crown - full cast predominantly base metal	$55.00
D2792	Crown - full cast noble metal	$60.00
D2794	Crown - titanium	$70.00
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	No Cost
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	No Cost
D2920	Re-cement or re-bond crown	No Cost
D2921	Reattachment of tooth fragment, incisal edge or cusp *(anterior)*	No Cost
D2929	Prefabricated porcelain/ceramic crown - primary tooth - *anterior*	No Cost
D2930	Prefabricated stainless steel crown - primary tooth	No Cost
D2931	Prefabricated stainless steel crown - permanent tooth	No Cost
D2932	Prefabricated resin crown - *anterior primary tooth*	No Cost
D2933	Prefabricated stainless steel crown with resin window - *anterior primary tooth*	No Cost
D2940	Protective restoration	No Cost
D2941	Interim therapeutic restoration - primary dentition	No Cost
D2949	Restorative foundation for an indirect restoration	No Cost
D2950	Core buildup, including any pins when required	No Cost
D2951	Pin retention - per tooth, in addition to restoration	No Cost
D2952	Post and core in addition to crown, indirectly fabricated - *includes canal preparation*	No Cost
D2953	Each additional indirectly fabricated post - same tooth - *includes canal preparation*	No Cost
D2954	Prefabricated post and core in addition to crown - *base metal post; includes canal preparation*	No Cost
D2955	Post removal	No Cost
D2957	Each additional prefabricated post - same tooth - *base metal post; includes canal preparation*	No Cost
D2960	Labial veneer (resin laminate) - chairside - *limited to replacement of significant tooth structure loss due to caries or fracture*	$245.00
D2961	Labial veneer (resin laminate) - laboratory - *limited to replacement of significant tooth structure loss due to caries or fracture*	$295.00
D2962	Labial veneer (porcelain laminate) - laboratory - *limited to replacement of significant tooth structure loss due to caries or fracture*	$345.00
D2971	Additional procedures to construct new crown under existing partial denture framework	$14.00
D2980	Crown repair necessitated by restorative material failure	No Cost
D2981	Inlay repair necessitated by restorative material failure	No Cost
D2982	Onlay repair necessitated by restorative material failure	No Cost
D2983	Veneer repair necessitated by restorative material failure	No Cost
D2990	Resin infiltration of incipient smooth surface lesions - *limited to permanent molars through age 15*	No Cost

D3000-D3999 IV. ENDODONTICS

D3110	Pulp cap - direct (excluding final restoration)	No Cost
D3120	Pulp cap - indirect (excluding final restoration)	No Cost
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	No Cost
D3221	Pulpal debridement, primary and permanent teeth	No Cost
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	No Cost
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	No Cost
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	No Cost

D3310	*Root canal* - endodontic therapy, anterior tooth (excluding final restoration)	$20.00
D3320	*Root canal* - endodontic therapy, bicuspid tooth (excluding final restoration)	$40.00
D3330	*Root canal* - endodontic therapy, molar (excluding final restoration)	$60.00
D3331	Treatment of root canal obstruction; non-surgical access	$40.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$40.00
D3333	Internal root repair of perforation defects	$40.00
D3346	Retreatment of previous root canal therapy - anterior	$35.00
D3347	Retreatment of previous root canal therapy - bicuspid	$50.00
D3348	Retreatment of previous root canal therapy - molar	$95.00
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$55.00
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)	$45.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	$45.00
D3410	Apicoectomy - anterior	No Cost
D3421	Apicoectomy - bicuspid (first root)	No Cost
D3425	Apicoectomy - molar (first root)	No Cost
D3426	Apicoectomy (each additional root)	No Cost
D3427	Periradicular surgery without apicoectomy	No Cost
D3430	Retrograde filling - per root	No Cost
D3450	Root amputation - per root	No Cost
D3920	Hemisection (including any root removal), not including root canal therapy	No Cost

D4000-D4999 V. PERIODONTICS

- Includes preoperative and postoperative evaluations and treatment under a local anesthetic.

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	No Cost
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	No Cost
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	No Cost
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	No Cost
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	No Cost
D4245	Apically positioned flap	$45.00
D4249	Clinical crown lengthening - hard tissue	$45.00
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	$75.00
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	$60.00
D4263	Bone replacement graft - first site in quadrant	$125.00
D4264	Bone replacement graft - each additional site in quadrant	$45.00
D4266	Guided tissue regeneration - resorbable barrier, per site	$100.00
D4267	Guided tissue regeneration - nonresorbable barrier, per site (includes membrane removal)	$140.00
D4270	Pedicle soft tissue graft procedure	$125.00
D4273	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft	$75.00
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)	No Cost
D4275	Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft	$115.00
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft	$125.00
D4278	Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant, or edentulous tooth position in same graft site	$125.00
D4283	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) - each additional contiguous tooth, implant or edentulous tooth position in same graft site	$45.00
D4285	Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) - each additional contiguous tooth, implant or edentulous tooth position in same graft site	$69.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	No Cost

D4342	Periodontal scaling and root planing - one to three teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	No Cost
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis - *limited to 1 treatment in any 12 consecutive months*	No Cost
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth - *for each of the first two teeth treated within a quadrant following root planing or periodontal maintenance*	$60.00
D4381	*Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth - for an additional tooth treated in the same quadrant following root planing or periodontal maintenance*	No Cost
D4910	Periodontal maintenance - *limited to 1 treatment each 6 month period*	No Cost
D4910	*Additional periodontal maintenance (within the 6 month period)*	$55.00
D4921	Gingival irrigation - per quadrant	No Cost

D5000-D5899 VI. PROSTHODONTICS (removable)

- For all listed dentures and partial dentures, Copayment includes after delivery adjustments and tissue conditioning, if needed, for the first six months after placement. The Enrollee must continue to be eligible, and the service must be provided at the Contract Dentist's facility where the denture was originally delivered.
- Rebases, relines and tissue conditioning are limited to 1 per denture during any 12 consecutive months.
- Replacement of a denture or a partial denture requires the existing denture to be 5+ years old.

D5110	Complete denture - maxillary	$75.00
D5120	Complete denture - mandibular	$75.00
D5130	Immediate denture - maxillary	$85.00
D5140	Immediate denture - mandibular	$85.00
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	$80.00
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	$80.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$95.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$95.00
D5221	Immediate maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	$80.00
D5222	Immediate mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	$80.00
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$95.00
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$95.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	$195.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	$195.00
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth)	$80.00
D5410	Adjust complete denture - maxillary	No Cost
D5411	Adjust complete denture - mandibular	No Cost
D5421	Adjust partial denture - maxillary	No Cost
D5422	Adjust partial denture - mandibular	No Cost
D5510	Repair broken complete denture base	No Cost
D5520	Replace missing or broken teeth - complete denture (each tooth)	No Cost
D5610	Repair resin denture base	No Cost
D5620	Repair cast framework	No Cost
D5630	Repair or replace broken clasp - per tooth	No Cost
D5640	Replace broken teeth - per tooth	No Cost
D5650	Add tooth to existing partial denture	No Cost
D5660	Add clasp to existing partial denture - per tooth	No Cost
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	$65.00
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	$65.00
D5710	Rebase complete maxillary denture	$30.00
D5711	Rebase complete mandibular denture	$30.00
D5720	Rebase maxillary partial denture	$30.00
D5721	Rebase mandibular partial denture	$30.00
D5730	Reline complete maxillary denture (chairside)	No Cost
D5731	Reline complete mandibular denture (chairside)	No Cost
D5740	Reline maxillary partial denture (chairside)	No Cost
D5741	Reline mandibular partial denture (chairside)	No Cost

D5750	Reline complete maxillary denture (laboratory)	$25.00
D5751	Reline complete mandibular denture (laboratory)	$25.00
D5760	Reline maxillary partial denture (laboratory)	$25.00
D5761	Reline mandibular partial denture (laboratory)	$25.00
D5820	Interim partial denture (maxillary) - *limited to 1 in any 12 consecutive months*	No Cost
D5821	Interim partial denture (mandibular) - *limited to 1 in any 12 consecutive months*	No Cost
D5850	Tissue conditioning, maxillary	No Cost
D5851	Tissue conditioning, mandibular	No Cost

D5900-D5999 VII. MAXILLOFACIAL PROSTHETICS - Not Covered

D6000-D6199 VIII. IMPLANT SERVICES - Not Covered

D6200-D6999 IX. PROSTHODONTICS, fixed (each retainer and each pontic constitutes a unit in a fixed partial denture [bridge])

- When a crown and/or pontic exceeds six units in the same treatment plan, an Enrollee may be charged an additional $125.00 per unit, beyond the 6th unit.
- Replacement of a crown, pontic, inlay, onlay or stress breaker requires the existing bridge to be 5+ years old.
** Name brand, laboratory processed or in-office processed crowns/pontics produced through specialized technique or materials are material upgrades. The Contract Dentist may charge an additional fee not to exceed $325.00 in addition to the listed Copayment. Refer to Limitation of Benefits #4 for additional information.*

D6205	Pontic - indirect resin based composite	$30.00
D6210	Pontic - cast high noble metal	$70.00
D6211	Pontic - cast predominantly base metal	$55.00
D6212	Pontic - cast noble metal	$60.00
D6214	Pontic - titanium	$70.00
D6240	Pontic - porcelain fused to high noble metal*	$70.00
D6241	Pontic - porcelain fused to predominantly base metal	$55.00
D6242	Pontic - porcelain fused to noble metal	$60.00
D6245	Pontic - porcelain/ceramic*	$70.00
D6250	Pontic - resin with high noble metal	$30.00
D6251	Pontic - resin with predominantly base metal	$15.00
D6252	Pontic - resin with noble metal	$20.00
D6600	Retainer inlay - porcelain/ceramic, two surfaces	$60.00
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces	$65.00
D6602	Retainer inlay - cast high noble metal, two surfaces	$70.00
D6603	Retainer inlay - cast high noble metal, three or more surfaces	$70.00
D6604	Retainer inlay - cast predominantly base metal, two surfaces	No Cost
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces	No Cost
D6606	Retainer inlay - cast noble metal, two surfaces	$60.00
D6607	Retainer inlay - cast noble metal, three or more surfaces	$60.00
D6608	Retainer onlay - porcelain/ceramic, two surfaces	$55.00
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces	$65.00
D6610	Retainer onlay - cast high noble metal, two surfaces	$70.00
D6611	Retainer onlay - cast high noble metal, three or more surfaces	$70.00
D6612	Retainer onlay - cast predominantly base metal, two surfaces	No Cost
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	No Cost
D6614	Retainer onlay - cast noble metal, two surfaces	$60.00
D6615	Retainer onlay - cast noble metal, three or more surfaces	$60.00
D6710	Retainer crown - indirect resin based composite	$30.00
D6720	Retainer crown - resin with high noble metal	$30.00
D6721	Retainer crown - resin with predominantly base metal	$15.00
D6722	Retainer crown - resin with noble metal	$20.00
D6740	Retainer crown - porcelain/ceramic*	$70.00
D6750	Retainer crown - porcelain fused to high noble metal*	$70.00
D6751	Retainer crown - porcelain fused to predominantly base metal	$55.00
D6752	Retainer crown - porcelain fused to noble metal	$60.00
D6780	Retainer crown - ¾ cast high noble metal	$70.00
D6781	Retainer crown - ¾ cast predominantly base metal	$55.00

D6782	Retainer crown - ¾ cast noble metal	$60.00
D6783	Retainer crown - ¾ porcelain/ceramic*	$70.00
D6790	Retainer crown - full cast high noble metal	$70.00
D6791	Retainer crown - full cast predominantly base metal	$50.00
D6792	Retainer crown - full cast noble metal	$60.00
D6794	Retainer crown - titanium	$70.00
D6930	Re-cement or re-bond fixed partial denture	No Cost
D6940	Stress breaker	No Cost
D6980	Fixed partial denture repair necessitated by restorative material failure	No Cost

D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY

- Includes preoperative and postoperative evaluations and treatment under a local anesthetic.

D7111	Extraction, coronal remnants - deciduous tooth	No Cost
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	No Cost
D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$10.00
D7220	Removal of impacted tooth - soft tissue	$15.00
D7230	Removal of impacted tooth - partially bony	$25.00
D7240	Removal of impacted tooth - completely bony	$35.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$50.00
D7250	Surgical removal of residual tooth roots (cutting procedure)	No Cost
D7251	Coronectomy - intentional partial tooth removal	$50.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$35.00
D7280	Surgical access of an unerupted tooth	$25.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	$25.00
D7283	Placement of device to facilitate eruption of impacted tooth	No Cost
D7286	Incisional biopsy of oral tissue - soft - *does not include pathology laboratory procedures*	No Cost
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	No Cost
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	No Cost
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	No Cost
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	No Cost
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	No Cost
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	No Cost
D7471	Removal of lateral exostosis (maxilla or mandible)	No Cost
D7472	Removal of torus palatinus	No Cost
D7473	Removal of torus mandibularis	No Cost
D7510	Incision and drainage of abscess - intraoral soft tissue	No Cost
D7960	Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure	No Cost
D7970	Excision of hyperplastic tissue - per arch	No Cost
D7971	Excision of pericoronal gingiva	No Cost

D8000-D8999 XI. ORTHODONTICS

- The listed Copayment for each phase of orthodontic treatment (limited, interceptive or comprehensive) covers up to 24 months of active treatment. Beyond 24 months, an additional monthly fee, not to exceed $125.00, may apply.
- The Retention Copayment includes adjustments and/or office visits up to 24 months.

Pre and post orthodontic records include:

	The benefit for pre-treatment records and diagnostic services includes:	$200.00
D0210	Intraoral - complete series of radiographic images	
D0322	Tomographic survey	
D0330	Panoramic radiographic image	
D0340	2D cephalometric radiographic image - acquisition, measurement and analysis	
D0350	2D oral/facial photographic images obtained intraorally or extraorally	
D0351	3D photographic image	
D0470	Diagnostic casts	
	The benefit for post-treatment records includes:	$70.00
D0210	Intraoral - complete series of radiographic images	
D0470	Diagnostic casts	

D8010	Limited orthodontic treatment of the primary dentition	$725.00
D8020	Limited orthodontic treatment of the transitional dentition - *child or adolescent to age 19*	$725.00
D8030	Limited orthodontic treatment of the adolescent dentition - *adolescent to age 19*	$725.00
D8040	Limited orthodontic treatment of the adult dentition - *adults, including covered dependent adult children*	$925.00
D8050	Interceptive orthodontic treatment of the primary dentition	$725.00
D8060	Interceptive orthodontic treatment of the transitional dentition	$725.00
D8070	Comprehensive orthodontic treatment of the transitional dentition - *child or adolescent to age 19*	$1,700.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition - *adolescent to age 19*	$1,700.00
D8090	Comprehensive orthodontic treatment of the adult dentition - *adults, including covered dependent adult children*	$1,900.00
D8660	Pre-orthodontic treatment examination to monitor growth and development	$25.00
D8670	Periodic orthodontic treatment visit - *included in comprehensive case fee*	No Cost
D8680	Orthodontic retention (removal of appliances, construction and placement of *removable* retainers)	$275.00
D8681	Removable orthodontic retainer adjustment	No Cost
D8693	Re-bond or re-cement fixed retainer - *limited to 2 per 6 month period*	No Cost
D8694	Repair of fixed retainers, includes reattachment - *limited to 2 per 6 month period*	No Cost
D8999	Unspecified orthodontic procedure, by report - *includes treatment planning session*	$100.00

D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES

D9110	Palliative (emergency) treatment of dental pain - minor procedure	No Cost
D9211	Regional block anesthesia	No Cost
D9212	Trigeminal division block anesthesia	No Cost
D9215	Local anesthesia in conjunction with operative or surgical procedures	No Cost
D9219	Evaluation for deep sedation or general anesthesia	No Cost
D9223	Deep sedation/general anesthesia - each 15 minute increment	$80.00
D9243	Intravenous moderate (conscious) sedation/analgesia - each 15 minute increment	$80.00
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	No Cost
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	No Cost
D9440	Office visit - after regularly scheduled hours	$20.00
D9450	Case presentation, detailed and extensive treatment planning	No Cost
D9932	Cleaning and inspection of removable complete denture, maxillary	No Cost
D9933	Cleaning and inspection of removable complete denture, mandibular	No Cost
D9934	Cleaning and inspection of removable partial denture, maxillary	No Cost
D9935	Cleaning and inspection of removable partial denture, mandibular	No Cost
D9940	Occlusal guard, by report - *limited to 1 in 3 years*	$75.00
D9943	Occlusal guard adjustment	$10.00
D9951	Occlusal adjustment, limited	No Cost
D9952	Occlusal adjustment, complete	No Cost
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays - *limited to one bleaching tray and gel for two weeks of self-treatment*	$125.00
D9986	Missed appointment - *without 24 hour notice - per 15 minutes of appointment time - up to an overall maximum of $40.00*	$10.00
D9987	Canceled appointment - *without 24 hour notice - per 15 minutes of appointment time - up to an overall maximum of $40.00*	$10.00

If services for a listed procedure are performed by the assigned Contract Dentist, the Enrollee pays the specified Copayment. Listed procedures which require a Dentist to provide Specialist Services, and are referred by the assigned Contract Dentist, must be authorized by Delta Dental. The Enrollee pays the Copayment specified for such services.

Procedures not listed above are not covered, however, may be available at the Contract Dentist's "filed fees." "Filed fees" mean the Contract Dentist's fees on file with Delta Dental. Questions regarding these fees should be directed to the Customer Service department at 800-422-4234.

SCHEDULE B

Limitations of Benefits

1. The frequency of certain Benefits is limited. All frequency limitations are listed in *Schedule A, Description of Benefits and Copayments.*
2. If the Enrollee accepts a treatment plan from the Contract Dentist that includes any combination of more than six crowns, bridge pontics and/or bridge retainers, the Enrollee may be charged an additional $100.00 above the listed Copayment for each of these services after the sixth unit has been provided.
3. General anesthesia and/or intravenous sedation/analgesia is limited to treatment by a contracted oral surgeon and in conjunction with an approved referral for the removal of one or more partial or full bony impactions, (Procedures D7230, D7240, and D7241).
4. Benefits provided by a pediatric Dentist are limited to children through age seven following an attempt by the assigned Contract Dentist to treat the child and upon prior authorization by Delta Dental, less applicable Copayments. Exceptions for medical conditions, regardless of age limitation, will be considered on an individual basis.
5. The cost to an Enrollee receiving orthodontic treatment whose coverage is cancelled or terminated for any reason will be based on the Contract Orthodontist's usual fee for the treatment plan. The Contract Orthodontist will prorate the amount for the number of months remaining to complete treatment. The Enrollee makes payment directly to the Contract Orthodontist as arranged.
6. Orthodontic treatment in progress is limited to new DeltaCare USA Enrollees who, at the time of their original effective date, are in active treatment started under their previous employer sponsored dental plan, as long as they continue to be eligible under the DeltaCare USA Program. Active treatment means tooth movement has begun. Enrollees are responsible for all Copayments and fees subject to the provisions of their prior dental plan. Delta Dental is financially responsible only for amounts unpaid by the prior dental plan for qualifying orthodontic cases.

Exclusions of Benefits

1. Any procedure that is not specifically listed under *Schedule A, Description of Benefits and Copayments.*
2. Any procedure that in the professional opinion of the Contract Dentist:
   a. has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, **or**
   b. is inconsistent with generally accepted standards for dentistry.
3. Services solely for cosmetic purposes, with the exception of procedure D9975 (External bleaching for home application, per arch), or for conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel, except for the treatment of newborn children with congenital defects or birth abnormalities.
4. Porcelain crowns, porcelain fused to metal, cast metal or resin with metal type crowns and fixed partial dentures (bridges) for children under 16 years of age.
5. Lost or stolen appliances including, but not limited to, full or partial dentures, space maintainers, crowns and fixed partial dentures (bridges).
6. Procedures, appliances or restoration if the purpose is to change vertical dimension, or to diagnose or treat abnormal conditions of the temporomandibular joint (TMJ).
7. Precious metal for removable appliances, metallic or permanent soft bases for complete dentures, porcelain denture teeth, precision abutments for removable partials or fixed partial dentures (overlays, implants, and appliances associated therewith) and personalization and characterization of complete and partial dentures.
8. Implant-supported dental appliances and attachments, implant placement, maintenance, removal and all other services associated with a dental implant.
9. Consultations for non-covered benefits.
10. Dental services received from any dental facility other than the assigned Contract Dentist, a preauthorized dental specialist, or a Contract Orthodontist except for *Emergency Services* as described in the Contract and/or Evidence of Coverage.
11. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.
12. Prescription drugs.

13. Dental expenses incurred in connection with any dental or orthodontic procedure started before the Enrollee's eligibility with the DeltaCare USA Program. Examples include: teeth prepared for crowns, root canals in progress, full or partial dentures for which an impression has been taken and orthodontics unless qualified for the orthodontic treatment in progress provision.

14. Lost, stolen or broken orthodontic appliances.

15. Changes in orthodontic treatment necessitated by accident of any kind.

16. Myofunctional and parafunctional appliances and/or therapies, with the exception of procedure D9940 (occlusal guard, per report).

17. Composite or ceramic brackets, lingual adaptation of orthodontic bands and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances.

18. Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services.

Getting the most from your plan

DELTACARE® USA

Quality
Convenience
Predictable
Costs

With DeltaCare USA, there are no claim forms to submit.

Select a DeltaCare USA dentist

Receive your welcome kit

Schedule an appointment

Receive dental care

Pay only your copayment directly to dentist

No paperwork. No hassle.

Save money with a DeltaCare® USA dentist

DeltaCare USA plans feature:

- Set copayments.
- No annual deductibles and no maximums for covered benefits.
- Low out-of-pocket costs for many diagnostic and preventive services (such as professional cleanings and regular dental exams).

Choosing your DeltaCare USA dentist

When you enroll, you choose from many conveniently located DeltaCare USA contracted general dentists to receive benefits under your plan. To find the most current listing of DeltaCare USA network dental offices:

- Visit our website and click on "Find a Dentist" on our home page.
- Select "DeltaCare USA" as your plan network.

You can also call Customer Service for help in finding a dentist.

Visit your DeltaCare USA dentist

You must visit your selected DeltaCare USA dentist to receive benefits under your plan.

- If you do not select a dentist, we will select a dentist for you.
- Family members may select a different dentist for treatment within the covered service area. Refer to your plan booklet for details.
- You can change your selected network dentist by telephone or through our website.
- Changes received by the 21st of the month will be effective the first day of the following month.

Easy to use

- We will notify your DeltaCare USA dentist about your enrollment in the plan and other important details about your coverage such as dependent information, group number and enrollee ID number.
- No ID card is required to receive services; simply provide the dental office with your name, date of birth and social security or enrollee ID number.
- With DeltaCare USA, there are no claim forms to submit. And, since you are responsible only for the copayment at the time of treatment, you will not receive a claims statement.
- Predictable costs: you'll find a complete list of covered procedures, copayments, plan limitations and exclusions in your plan booklet.

Specialty care and authorizations

If you require treatment from a specialist, your DeltaCare USA general dentist will coordinate any referrals for you.

In some states, Delta Dental must pre-authorize any dental services, with the exception of emergency treatment, that are not performed by your DeltaCare USA general dentist. Please refer to your plan booklet for specific details about your plan.

Dual coverage/Coordination of benefits

If your spouse has coverage with another dental plan, you or your family members may be covered by both dental plans.*

- We do not coordinate benefits with the other plan when you receive treatment from your DeltaCare USA general dentist. However, if you receive authorized treatment from a specialist (such as an oral surgeon), we will coordinate benefits with the other carrier.
- Ask your specialist to submit the other plan's explanation of benefits with the DeltaCare USA claim form and we'll take it from there.

Orthodontic treatment in progress

DeltaCare USA has an orthodontic treatment-in-progress provision that allows new enrollees to continue treatment with their current orthodontist, as long as the enrollee is in active treatment started under his or her previous employer-sponsored dental plan. Enrollees are responsible for all copayments and fees subject to the provisions of their prior dental plan.**

Transitioning from another plan?

Your DeltaCare USA plan covers treatment started and completed only after your plan's effective date of coverage. If you have any dental treatment in progress when your coverage begins — root canals in progress, teeth prepared for crowns and dentures for which an impression has been taken — those expenses are not covered by your DeltaCare USA plan. However, DeltaCare USA plans have no exclusion for pre-existing dental conditions or missing teeth.

Visit our website: deltadentalins.com

On our website, you can:

- Find a dentist in our online directory
- Review benefits
- Verify eligibility
- Print an ID card and much more

To access some services, you'll need to log in: simply enter your username and password in the designated boxes and submit. If you are visiting our website for the first time, you'll need to complete a quick one-time registration process by clicking the "Register Today" link.

Questions about your plan?

If you have questions, you can check your benefits and eligibility information on our website or on our interactive voice response telephone line. For more information, you may also contact us through our website or call one of our helpful multilingual Customer Service representatives toll-free during business hours.

With DeltaCare USA, you and your family will enjoy many new features including:

Expanded business hours/ toll-free customer service

Out-of-area emergency coverage

Orthodontic treatment in progress provision

* Group-specific exceptions may apply. Please review your plan booklet for specific details about your plan's coordination of benefits, including rules for determining primary and secondary coverage.

** This provision may not apply to all plans. Please refer to your plan booklet for specific coverage details.

SmileWay® Wellness Program

Find all of our dental health resources, including risk assessment quizzes, articles, videos and a free newsletter subscription, at: **mysmileway.com.**

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twitter.com/deltadentalins
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We Keep You Smiling
Advancing dental health and access through exceptional dental benefits service, technology and professional support.

Delta Dental Customer Service

Delta Dental PPO
Call 800-765-6003
100 First Street
San Francisco, CA 94105

DeltaCare USA
Call 800-422-4234
P.O. Box 1803
Alpharetta, GA 30023

DELTA DENTAL®

deltadentalins.com

Your Vision Benefits Summary

Get the best in eye care and eyewear with COUNTY OF TULARE and VSP® Vision Care.

Using your VSP benefit is easy.

- **Create an account at vsp.com.** Once your plan is effective, review your benefit information.
- **Find an eye care provider who's right for you.** The decision is yours to make—choose a VSP doctor, a participating retail chain, or any out-of-network provider. To find a VSP provider, visit **vsp.com** or call **800.877.7195**.
- **At your appointment, tell them you have VSP.** There's no ID card necessary. If you'd like a card as a reference, you can print one on **vsp.com**.

That's it! We'll handle the rest—there are no claim forms to complete when you see a VSP provider.

Primary Eye Care

As a VSP member, you can visit your VSP doctor for medical and urgent eye care. Your VSP doctor can diagnose, treat, and monitor common eye conditions like pink eye, and more serious conditions like sudden vision loss, glaucoma, diabetic eye disease, and cataracts. Ask your VSP doctor for details.

Choice in Eyewear

From classic styles to the latest designer frames, you'll find hundreds of options. Choose from featured frame brands like bebe®, Calvin Klein, Cole Haan, Flexon®, Lacoste, Nike, Nine West, and more[1]. Visit **vsp.com** to find a Premier Program location that carries these brands. Prefer to shop online? Check out all of the brands at **Eyeconic.com**, VSP's online eyewear store.

Plan Information

VSP Coverage Effective Date: 01/01/2017
VSP Provider Network: VSP Choice

SAN JOAQUIN VALLEY INSURANCE AUTHORITY and VSP provide you with an affordable eyecare plan.

Visit vsp.com or call 800.877.7195 for more details on your vision coverage and exclusive savings and promotions for VSP members.

[1]Brands/Promotion subject to change.

	Your Coverage with a VSP Provider	
WellVision Exam	• Focuses on your eyes and overall wellness • Every 12 months	$10
Prescription Glasses		$25
Frame	• $130 allowance for a wide selection of frames • $150 allowance for featured frame brands (see 'Extra Savings' below) • 20% savings on the amount over your allowance • $70 Costco® frame allowance • Every 24 months	Included in Prescription Glasses
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children • Every 12 months	Included in Prescription Glasses
Lens Enhancements	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 20-25% on other lens enhancements • Every 12 months	$55 $95 - $105 $150 - $175
Contacts (instead of glasses)	• $120 allowance for contacts and contact lens exam (fitting and evaluation) • 15% savings on a contact lens exam (fitting and evaluation) • Every 12 months	$0
Primary Eyecare	• Treatment and diagnosis of eye conditions like pink eye, vision loss and monitoring of cataracts, glaucoma and diabetic retinopathy. Limitations and coordination with medical coverage may apply. Ask your VSP doctor for details. • As needed	$20
Extra Savings	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. Go to vsp.com/specialoffers for details. • 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam.	
	Retinal Screening • No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam	
	Laser Vision Correction • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities	

Your Coverage with Out-of-Network Providers

Visit **vsp.com** for details, if you plan to see a provider other than a VSP network provider.

Exam	up to $45
Frame	up to $70
Single Vision Lenses	up to $30
Lined Bifocal Lenses	up to $50
Lined Trifocal Lenses	up to $65
Progressive Lenses	up to $50
Contacts	up to $105

Exhibit B - April 1, 2017 - December 31, 2017

San Joaquin Valley Insurance Authority
County of Tulare
Plan Rates
Effective January 1, 2017 through December 31, 2017

Anthem Blue Cross				
Anthem $0	$878.65	$1,756.37	$1,603.29	$2,662.81
Anthem $500	$661.64	$1,323.94	$1,212.57	$2,088.17
Anthem $1000	$581.20	$1,161.58	$1,065.82	$1,770.73
Anthem $2500	$550.83	$1,100.79	$1,010.06	$1,678.12
Kaiser				
Kaiser HMO	$805.20	$1,586.43	$1,437.98	$2,367.67
Kaiser DHMO	$625.56	$1,227.16	$1,112.86	$1,828.77

Kaiser Senior Advantage Rates	
Subscriber with Medicare	$303.25
Subscriber with Medicare + Spouse Non-Medicare	$1,084.48
Subscriber with Non-Medicare + Spouse with Medicare	$1,084.49
Subscriber with Medicare + Spouse with Medicare	$582.54
Subscriber with Medicare + Child Non-Medicare	$936.03
Subscriber with Medicare + Children Non-Medicare	$936.03
Subscriber with Medicare + Spouse with Medicare + Child Non-Medicare	$1,363.79
Subscriber with Medicare + Spouse with Non-Medicare + Child Non-Medicare	$1,865.73
Subscriber with Non-Medicare + Spouse with Medicare + Child Non-Medicare	$1,865.74
Subscriber with Medicare + Spouse with Medicare + Children Non-Medicare	$1,363.79
Subscriber with Medicare + Spouse Non-Medicare + Children Non-Medicare	$1,865.73
Subscriber with Non-Medicare + Spouse with Medicare + Children Non-Medicare	$1,865.74

SJVIA Dental & Vision Rates				
Delta Dental DPPO	$35.43	$61.42	$69.60	$103.32
Delta Dental DHMO	$25.04	$42.96	$43.26	$62.35
VSP Vision	$4.76	$8.04	$8.51	$12.68

Exhibit A January 1, 2018 - December 31, 2018

Anthem Blue Cross

SJVIA County of Tulare
Custom Classic PPO 0/500/20/90/70

PPO Benefits

Anthem believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that this plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections of the Affordable Care Act apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Anthem at the telephone number printed on the back of your member identification card, or contact your group benefits administrator if you do not have an identification card. For ERISA plans, you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This Web site has a table summarizing which protections do and do not apply to grandfathered health plans. For nonfederal governmental plans, you may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

In addition to dollar and percentage copays, members are responsible for deductibles, as described below. Please review the deductible information to know if a deductible applies to a specific covered service. Certain Covered Services have maximum visit and/or day limits per year. The number of visits and/or days allowed for these services will begin accumulating on the first visit and/or day, regardless of whether your Deductible has been met. Members are also responsible for all costs over the plan maximums. Plan maximums and other important information appear in italics.

Benefits are subject to all terms, conditions, limitations, and exclusions of the Policy.

Explanation of Maximum Allowed Amount

Maximum Allowed Amount is the total reimbursement payable under the plan for covered services received from Participating and Non-Participating Providers. It is the payment towards the services billed by a provider combined with any applicable deductible, copayment or coinsurance.

Participating Providers - The rate the provider has agreed to accept as reimbursement for covered services. Members are not responsible for the difference between the provider's usual charges & the maximum allowed amount.

Non-Participating Providers & Other Health Care Providers (includes those not represented in the PPO provider network)-Reimbursement amount is based on: an Anthem Blue Cross rate or fee schedule, a rate negotiated with the provider, information from a third party vendor, or billed charges. For Medical Emergency care rendered by a Non-Participating Provider or Non-Contracting Hospital, reimbursement may be based on the reasonable and customary value. Members may be responsible for any amount in excess of the reasonable and customary

When using Non-PPO and Other Health Care Providers, members are responsible for any difference between the covered expense & actual charges, as well as any deductible & percentage copay.

Calendar year deductible		
For PPO Providers & Other Health Providers	None	
For non-PPO Providers	$500/member; $1,000/family	
Deductible for non-Anthem Blue Cross PPO hospital or residential treatment center	None	
Deductible for non-Anthem Blue Cross PPO hospital or residential treatment center if utilization review not obtained	$250/admission *(waived for emergency admission)*	
Deductible for emergency room services	$100/visit *(waived if admitted directly from ER)*	
Annual Out-of-Pocket Maximums *(no cross application)*		
PPO Providers & Other Health Care Providers	$2,000/member/year; $4,000/family/year	
Non-PPO Providers	$5,000/member/year; $10,000/family/year	
The following do not apply to out-of-pocket maximums: non-covered expense. After a member reaches the out-of-pocket maximum, the member remains responsible for non-PPO providers & other health care providers, costs in excess of the covered expense.		
Lifetime Maximum	Unlimited	
Covered Services	**PPO: Per Member Copay**	**Non-PPO: Per Member Copay[1]**
Hospital Medical Services *(subject to utilization review for inpatient services, waived for emergency admissions)*		
➢ Semi-private room, meals & special diets, & ancillary services	10%	30% *(benefit limited to $600/day)*
➢ Outpatient medical care, surgical services & supplies *(hospital care other than emergency room care)*	10%	30% *(benefit limited to $600/day)*
Ambulatory Surgical Centers		
➢ Outpatient surgery, services & supplies	10%	30% *(benefit limited to $350/day)*
Skilled Nursing Facility *(subject to utilization review)*		
➢ Semi-private room, services & supplies *(limited to 100 days/calendar year)*	10%	10%
Hospice Care *(subject to utilization review)*		
➢ Inpatient or outpatient services for member with up to one-year life expectancy, family bereavement services	No copay[2]	

[1] The percentage copay for non-emergency services from non-Anthem Blue Cross PPO providers is based on the scheduled amount.

[2] These providers are not represented in the Anthem Blue Cross PPO network.

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay[1]
Home Health Care *(subject to utilization review)*		
➢ Services & supplies from a home health agency *(limited to combined 100 prior authorized visits/calendar year, one visit by a home health aide equals four hours or less; not covered while member receives hospice care)*	10%	10% with authorization
Home Infusion Therapy *(subject to utilization review)*		
➢ Includes medication, ancillary services & supplies; caregiver training & visits by provider to monitor therapy; durable medical equipment; lab services	10%	10%
Physician Medical Services		
➢ Office & home visits	$20/visit[2]	30%
➢ Hospital & skilled nursing facility visits	10%	30%
➢ Surgeon & surgical assistant; anesthesiologist or anesthetist	10%	30%
➢ Drugs administered by a medical provider *(certain drugs are subject to utilization review)*	10%	30%
Diagnostic X-ray & Lab		
➢ MRI, CT scan, PET scan & nuclear cardiac scan *(subject to utilization review)*	10%	30%
➢ Other diagnostic x-ray & lab	No copay	30%
Preventive Care Services Preventive Care Services including*, physical exams, preventive screenings (including screenings for cancer, HPV, diabetes, cholesterol, blood pressure, hearing and vision immunizations, health education, intervention services, HIV testing), and additional preventive care for women provided for in the guidelines supported by the Health Resources and Services Administration *This list is not exhaustive. This benefit includes all Preventive Care Services required by federal and state law.	No copay	30%
Physical Therapy, Physical Medicine & Occupational Therapy	$25/visit	30%
Chiropractic Services *(up to 12 visits/calendar year; additional visits may be approved, if medically necessary)*	$25/visit	30%
Speech Therapy		
➢ Outpatient speech therapy following injury or organic disease	$20/visit	30%
Acupuncture		
➢ Services for the treatment of disease, illness or injury *(limited to 20 visits/calendar year)*	$25/visit[2]	$25/visit[2]
Temporomandibular Joint Disorders		
➢ Splint therapy & surgical treatment	10%	30%
Pregnancy & Maternity Care		
➢ Physician office visits	$20/visit[2]	30%
➢ Prescription drug for elective abortion *(mifepristone)*	10%	Not covered
Normal delivery, cesarean section, complications of pregnancy & abortion		
➢ Inpatient physician services	10%	30%
➢ Hospital & ancillary services	10%	30% *(benefit limited to $600/day)*
➢ Family planning counseling	$20/visit	Not covered

[1] The percentage copay for non-emergency services from non-Anthem Blue Cross PPO providers is based on the schedule amount.

[2] The dollar copay applies only to the visit itself. An additional 10% copay applies for any services performed in office (i.e., X-ray, lab, surgery), after any applicable deductible.

[3] Acupuncture services can be performed by a certified acupuncturist (C.A.), a doctor of medicine (M.D.), a doctor of osteopathy (D.O.), a podiatrist (D.P.M.), or a dentist (D.D.S.).

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay[1]
Organ & Tissue Transplants *(subject to utilization review; specified organ transplants covered only when performed at a Center of Expertise (COE))*		
➢ Inpatient services provided in connection with non-investigative organ or tissue transplants	10%	
➢ Transplant travel expense for an authorized, specified transplant at a COE *(recipient & companion transportation limited to 6 trips/episode & $250/person/trip for round-trip coach airfare, hotel limited to 1 room double occupancy & $100/day for 21 days/trip, other expenses limited to $25/day/person for 21 days/trip; donor transportation limited to 1 trip/episode & $250 for round-trip coach airfare; hotel limited to $100/day for 7 days; other expenses limited to $25/day for 7 days*	No copay	
Bariatric Surgery *(subject to utilization review; medically necessary surgery for weight loss, only for morbid obesity; covered only when performed at a Center of Expertise (COE))*		
➢ Inpatient services provided in connection with medically necessary surgery for weight loss, only for morbid obesity	10%	
➢ Bariatric travel expense when member's home is 50 miles or more from the nearest Bariatric CME *(member's transportation to & from CME limited to $130/person/trip for 3 trips (pre-surgical visit, initial surgery & one follow-up visit); one companion's transportation to & from CME limited to $130/person/trip for 2 trips (initial surgery & one follow-up visit); hotel for member & one companion limited to one room double occupancy & $100/day for 2 days/trip, or as medically necessary, for pre-surgical & follow-up visit; hotel for one companion limited to one room double occupancy & $100/day for duration of member's initial surgery stay for 4 days; other reasonable expenses limited to $25/day/person for 4 days/trip)*	No copay	
Diabetes Education Programs *(requires physician supervision)*		
➢ Teach members & their families about the disease process, the daily management of diabetic therapy & self-management training	$20/visit	30%
Prosthetic Devices		
➢ Coverage for breast prostheses; prosthetic devices to restore a method of speaking; surgical implants; artificial limbs or eyes; the first pair of contact lenses or eyeglasses when required as a result of eye surgery; & therapeutic shoes & inserts	10%	30%
Durable Medical Equipment		
➢ Rental or purchase of DME including , dialysis equipment & supplies, home medical equipment, prosthetic/orthotics *(hearing aids benefit available for one hearing aid per ear every three years; breast pump and supplies are covered under preventive care at no charge for in-network)*	10%	30%
Related Outpatient Medical Services & Supplies		
➢ Ground or air ambulance transportation, services & disposable supplies	10%[2]	
➢ Blood transfusions, blood processing & the cost of unreplaced blood & blood products	10%[2]	
➢ Autologous blood *(self-donated blood collection, testing, processing & storage for planned surgery)*	10%[2]	

[1] The percentage copay for non-emergency services from non-Anthem Blue Cross PPO providers is based on the scheduled amount.

[2] These providers are not represented in the Anthem Blue Cross PPO network.

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay[1]
Emergency Care		
➢ Emergency room services & supplies *($100 deductible waived if admitted)*	10%	10%
➢ Inpatient hospital services & supplies	10%	10%
➢ Physician services	10%	10%
Mental or Nervous Disorders and Substance Abuse		
Inpatient Care		
➢ Facility-based care *(subject to utilization review; waived for emergency admissions)*	10%	30% *(benefit limited to $600/day)*
➢ Inpatient physician visits	10%	30%
Outpatient Care		
➢ Facility-based care *(subject to utilization review; waived for emergency admission)*	10%	30% *(benefit limited to $600/day)*
➢ Outpatient physician visits *(Behavioral Health treatment for Autism & Pervasive disorder will be subject to pre-service review)*	$20/visit[2]	30%

[1] The percentage copay for non-emergency services from non-Anthem Blue Cross PPO providers is based on the scheduled amount.

[2] The dollar copay applies only to the visit itself. An additional 10% copay applies for any services performed in office (i.e., X-ray, lab, surgery), after any applicable deductible.

This Summary of Benefits is a brief review of benefits. Once enrolled, members will receive a Combined Evidence of Coverage and Disclosure Form, which explains the exclusions and limitations, as well as the full range of covered services of the plan, in detail.

Classic PPO Exclusions and Limitations

Not Medically Necessary. Services or supplies that are not medically necessary, as defined.

Experimental or Investigative. Any experimental or investigative procedure or medication. But, if member is denied benefits because it is determined that the requested treatment is experimental or investigative, the member may request an independent medical review, as described in the Evidence of Coverage (EOC).

Outside the United States. Services or supplies furnished and billed by a provider outside the United States, unless such services or supplies are furnished in connection with urgent care or an emergency.

Crime or Nuclear Energy. Conditions that result from: (1) the member's commission of or attempt to commit a felony, as long as any injuries are not a result of a medical condition or an act of domestic violence; or (2) any release of nuclear energy, whether or not the result of war, when government funds are available for the treatment of illness or injury arising from the release of nuclear energy.

Not Covered. Services received before the member's effective date. Services received after the member's coverage ends, except as specified as covered in the EOC.

Excess Amounts. Any amounts in excess of covered expense or the Plans maximum.

Work Related. Work related conditions if benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation, employer's liability law or occupational disease law, whether or not the member claims those benefits. If there is a dispute of substantial uncertainty as to whether benefits may be recovered for those conditions pursuant to workers' compensation, we will provide the benefits of this plan for such conditions, subject to a right of recovery and reimbursement under California Labor Code Section 4903, as specified as covered in the EOC.

Government Treatment. Any services the member actually received that were provided by a local, state or federal government agency, except when payment under this plan is expressly required by federal or state law. We will not make payment for these services if the member is not required to pay for them or they are given to the member for free.

Services of Relatives. Professional services received from a person living in the member's home or who is related to the member by blood or marriage, except as specified as covered in the EOC.

Voluntary Payment. Services for which the member has no legal obligation to pay, or for which no charge would be made in the absence of insurance coverage or other health plan coverage, except services received at a non-governmental charitable research hospital. Such a hospital must meet the following guidelines:

1. It must be internationally known as being devoted mainly to medical research,
2. at least 10% of its yearly budget must be spent on research not directly related to patient care,
3. at least one-third of its gross income must come from donations or grants other than gifts or payments for patient care,
4. It must accept patients who are unable to pay, and
5. two-thirds of its patients must have conditions directly related to the hospital's research.

Not Specifically Listed. Services not specifically listed in the plan as covered services.

Private Contracts. Services or supplies provided pursuant to a private contract between the member and a provider, for which reimbursement under Medicare program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act.

Inpatient Diagnostic Tests. Inpatient room and board charges in connection with a hospital stay primarily for diagnostic tests which could have been performed safely in an outpatient basis.

Mental or Nervous Disorders. Academic or educational testing, counseling, and remediation. Mental or nervous disorders or substance abuse, including rehabilitative care in relation to these conditions, except as specified as covered in the EOC.

Orthodontia. Braces, other orthodontic appliances or orthodontic services.

Dental Services or Supplies. Dental plates, bridges, crowns, caps or other dental prostheses, dental implants, dental services, extraction of teeth, treatment to the teeth or gums, or treatment to or for any disorders for the temporomandibular (jaw) joint, except as specified as covered in the EOC. Cosmetic dental surgery or other dental services for beautification.

Hearing Aids or Tests.

Optometric Services or Supplies. Optometric services, eye exercises including orthoptics. Routine eye exams and routine eye refractions, as specified as covered in the EOC. Eyeglasses or contact lenses, except as specified as covered in the EOC.

Outpatient Occupational Therapy. Outpatient occupational therapy, except by a home health agency, hospice, or home infusion therapy provider, as specified as covered in the EOC.

Outpatient Speech Therapy. Outpatient speech therapy, except as specified as covered in the EOC.

Cosmetic Surgery. Cosmetic surgery or other services performed solely for beautification or to alter or reshape normal (including aged) structures or tissues of the body to improve appearance. This exclusion does not apply to reconstructive surgery (that is, surgery performed to correct deformities caused by congenital or developmental abnormalities, illness, or injury for the purpose of improving bodily function or symptomatology or to create a normal appearance), including surgery performed to restore symmetry following mastectomy. Cosmetic surgery does not become reconstructive surgery because of psychological or psychiatric reasons.

Commercial Weight Loss Programs. Weight loss programs, whether or not they are pursued under medical or physician supervision, unless specifically listed as covered in this plan.

This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and dietary programs.

This exclusion does not apply to medically necessary treatments for morbid obesity or bariatric evaluations and counseling, and behavioral modification programs for the treatment of anorexia nervosa or bulimia nervosa. Surgical treatment for morbid obesity is covered as described in the Evidence of Coverage (EOC).

Sterilization Reversal.

Infertility Treatment. Any services or supplies furnished in connection with the diagnosis and treatment of infertility, including, but not limited to diagnostic tests, medication, surgery, artificial insemination, in vitro fertilization, sterilization reversal and gamete intrafallopian transfer.

Surrogate Mother Services. For any services or supplies provided to a person not covered under the plan in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

Orthopedic shoes and shoe inserts. This exclusion does not apply to orthopedic footwear used as an integral part of a brace, shoe inserts that are custom molded to the patient, or therapeutic shoes and inserts designed to treat foot complications due to diabetes, as specifically stated in the EOC.

Air Conditioners. Air purifiers, air conditioners or humidifiers.

Custodial Care or Rest Cures. Inpatient room and board charges in connection with a hospital stay primarily for environmental change or physical therapy. Services provided by a rest home, a home for the aged, a nursing home or any similar facility. Services provided by a skilled nursing facility or custodial care or rest cures, except as specified as covered in the EOC.

Health Club Memberships. Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges or activities, equipment or facilities used for developing or maintaining physical fitness, even if ordered by a physician. This exclusion also applies to health spas.

Personal Items. Any supplies for comfort, hygiene or beautification.

Education or Counseling. Educational services or nutritional counseling, except as specified as covered in the EOC. This exclusion does not apply to counseling for the treatment of anorexia nervosa or bulimia nervosa.

Food or Dietary Supplements. Nutritional and/or dietary supplements, except as provided in this plan or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written prescription or dispensing by a licensed pharmacist.

Telephone and Facsimile Machine Consultations. Consultations provided by telephone or facsimile machine.

Routine Exams or Tests. Routine physical exams or tests which do not directly treat an active illness, injury or condition, including those required by employment or government authority, except as specified as covered in the EOC.

Acupuncture. Acupuncture treatment, except as specified as covered in the EOC. Acupressure or massage to control pain, treat illness or promote health by applying pressure to one or more specific areas of the body based on descriptions of acupuncture points.

Eye Surgery for Refractive Defects. Any eye surgery solely or primarily for the purpose of correcting refractive defects of the eye such as nearsightedness (myopia) and/or astigmatism. Contact lenses and eyeglasses required as a result of this surgery.

Physical Therapy or Physical Medicine. Services of a physician for physical therapy or physical medicine, except when provided during a covered inpatient confinement or as specified as covered in the EOC.

Outpatient Prescription Drugs and Medications. Outpatient prescription drugs or medications and insulin, except as specified as covered in the EOC. Any non-prescription, over-the-counter patent or proprietary drug or medicine. Cosmetics, health or beauty aids.

Specialty Pharmacy Drugs. Specialty pharmacy drugs that must be obtained from the specialty pharmacy program, but, which are obtained from a retail pharmacy, are not covered by this plan. Member will have to pay the full cost of the specialty pharmacy drugs obtained from a retail pharmacy that should have been obtained from the specialty pharmacy program.

Contraceptive Devices. Contraceptive devices prescribed for birth control except as specified as covered in the EOC.

Diabetic Supplies. Prescription and non-prescription diabetic supplies except as specified as covered in the EOC.

Private Duty Nursing. Inpatient or outpatient services of a private duty nurse.

Lifestyle Programs. Programs to alter one's lifestyle which may include but are not limited to diet, exercise, surgery or nutrition. This exclusion will not apply to cardiac rehabilitation programs approved by us.

Wigs.

Third Party Liability -- Anthem Blue Cross is entitled to reimbursement of benefits paid if the member recovers damages from a legally liable third party.

Coordination of Benefits -- The benefits of this plan may be reduced if the member has any other group health or dental coverage so that the services received from all group coverages do not exceed 100% of the covered expense.

SJVIA County of Tulare
Custom Classic PPO 500/35/80/60

Anthem believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that this plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections of the Affordable Care Act apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Anthem at the telephone number printed on the back of your member identification card, or contact your group benefits administrator if you do not have an identification card. For ERISA plans, you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This Web site has a table summarizing which protections do and do not apply to grandfathered health plans. For nonfederal governmental plans, you may also contact the U.S. Department of Health and Human Services at www.hhs.gov/ociohrsa.

In addition to dollar and percentage copays, members are responsible for deductibles, as described below. Please review the deductible information to know if a deductible applies to a specific covered service. Certain Covered Services have maximum visit and/or day limits per year. The number of visits and/or days allowed for these services will begin accumulating on the first visit and/or day, regardless of whether your Deductible has been met. Members are also responsible for all costs over the plan maximums.
Plan maximums and other important information appear in italics. Benefits are subject to all terms, conditions, limitations, and exclusions of the Policy.

Explanation of Maximum Allowed Amount
Maximum Allowed Amount is the total reimbursement payable under the plan for covered services received from Participating and Non-Participating Providers. It is the payment towards the services billed by a provider combined with any applicable deductible, copayment or coinsurance. Participating Providers- The rate the provider has agreed to accept as reimbursement for covered services. Members are not responsible for the difference between the provider's usual charges & the maximum allowed amount. Non-Participating Providers & Other Health Care Providers- (includes those not represented in the PPO provider network)-Reimbursement amount is based on: an Anthem Blue Cross rate or fee schedule, a rate negotiated with the provider, information from a third party vendor, or billed charges. For Medical Emergency care rendered by a Non-Participating Provider or Non-Contracting Hospital, reimbursement may be based on the reasonable and customary value. Members may be responsible for any amount in excess of the reasonable and customary

When using Non-PPO and Other Health Care Providers, members are responsible for any difference between the covered expense & actual charges, as well as any deductible & percentage copay.

Calendar year deductible for all providers	$500/member; $1,000/family	
Deductible for non-Anthem Blue Cross PPO hospital or residential treatment center	$250/admission *(waived for emergency admission)*	
Deductible for non-Anthem Blue Cross PPO hospital or residential treatment center if utilization review not obtained	$250/admission *(waived for emergency admission)*	
Deductible for emergency room services	$100/visit *(waived if admitted directly from ER)*	
Annual Out-of-Pocket Maximums *(no cross application)* PPO Providers & Other Health Care Providers Non-PPO Providers The following do not apply to out-of-pocket maximums: non-covered expense. After a member reaches the out-of-pocket maximum, the member remains responsible for non-PPO providers & other health care providers, costs in excess of the covered expense	 $3,000/member/year; $6,000/family/year $10,000/member/year; $20,000/family/year	
Lifetime Maximum	Unlimited	
Covered Services	**PPO: Per Member Copay**	**Non-PPO: Per Member Copay[1]**
Hospital Medical Services *(subject to utilization review for inpatient services, waived for emergency admissions)*		
➢ Semi-private room, meals & special diets, & ancillary services	$250/admission + 20%	40% *(benefit limited to $600/day)*
➢ Outpatient medical care, surgical services & supplies *(hospital care other than emergency room care)*	20%	40% *(benefit limited to $600/day)*
Ambulatory Surgical Centers		
➢ Outpatient surgery, services & supplies	$125/surgery + 20%	40% *(benefit limited to $350/day)*
Skilled Nursing Facility *(subject to utilization review)*		
➢ Semi-private room, services & supplies *(limited to 100 days/calendar year)*	20%	20%
Hospice Care *(subject to utilization review)*		
➢ Inpatient or outpatient services for members with up to one year life expectancy; family bereavement services	No copay[2]	

[1] The percentage copay for non-emergency services from non-Anthem Blue Cross PPO providers is based on the scheduled amount. [2] Hospice providers are not represented in the Anthem Blue Cross PPO network.

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay[1]
Home Health Care *(subject to utilization review)*		
➢ Services & supplies from a home health agency *(limited to combined 100 prior authorized visits/calendar year; one visit by a home health aide equals four hours or less; not covered while member receives hospice care)*	20%	20% with authorization
Home Infusion Therapy *(subject to utilization review)*		
➢ Includes medication, ancillary services & supplies; caregiver training & visits by provider to monitor therapy; durable medical equipment; lab services	20%	20%
Physician Medical Services		
➢ Office & home visits	$35/visit[2] *(deductible waived)*	40%
➢ Hospital & skilled nursing facility visits	20%	40%
➢ Surgeon & surgical assistant, anesthesiologist or anesthetist	20%	40%
➢ Drugs administered by a medical provider *(certain drugs are subject to utilization review)*	20%	40%
Diagnostic X-ray & Lab		
➢ MRI, CT scan, PET scan & nuclear cardiac scan *(subject to utilization review)*	20%	40%
➢ Other diagnostic X-ray & lab	No copay	40%
Preventive Care Services		
Preventive Care Services including*, physical exams, preventive screenings (including screenings for cancer, HPV, diabetes, cholesterol, blood pressure, hearing and vision immunizations, health education, intervention services, HIV testing), and additional preventive care for women provided for in the guidelines supported by the Health Resources and Services Administration. *This list is not exhaustive. This benefit includes all Preventive Care Services required by federal and state law.	No copay (deductible waived)	40%
Physical Therapy, Physical Medicine & Occupational Therapy	$20/visit *(deductible waived)*	40%
Chiropractic Services *(up to 12 visits/calendar year; additional visits may be approved, if medically necessary)*	$25/visit *(deductible waived)*	40%
Speech Therapy		
➢ Outpatient speech therapy following injury or organic disease	$35/visit *(deductible waived)*	40%
Acupuncture		
➢ Services for the treatment of disease, illness or injury *(limited to 20 visits/calendar year)*	20%[3]	40%[3]
Temporomandibular Joint Disorders		
➢ Splint therapy & surgical treatment	20%	40%
Pregnancy & Maternity Care		
➢ Physician office visits	$35/visit[2] *(deductible waived)*	40%
➢ Prescription drug for elective abortion *(mifepristone)*	20%	Not covered
Normal delivery, cesarean section, complications of pregnancy & abortion		
➢ Inpatient physician services	20%	40%
➢ Hospital & ancillary services	$250/admission + 20%	40% *(benefit limited to $300/day)*
➢ Female Sterilization *(including tubal ligation and counseling/consultation)*	*No copay*	Not covered
➢ Male Sterilization	20%	Not covered
➢ Family Planning counseling	$35/visit *(deductible waived)*	Not covered

[1] The percentage copay for out-of-network services from non-Anthem Blue Cross PPO providers is based on the contracted amount.

[2] The dollar copay applies only to the visit itself. An additional 20% copay applies for any services performed in office (i.e., X-ray, lab, surgery), after any applicable deductible.

[3] Acupuncture services can be performed by a certified acupuncturist (C.A.), a doctor of medicine (M.D.), a doctor of osteopathy (D.O.), a podiatrist (D.P.M.), or a dentist (D.D.S.).

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay[1]
Organ & Tissue Transplants *(subject to utilization review; specified organ transplants covered only when performed at a Center of Expertise [COE])*		
➢ Inpatient services provided in connection with non-investigative organ or tissue transplants		$250/admission + 20%
➢ Transplant travel expense for an authorized, specified transplant at a COE *(recipient & companion transportation limited to 6 trips/episode & $250/person/trip for round-trip coach airfare, hotel limited to 1 room double occupancy & $110/day for 21 days/trip, other expenses limited to $25/day/person for 21 days/trip; donor transportation limited to 1 trip/episode & $250 for round-trip coach airfare, hotel limited to $100/day for 7 days, other expenses limited to $25/day for 7 days)*		No copay *(deductible waived)*
Bariatric Surgery *(subject to utilization review; medically necessary surgery for weight loss, only for morbid obesity, covered only when performed at a Center of Expertise [COE])*		
➢ Inpatient services provided in connection with medically necessary surgery for weight loss, only for morbid obesity		$250/admission + 20%
➢ Bariatric travel expense when member's home is 50 miles or more from the nearest Bariatric CME *(member's transportation to & from CME limited to $130/person/trip for 3 trips (pre-surgical visit, initial surgery & one follow-up visit); one companion's transportation to & from CME limited to $130/person/trip for 2 trips (initial surgery & one follow-up visit); hotel for member & one companion limited to one room double occupancy & $100/day for 2 days/trip, or as medically necessary, for pre-surgical & follow-up visit; hotel for one companion limited to one room double occupancy & $160/day for duration of member's initial surgery stay for 4 days; other reasonable expenses limited to $25/day/person for 4 days/trip)*		No copay *(deductible waived)*
Diabetes Education Programs *(requires physician supervision)*		
➢ Teach members & their families about the disease process, the daily management of diabetic therapy & self-management training	$35/visit *(deductible waived)*	40%
Prosthetic Devices		
➢ Coverage for breast prostheses; prosthetic devices to restore a method of speaking; surgical implants; artificial limbs or eyes; the first pair of contact lenses or eyeglasses when required as a result of eye surgery; & therapeutic shoes & inserts	20%	40%
Durable Medical Equipment		
➢ Rental or purchase of DME including , dialysis equipment & supplies, home medical equipment, prosthetic/orthotics *(hearing aids: benefit available for one hearing aid per ear every three years; breast pump and supplies are covered under preventive care at no charge for in-network)*	20%	20%
Related Outpatient Medical Services & Supplies		
➢ Ground or air ambulance transportation, services & disposable supplies		20%[2]
➢ Blood transfusions, blood processing & the cost of unreplaced blood & blood products		20%[2]
➢ Autologous blood *(self-donated blood collection, testing, processing & storage for planned surgery)*		20%[2]

[1] The percentage copay for non-emergency services from non-Anthem Blue Cross PPO providers is based on the scheduled amount.

[2] These providers are not represented in the Anthem Blue Cross PPO network.

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay[1]
Emergency Care		
➢ Emergency room services & supplies *($100 deductible waived if admitted)*	20%	20%
➢ Inpatient hospital services & supplies	$250/admission + 20%	$250/admission + 20%
➢ Physician services	20%	20%
Mental or Nervous Disorders and Substance Abuse		
Inpatient Care		
➢ Facility-based care *(subject to utilization review; waived for emergency admissions)*	$250/admission + 20%	40% *(benefit limited to $600/day)*
➢ Inpatient physician visits	20%	40%
Outpatient Care		
➢ Facility-based care *(subject to utilization review; waived for emergency admissions)*	20%	40% *(benefit limited to $600/day)*
➢ Outpatient physician visits *(Behavioral Health treatment for Autism & Pervasive Disorder will be subject to pre-service review)*	$30/visit[2] *(deductible waived)*	40%

[1] The percentage copay for non-emergency services from non-Anthem Blue Cross PPO providers is based on the scheduled amount.

[2] The dollar copay applies only to the visit itself. An additional 20% copay applies for any services performed in office (i.e., X-ray, lab, surgery), after any applicable deductible.

This Summary of Benefits is a brief review of benefits. Once enrolled, members will receive a Combined Evidence of Coverage and Disclosure Form, which explains the exclusions and limitations, as well as the full range of covered services of the plan, in detail.

Classic PPO Plan Exclusions and Limitations

Not Medically Necessary. Services or supplies that are not medically necessary, as defined.

Experimental or Investigative. Any experimental or investigative procedure or medication. But, if a member is denied benefits because it is determined that the requested treatment is experimental or investigative, the member may request an independent medical review, as described in the Evidence of Coverage (EOC).

Outside the United States. Services or supplies furnished and billed by a provider outside the United States, unless such services or supplies are furnished in connection with urgent care or an emergency.

Crime or Nuclear Energy. Conditions that result from (1) the member's commission of or attempt to commit a felony, as long as any injuries are not a result of a medical condition or an act of domestic violence; or (2) any release of nuclear energy, whether or not the result of war, when government funds are available for the treatment of illness or injury arising from the release of nuclear energy.

Not Covered. Services received before the member's effective date. Services received after the member's coverage ends, except as specified as covered in the EOC.

Excess Amounts. Any amounts in excess of covered expense or the lifetime maximum.

Work-Related. Work-related conditions if benefits are recovered or can be recovered, either by stipulation, settlement or otherwise, under any workers' compensation, employer's liability law or occupational disease law, whether or not the member claims those benefits. If there is a dispute or uncertainty as to whether benefits may be recovered for these conditions pursuant to workers' compensation, we will provide the benefits of this plan for such conditions, subject to a right of recovery and reimbursement under California Labor Code Section 4903, as specified as covered in the EOC.

Government Treatment. Any services the member actually received that were provided by a local, state or federal government agency, except when payment under this plan is expressly required by federal or state law. We will not cover payment for these services if the member is not required to pay for them or they are given to the member for free.

Services of Relatives. Professional services received from a person living in the member's home or who is related to the member by blood or marriage, except as specified as covered in the EOC.

Voluntary Payment. Services for which the member has no legal obligation to pay, or for which no charge would be made in the absence of insurance coverage or other health plan coverage, except services received at a non-governmental charitable research hospital. Such a hospital must meet the following guidelines:

1. It must be internationally known as being devoted mainly to medical research;
2. At least 10% of its yearly budget must be spent on research not directly related to patient care;
3. At least one-third of its gross income must come from donations or grants other than gifts or payments for patient care;
4. It must accept patients who are unable to pay; and
5. Two-thirds of its patients must have conditions directly related to the hospital's research.

Not Specifically Listed. Services not specifically listed in the plan as covered services.

Private Contracts. Services or supplies provided pursuant to a private contract between the member and a provider, for which reimbursement under Medicare program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act.

Important Diagnostic Tests. Inpatient room and board charges in connection with a hospital stay primarily for diagnostic tests which could have been performed safely on an outpatient basis.

Mental or Nervous Disorders. Academic or educational testing, counseling, and remediation. Mental or nervous disorders or substance abuse, including rehabilitative care in relation to these conditions, except as specified as covered in the EOC.

Orthodontia. Braces, other orthodontic appliances or orthodontic services.

Dental Services or Supplies. Dental plates, bridges, crowns, caps or other dental prosthesis, dental implants, dental services, extraction of teeth, treatment to the teeth or gums, or treatment to or for any disorders of the temporomandibular (jaw) joint, except as specified as covered in the EOC. Cosmetic dental surgery or other dental services for beautification.

Hearing Aids or Tests.

Optometric Services or Supplies. Optometric services, eye exercises including orthoptics. Routine eye exams and routine eye refractions, as specified as covered in the EOC. Eyeglasses or contact lenses, except as specified as covered in the EOC.

Outpatient Occupational Therapy. Outpatient occupational therapy, except by a home health agency, hospice, or home infusion therapy provider, as specified as covered in the EOC.

Outpatient Speech Therapy. Outpatient speech therapy, except as specified as covered in the EOC.

Cosmetic Surgery. Cosmetic surgery or other services performed solely for beautification or to alter or reshape normal (including aged) structures or factors of the body to improve appearance. This exclusion does not apply to reconstructive surgery (that is, surgery performed to correct deformities caused by congenital or developmental abnormalities, illness, or injury for the purpose of improving bodily function or symptomatology or to create a normal appearance), including surgery performed to restore symmetry following mastectomy. Cosmetic surgery does not bar even reconstructive surgery because of psychological or psychiatric reasons.

Commercial Weight Loss Programs. Weight loss programs, whether or not they are provided under medical or physician supervision, unless specifically listed as covered in this plan.

This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

This exclusion does not apply to medically necessary treatments for morbid obesity or dietary evaluations and counseling, and behavioral modification programs for the treatment of anorexia nervosa or bulimia nervosa. Surgical treatment for morbid obesity is covered as described in the Evidence of Coverage (EOC).
Sterilization Reversal.

Infertility Treatment. Any services or supplies prescribed in connection with the diagnosis and treatment of infertility, including, but not limited to diagnostic tests, ovulation, surgery, artificial insemination, in vitro fertilization, sterilization reversal and gamete transfer/zygote transfer.

Surrogate Mother Services. For any services or supplies provided to a person not covered under the plan in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

Orthopedic shoes and shoe inserts. This exclusion does not apply to orthopedic footwear used as an integral part of a brace, shoe inserts that are custom molded to the patient, or therapeutic shoes and inserts designed to treat foot complications due to diabetes, as specifically stated in the EOC.

Air Conditioners. Air purifiers, air conditioners or humidifiers.

Custodial Care or Rest Cures. Inpatient room and board charges in connection with a hospital stay primarily for environmental change or physical therapy. Services provided by a rest home, a home for the aged, a nursing home or any similar facility. Services provided by a skilled nursing facility or custodial care or rest cures, except as specified as covered in the EOC.

Health Club Memberships. Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment or facilities used for developing or maintaining physical fitness, even if ordered by a physician. This exclusion also applies to health spas.

Personal Items. Any supplies for comfort, hygiene or beautification.

Education or Counseling. Educational services or nutritional counseling, except as specified as covered in the EOC. This exclusion does not apply to counseling for the treatment of anorexia nervosa or bulimia nervosa.

Food or Dietary Supplements. Nutritional and/or dietary supplements, except as provided in this plan or as required by law. This exclusion includes, but is not limited to, these nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require/need either a written prescription or dispensing by a licensed pharmacist.

Telephone and Facsimile Machine Consultations. Consultations provided by telephone or facsimile machine.

Routine Exams or Tests. Routine physical exams or tests when do not directly treat an actual illness, injury or condition, including those required by employment or government authority, except as specified as covered in the EOC.

Acupuncture. Acupuncture treatment, except as specified as covered in the EOC. Acupressure or massage to control pain, treat illness or promote health by applying pressure to one or more specific areas of the body based on dermatomes or acupuncture points.

Eye Surgery for Refractive Defects. Any eye surgery solely or primarily for the purpose of correcting refractive defects of the eye such as nearsightedness (myopia) and/or astigmatism. Contact lenses and eyeglasses required as a result of this surgery.

Physical Therapy or Physical Medicine. Services of a physician for physical therapy or physical medicine, except when provided during a covered inpatient confinement or as specified as covered in the EOC.

Outpatient Prescription Drugs and Medications. Outpatient prescription drugs or medications and insulin, except as specified as covered in the EOC. Any non-prescription, over-the-counter patent or proprietary drug or medicine. Cosmetics, health or beauty aids.

Specialty Pharmacy Drugs. Specialty pharmacy drugs that must be obtained from the specialty pharmacy program, but which are obtained from a retail pharmacy, are not covered by this plan. Member will have to pay the full cost of the specialty pharmacy drugs obtained from a retail pharmacy that should have been obtained from the specialty pharmacy program.

Contraceptive Devices. Contraceptive devices prescribed for birth control except as specified as covered in the EOC.

Diabetic Supplies. Prescription and non-prescription diabetic supplies except as specified as covered in the EOC.

Private Duty Nursing. Inpatient or outpatient services of a private duty nurse.

Lifestyle Programs. Programs to alter one's lifestyle which may include but are not limited to diet, exercise, surgery or nutrition. This exclusion will not apply to cardiac rehabilitation programs approved by us.

Wigs.

Third Party Liability — Anthem Blue Cross is entitled to reimbursement of benefits paid if the member receives damages from a legally liable third party.

Coordination of Benefits — The benefits of this plan may be reduced if the member has any other group health or dental coverage so that the services received from all group coverages do not exceed 100% of the covered expense.

Anthem Blue Cross

SJVIA County of Tulare Custom Classic PPO (1000/45/80/50)

Anthem believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that this plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

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In addition to dollar and percentage copays, members are responsible for deductibles, as described below. Please review the deductible information to know if a deductible applies to a specific covered service. Certain Covered Services have maximum visit and/or day limits per year. The number of visits and/or days allowed for these services will begin accumulating on the first visit and/or day, regardless of whether your Deductible has been met. Members are also responsible for all costs over the plan maximums.

Plan maximums and other important information appear in italics. Benefits are subject to all terms, conditions, limitations, and exclusions of the Policy.

Explanation of Maximum Allowed Amount

Maximum Allowed Amount is the total reimbursement payable under the plan for covered services received from Participating and Non-Participating Providers. It is the payment towards the services billed by a provider combined with any applicable deductible, copayment or coinsurance.

Participating Providers- The rate the provider has agreed to accept as reimbursement for covered services. Members are not responsible for the difference between the provider's usual charges & the maximum allowed amount.

Non-Participating Providers & Other Health Care Providers-(includes those not represented in the PPO provider network)-Reimbursement amount is based on: an Anthem Blue Cross rate or fee schedule, a rate negotiated with the provider, information from a third party vendor, or billed charges. For Medical Emergency care rendered by a Non-Participating Provider or Non-Contracting Hospital, reimbursement may be based on the reasonable and customary value. Members may be responsible for any amount in excess of the reasonable and customary value.

When using Non-PPO and Other Health Care Providers, members are responsible for any difference between the covered expense & actual charges, as well as any deductible & percentage copay.

Calendar year deductible for all providers	$1,000/member; $2,000/family	
Deductible for non-Anthem Blue Cross PPO hospital or residential treatment center	None	
Deductible for non-Anthem Blue Cross PPO hospital or residential treatment center if utilization review not obtained	$250/admission *(waived for emergency admission)*	
Deductible for emergency room services	$100/visit *(waived if admitted directly from ER)*	
Annual Out-of-Pocket Maximums *(no cross application)*		
PPO Providers & Other Health Care Providers	$4,000/member/year; $8,000/family/year	
Non-PPO Providers	$10,000/member/year; $20,000/family/year	
The following do not apply to out-of-pocket maximums: non-covered expense. After a member reaches the out-of-pocket maximum, the member remains responsible for non-PPO providers & other health care providers, costs in excess of the covered expense.		
Lifetime Maximum	Unlimited	
Covered Services	**PPO: Per Member Copay**	**Non-PPO: Per Member Copay[1]**
Hospital Medical Services *(subject to utilization review for inpatient services; waived for emergency admissions)*		
➢ Semi-private room, meals & special diets, & ancillary services	$1,000/year[2] + 20%	50% *(benefit limited to $600/day)*
➢ Outpatient medical care, surgical services & supplies *(hospital care other than emergency room care)*	20%	50% *(benefit limited to $600/day)*
Ambulatory Surgical Centers		
➢ Outpatient surgery, services & supplies	$250/surgery + 20%	50% *(benefit limited to $350/visit)*
Skilled Nursing Facility *(subject to utilization review)*		
➢ Semi-private room, services & supplies *(limited to 100 days/calendar year)*	20%	20%
Hospice Care *(subject to utilization review)*		
➢ Inpatient or outpatient services for members with up to one year life expectancy; family Bereavement services	No copay	

[1] The percentage copay for non-emergency services from non-Anthem Blue Cross PPO providers is based on the scheduled amount.

[2] Applicable to the Annual Out-of-Pocket maximums.

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay[1]
Home Health Care *(subject to utilization review)*		
➢ Services & supplies from a home health agency *(limited to 100 prior authorized visits/calendar year; one visit by a home health aide equals four hours or less; not covered while member receives hospice care)*	20%	20% with authorization
Home Infusion Therapy *(subject to utilization review)*		
➢ Includes medication, ancillary services & supplies; caregiver training & visits by provider to monitor therapy; durable medical equipment; lab services	20%	20%
Physician Medical Services		
➢ Office & home visits	$45/visit[2] *(deductible waived)*	50%
➢ Hospital & skilled nursing facility visits	20%	50%
➢ Surgeon & surgical assistant; anesthesiologist or anesthetist	20%	50%
➢ Drugs administered by a medical provider *(certain drugs are subject to utilization review)*	20%	50%
Diagnostic X-ray & Lab		
➢ MRI, CT scan, PET scan & nuclear cardiac scan *(subject to utilization review)*	20%	50%
➢ Other diagnostic x-ray & lab	No copay	50%
Preventive Care Services Preventive Care Services including*, physical exams, preventive screenings (including screenings for cancer, HPV, diabetes, cholesterol, blood pressure, hearing and vision immunizations, health education, intervention services, HIV testing), and additional preventive care for women provided for in the guidelines supported by the Health Resources and Services Administration. *This list is not exhaustive. This benefit includes all Preventive Care Services required by federal and state law	No copay *(deductible waived)*	50%
Physical Therapy, Physical Medicine & Occupational Therapy	$25/visit *(deductible waived)*	50%
Chiropractic Services *(up to 12 visits/calendar year; additional visits may be approved, if medically necessary)*	$25/visit *(deductible waived)*	50%
Speech Therapy		
➢ Outpatient speech therapy following injury or organic disease	$45/visit *(deductible waived)*	50%
Acupuncture		
➢ Services for the treatment of disease, illness or injury *(limited to 20 visits/calendar year)*	20%[3]	50%[3]
Temporomandibular Joint Disorders		
➢ Splint therapy & surgical treatment	20%	50%
Pregnancy & Maternity Care		
➢ Physician office visits	$45/visit[2] *(deductible waived)*	50%
➢ Prescription drug for elective abortion *(mifepristone)*	20%	Not covered
Normal delivery, cesarean section, complications of pregnancy & abortion		
➢ Inpatient physician services	20%	50%
➢ Hospital & ancillary services	$1,000/year[4] + 20%	50% *(benefit limited to $600/day)*
➢ Female Sterilization *(including tubal ligation and counseling/consultation)*	No copay	Not covered
➢ Male Sterilization	20%	Not Covered
➢ Family planning counseling	$45/visit *(deductible waived)*	Not covered

[1] The percentage copay for non-emergency services from non-Anthem Blue Cross PPO providers is based on the scheduled amount.

[2] The dollar copay applies only to the visit itself. An additional 20% copay applies for any services performed or billed (i.e., X-ray, lab, surgery) after any applicable deductible.

[3] Acupuncture services can be performed by a certified acupuncturist (C.A.), a doctor of medicine (M.D.), a doctor of osteopathy (D.O.), a podiatrist (D.P.M.) or a dentist (D.D.S.).

[4] Applies to the Annual Out-of-Pocket Maximum

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay[1]
Organ & Tissue Transplants *(subject to utilization review; specified organ transplants covered only when performed at a Center of Expertise [COE])*		
➢ Inpatient services provided in connection with non-investigative organ or tissue transplants		$1,000/year[3] + 20%
➢ Transplant travel expense for an authorized, specified transplant at a COE *(recipient & companion transportation limited to 6 trips/episode & $250/person/trip for round-trip coach airfare, hotel limited to 1 room double occupancy & $100/day for 21 days/trip, other expenses limited to $25/day/person for 21 days/trip, donor transportation limited to 1 trip/episode & $250 for round-trip coach airfare, hotel limited to $100/day for 7 days, other expenses limited to $25/day for 7 days)*		No copay *(deductible waived)*
Bariatric Surgery *(subject to utilization review; medically necessary surgery for weight loss, only for morbid obesity, covered only when performed at a Center of Expertise [COE])*		
➢ Inpatient services provided in connection with medically necessary surgery for weight loss, only for morbid obesity		$1,000/year[3] + 20%
➢ Bariatric travel expense when member's home is 50 miles or more from the nearest Bariatric COE *(member's transportation to & from COE limited to $130/person/trip for 3 trips [pre-surgical visit, initial surgery & one follow-up visit]; one companion's transportation to & from COE limited to $130/person/trip for 2 trips [initial surgery & one follow-up visit]; hotel for member & one companion limited to one room double occupancy & $100/day for 2 days/trip, or as medically necessary, for pre-surgical & follow-up visit; hotel for one companion limited to one room double occupancy & $100/day for duration of member's initial surgery stay for 4 days; other reasonable expenses limited to $25/day/person for 4 days/trip)*		No copay *(deductible waived)*
Diabetes Education Programs *(requires physician supervision)*		
➢ Teach members & their families about the disease process, the daily management of diabetic therapy & self-management training	$45/visit *(deductible waived)*	50%
Prosthetic Devices		
➢ Coverage for breast prostheses; prosthetic devices to restore a method of speaking; surgical implants; artificial limbs or eyes; the first pair of contact lenses or eyeglasses when required as a result of eye surgery, & therapeutic shoes & inserts	50%	50%
Durable Medical Equipment		
➢ Rental or purchase of DME including dialysis equipment & supplies, home medical equipment, prosthetic/orthotics *(hearing aids benefit available for one hearing aid per ear every three years; breast pump and supplies are covered under preventive care at no charge for in-network)*	50%	50%
Related Outpatient Medical Services & Supplies		
➢ Ground or air ambulance transportation, services & disposable supplies		20%[2]
➢ Blood transfusions, blood processing & the cost of unreplaced blood & blood products		20%[2]
➢ Autologous blood *(self-donated blood collection, testing, processing & storage for planned surgery)*		20%[2]

[1] The percentage copay for non-emergency services from non-Anthem Blue Cross PPO providers is based on the scheduled amount.

[2] These providers are not represented in the Anthem Blue Cross PPO network.

[3] Applicable to the Annual Out-of-Pocket maximum.

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay[1]
Emergency Care		
➢ Emergency room services & supplies *($100 deductible waived if admitted)*	20%	20%
➢ Inpatient hospital services & supplies	$1,000/year[3] + 20%	20%
➢ Physician services	20%	20%
Mental or Nervous Disorders and Substance Abuse		
Inpatient Care		
➢ Facility-based care *(subject to utilization review; waived for emergency admissions)*	$1,000/year[3] + 20%	50% *(benefit limited to $800/day)*
➢ Inpatient physician visits	20%	50%
Outpatient Care		
➢ Facility-based care *(subject to utilization review; waived for emergency admissions)*	20%	50% *(benefit limited to $800/day)*
➢ Outpatient physician visits *(Behavioral Health treatment for Autism & Pervasive Disorder will be subject to pre-service review)*	$45/visit[2] *(deductible waived)*	50%

[1] The percentage copay for non-emergency services from non-Anthem Blue Cross PPO providers is based on the scheduled amount.

[2] The dollar copay applies only to the visit itself. An additional 20% copay applies for any services performed in office (i.e., X-ray, lab, surgery), after any applicable deductible.

[3] Applicable to the Annual Out-of-Pocket maximums

This Summary of Benefits is a brief review of benefits. Once enrolled, members will receive a Combined Evidence of Coverage and Disclosure Form, which explains the exclusions and limitations, as well as the full range of covered services of the plan, in detail.

Classic PPO Plan Exclusions and Limitations

Not Medically Necessary. Services or supplies that are not medically necessary, as defined.

Experimental or Investigative. Any experimental or investigative procedure or medication. But, if member is denied benefits because it is determined that the requested treatment is experimental or investigative, the member may request an independent medical review, as described in the Evidence of Coverage (EOC).

Outside the United States. Services or supplies furnished and billed by a provider outside the United States, unless such services or supplies are furnished in connection with urgent care or an emergency.

Crime or Nuclear Energy. Conditions that result from (1) the member's commission of or attempt to commit a felony, as long as any injuries are not a result of a medical condition or are not of domestic violence or (2) any release of nuclear energy, whether or not the result of war, when government funds are available for the treatment of illness or injury arising from the release of nuclear energy.

Not Covered. Services received before the member's effective date. Services received after the member's coverage ends, except as specified or covered in the EOC.

Excess Amounts. Any amounts in excess of covered expense or any Medical Benefit Maximum.

Work-Related. Work-related conditions if benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation, employer's liability law or occupational disease law, whether or not the member claims those benefits. If there is a dispute or substantial uncertainty as to whether benefits may be recovered for those conditions pursuant to workers' compensation, we will provide the benefits of this plan for such conditions, subject to a right of recovery and reimbursement under California Labor Code Section 4903, as specified or covered in the EOC.

Government Treatment. Any services the member actually received that were provided by a local, state or federal government agency, except when payment under this plan is expressly required by federal or state law. We will not cover payment for these services if the member is not required to pay for them or they are given to the member for free.

Servant or Relatives. Professional services received from a person living in the member's home or who is related to the member by blood or marriage, except as specified as covered in the EOC.

Voluntary Payment. Services for which the member has no legal obligation to pay, or for which no charge would be made in the absence of insurance coverage or other health plan coverage, except services received at a non-governmental charitable research hospital. Such a hospital must meet the following guidelines:

1. It must be internationally known as being devoted mainly to medical research;
2. at least 10% of its yearly budget must be used on research not directly related to patient care;
3. at least one-third of its gross income must come from donations or grants other than gifts or payments for patient care;
4. it must accept patients who are unable to pay; and
5. two-thirds of its patients must have conditions directly related to the hospital's research.

Not Specifically Listed. Services not specifically listed in the plan as covered services.

Private Contracts. Services or supplies provided pursuant to a private contract between the member and a provider, for which reimbursement under Medicare program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act.

Inpatient Diagnostic Tests. Inpatient room and board charges in connection with a hospital stay primarily for diagnostic tests which could have been performed safely on an outpatient basis.

Mental or Nervous Disorders. Academic or educational testing, counseling, and remediation. Mental or nervous disorders or substance abuse, including rehabilitative care in relation to these conditions, except as specified or covered in the EOC.

Orthodontia. Braces, other orthodontic appliances or orthodontic services.

Dental Services or Supplies. Dental plates, implants, crowns, caps or other dental prostheses, dental implants, dental services, extraction of teeth, treatment to the teeth or gums, or treatment of or for any disorders of the temporomandibular (jaw) joint, except as specified as covered in the EOC. Cosmetic dental surgery or other dental services for beautification.

Hearing Aids or Tests.

Optometric Services or Supplies. Optometric services, eye exercises including orthoptics. Routine eye exams and routine eye refractions, as specified as covered in the EOC. Eyeglasses or contact lenses, except as specified as covered in the EOC.

Outpatient Occupational Therapy. Outpatient occupational therapy, except by a home health agency, hospice, or home infusion therapy provider, as specified as covered in the EOC.

Outpatient Speech Therapy. Outpatient speech therapy, except as specified as covered in the EOC.

Cosmetic Surgery. Cosmetic surgery or other services performed solely for beautification or to alter or reshape normal (including aged) structures or tissues of the body to improve appearance. This exclusion does not apply to reconstructive surgery (that is, surgery performed to correct deformities caused by congenital or developmental abnormalities, illness, or injury for the purpose of improving bodily function or symptomatology or to create a normal appearance), including surgery performed to restore symmetry following mastectomy. Cosmetic surgery does not include reconstructive surgery because of psychological or psychiatric reasons.

Commercial Weight Loss Programs. Weight loss programs, whether or not they are pursued under medical or physician supervision, unless specifically listed as covered in this plan.

This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and dieting programs.

This exclusion does not apply to medically necessary treatments for morbid obesity or dietary evaluations and counseling, and behavioral modification programs, for the treatment of anorexia nervosa or bulimia nervosa. Surgical treatment for morbid obesity is covered, as described in the Evidence of Coverage (EOC).

Sterilization Reversal.

Infertility Treatment. Any services or supplies sometimes used in connection with the diagnosis and treatment of infertility, including, but not limited to, diagnostic tests, medication, surgery, artificial insemination, in vitro fertilization, sterilization reversal and gamete intrafallopian transfer.

Surrogate Mother Services. For any services or supplies provided to a person not covered under the plan in connection with a surrogate pregnancy (including, but not limited to, the hosting of a child by another woman for an infertile couple).

Orthopedic shoes and shoe inserts. This exclusion does not apply to orthopedic footwear used as an integral part of a brace, shoe inserts that are custom molded to the patient, or therapeutic shoes and inserts designed to treat foot complications due to diabetes, as specifically stated in the EOC.

Air Conditioners. Air purifiers, air conditioners or humidifiers.

Custodial Care or Rest Cures. Inpatient room and board charges in connection with a hospital stay primarily for environmental change or physical therapy. Services provided by a rest home, a home for the aged, a nursing home or any similar facility. Services provided by a skilled nursing facility or custodial care or rest cures, except as specified as covered in the EOC.

Health Club Memberships. Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment or facilities used for developing or maintaining physical fitness, even if ordered by a physician. This exclusion also applies to health spas.

Personal Items. Any supplies for comfort, hygiene or beautification.

Education or Counseling. Educational services or nutritional counseling, except as specified as covered in the EOC. This exclusion does not apply to counseling for the treatment of anorexia nervosa or bulimia nervosa.

Food or Dietary Supplements. Nutritional and/or dietary supplements, except as provided in this plan or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written prescription or dispensing by a licensed pharmacist.

Telephone and Facsimile Machine Consultations. Consultations provided by telephone or facsimile machine.

Routine Exams or Tests. Routine physical exams or tests which are not directly tied to active illness, injury or condition, including those required by employment or government authority, except as specified or covered in the EOC.

Acupuncture. Acupuncture treatment, except as specified as covered in the EOC. Acupressure or massage to control pain, treat illness or provide health by applying pressure to one or more specific areas of the body based on demonstrated or scientific points.

Eye Surgery for Refractive Defects. Any eye surgery solely or primarily for the purpose of correcting refractive defects of the eye such as nearsightedness (myopia) and/or astigmatism. Contact lenses and eyeglasses required as a result of this surgery.

Physical Therapy or Physical Medicine. Services of a physician for physical therapy or physical medicine, except when provided during a covered inpatient confinement or as specified as covered in the EOC.

Outpatient Prescription Drugs and Medications. Outpatient prescription drugs or medications and insulin, except as specified as covered in the EOC. Any non-prescription, over-the-counter patent or proprietary drug or medicine. Cosmetics, health or beauty aids.

Specialty Pharmacy Drugs. Specialty pharmacy drugs that must be obtained from the specialty pharmacy program, but which are obtained from a retail pharmacy, are not covered by this plan. Member will have to pay the full cost of the specialty pharmacy drugs obtained from a retail pharmacy that should have been obtained from the specialty pharmacy program.

Contraceptive Devices. Contraceptive devices prescribed for birth control, except as specified as covered in the EOC.

Diabetic Supplies. Prescription and non-prescription diabetic supplies except as specified as covered in the EOC.

Private Duty Nursing. Inpatient or outpatient services of a private duty nurse.

Lifestyle Programs. Programs to alter one's lifestyle which may include but are not limited to diet, exercise, imagery or nutrition. This exclusion will not apply to cardiac rehabilitation programs approved by us.

Wigs.

Third Party Liability — Anthem Blue Cross is entitled to reimbursement of benefits paid if the member recovers damages from a legally liable third party.

Coordination of Benefits — The benefits of this plan may be reduced if the member has any other group health or dental coverage so that the services received from all carriers coverages do not exceed 100% of the covered expense.

SJVIA County of Tulare
Lumenos® Health Savings Account (HSA)
Custom LHSA 289 (2500/90/50)
Rx Copay after Deductible

Anthem believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that this plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.
Questions regarding which protections of the Affordable Care Act apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Anthem at the telephone number printed on the back of your member identification card, or contact your group benefits administrator if you do not have an identification card. For ERISA plans, you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1–866–444–3272 or www.dol.gov/ebsa/healthreform. This Web site has a table summarizing which protections do and do not apply to grandfathered health plans. For nonfederal governmental plans, you may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

This Lumenos plan is an innovative type of coverage that allows an insured person to use a Health Savings Account to pay for routine medical care. The program also includes traditional health coverage, similar to a typical health plan, that protects the insured person against large medical expenses.
The insured person can spend the money in the HSA account the way the insured person wants on routine medical care, prescription drugs and other qualified medical expenses. There are no copays or deductibles to satisfy first. Unused dollars can be saved from year to year to reduce the amount the insured person may have to pay in the future. If covered expenses exceed the insured person's available HSA dollars, the traditional health coverage is available after a limited out-of-pocket amount is paid by the insured person.
Certain Covered Services have maximum visit and/or day limits per year. The number of visits and/or days allowed for those services will begin accumulating on the first visit and/or day, regardless of whether your Deductible has been met.
The insured person is responsible for all costs over the plan maximums. Plan maximums and other important information appear in *italics*. Benefits are subject to all terms, conditions, limitations, and exclusions of the Policy.

Explanation of Maximum Allowed Amount
Maximum Allowed Amount is the total reimbursement payable under the plan for covered services received from Participating and Non-Participating Providers. It is the payment towards the services billed by a provider combined with any applicable deductible, copayment or coinsurance.
Participating Providers- The rate the provider has agreed to accept as reimbursement for covered services. Members are not responsible for the difference between the provider's usual charges & the maximum allowed amount.
Non-Participating Providers & Other Health Care Providers-(includes those not represented in the PPO provider network)-Reimbursement amount is based on: an Anthem Blue Cross rate or fee schedule, a rate negotiated with the provider, information from a third party vendor, or billed charges. For Medical Emergency care rendered by a Non-Participating Provider or Non-Contracting Hospital, reimbursement may be based on the reasonable and customary value. Members may be responsible for any amount in excess of the reasonable and customary value.
Participating Pharmacies & Mail Service Program-members are not responsible for any amount in excess of the prescription drug maximum allowed amount.
Non-Participating Pharmacies-members are responsible for any expense not covered under this plan & any amount in excess of the prescription drug maximum allowed amount. When using non-participating providers, the insured person is responsible for any difference between the covered expense & actual charges, as well as any deductible & percentage copay.
When using the outpatient prescription drug benefits, the insured person is always responsible for drug expenses which are not covered under this plan, as well as any deductible, percentage or dollar copay.

Calendar year deductible for all providers *(applicable to medical care & prescription drug benefits)*	
➢ Individual insured person	$2,500/individual insured person
➢ Insured family *(includes insured employee & one or more members of the employee's family; no coverage may be paid for any member of a family unless this $5,000 deductible is met)*	$5,000/insured family
Deductible for hospital if utilization review not obtained	$250/admission *(waived for emergency admission)*
Annual Out-of-Pocket Maximums *(in-network/out-of-network out-of-pocket maximums are exclusive of each other; includes calendar year deductible & prescription drug covered expense)*	
➢ For all Providers & Other Health Care Providers & all Participating Pharmacies	$5,000/individual insured person, $10,000/insured family/year

The following do not apply to out-of-pocket maximums: costs in excess of the covered expense & non-covered expense. After an individual insured person or insured family *(includes insured employee & one or more members of the employee's family)* reaches the out-of-pocket maximum for all medical and prescription drug covered expense the individual insured person or insured family incurs during that calendar year, the individual insured person or insured family will no longer be required to pay a copay for the remainder of that year. The individual insured person or insured family remains responsible for costs in excess of the covered expense when provided by non-participating providers and other health care providers' non-covered expense.

Lifetime Maximum	Unlimited

Covered Services	Traditional Health Coverage Insured Person Copay In-Network	Out-of-Network *(insured is also responsible for charges in excess of covered expense.)*
Hospital Medical Services *(subject to utilization review for inpatient services; waived for emergency admissions)*		
➢ Semi-private room, meals & special diets, & ancillary services	10%	50% up to $580 plan payment per day
➢ Outpatient medical care, surgical services & supplies *(hospital care other than emergency room care)*	10%	50% *(benefit limited to $350/day)*
Ambulatory Surgical Centers		
➢ Outpatient surgery, services & supplies	10%	50% *(benefit limited to $350/day)*
Skilled Nursing Facility *(subject to utilization review)*		
➢ Semi-private room, services & supplies *(limited to 100 days/calendar year)*	10%	10%
Hospice Care *(subject to utilization review)* *($10,000 combined maximum per member per lifetime)*		
➢ Inpatient or outpatient services for insured persons with up to one year life expectancy; family bereavement services	10%	10%
Home Health Care *(subject to utilization review)*		
➢ Services & supplies from a home health agency *(limited to 100 visits/calendar year, one visit by a home health aide equals four hours or less; not covered while insured person receives hospice care)*	10%	10%
Home Infusion Therapy		
➢ Includes medication, ancillary services & supplies, caregiver training & visits by provider to monitor therapy; durable medical equipment; lab services	10%	10%
Physician Medical Services		
➢ Office & home visits	10%	50%
➢ Hospital & skilled nursing facility visits	10%	50%
➢ Surgeon & surgical assistant; anesthesiologist or anesthetist	10%	50%
➢ Drugs administered by a medical provider *(certain drugs are subject to utilization review)*	10%	50%
Diagnostic X-ray & Lab		
➢ MRI, CT scan, PET scan & nuclear cardiac scan *(subject to utilization review)*	10%	50%
➢ Other diagnostic x-ray & lab	10%	50%
Preventive Care Services Preventive Care Services including*, physical exams, preventive screenings (including screenings for cancer, HPV, diabetes, cholesterol, blood pressure, hearing and vision immunizations, health education, intervention services, HIV testing), and additional preventive care for women provided for in the guidelines supported by the Health Resources and Services Administration *This list is not exhaustive. This benefit includes all Preventive Care Services required by federal and state law.	No copay (deductible waived)	50%
Physical Therapy, Physical Medicine & Occupational Therapy, including Chiropractic Services *(limited to 12 visits/calendar year; additional visits may be approved if medically necessary)*	10%	50%
Speech Therapy		
➢ Outpatient speech therapy following injury or organic disease	10%	50%

Covered Services	Traditional Health Coverage Insured Person Copay In-Network	 Out-of-Network *(Insured is also responsible for charges in excess of covered expense.)*
Acupuncture		
➢ Services for the treatment of disease, illness or injury *(limited to 20 visits/calendar year)*	10%[1]	50%[1]
Temporomandibular Joint Disorders		
➢ Splint therapy & surgical treatment	10%	50%
Pregnancy & Maternity Care		
➢ Physician office visits	10%	50%
➢ Prescription drug for elective abortion *(mifepristone)*	10%	50%
Normal delivery, cesarean section, complications of pregnancy & abortion		
➢ Inpatient physician services	10%	50%
➢ Hospital & ancillary services	10%	50% *(benefit limited to $580/day)*
Organ & Tissue Transplants *(subject to utilization review; specified organ transplants covered only when performed at a Center of Expertise (COE).)*		
➢ Inpatient services provided in connection with non-investigative organ or tissue transplants	10%	
➢ Transplant travel expense for an authorized, specified transplant at a COE *(recipient & companion transportation limited to 6 trips/episode & $250/person/trip for round-trip coach airfare; hotel limited to 1 room double occupancy & $100/day for 21 days/trip; other expenses limited to $25/day/person for 21 days/trip; donor transportation limited to 1 trip/episode & $250 for round-trip coach airfare; hotel limited to $100/day for 7 days; other expenses limited to $25/day for 7 days)*	No copay	
Bariatric Surgery *(subject to utilization review; medically necessary surgery for weight loss, only for morbid obesity, covered only when performed at a Center of Expertise (COE).)*		
➢ Inpatient services provided in connection with medically necessary surgery for weight loss, only for morbid obesity	10%	
➢ Bariatric travel expense when insured person's home is 50 miles or more from the nearest bariatric COE *(insured person's transportation to & from COE limited to $130/person/trip for 3 trips (pre-surgical visit, initial surgery & one follow-up visit); one companion's transportation to & from COE limited to $130/person/trip for 2 trips (initial surgery & one follow-up visit); hotel for insured person & one companion limited to one room double occupancy & $100/day for 2 days/trip, or as medically necessary, for pre-surgical & follow-up visit; hotel for one companion limited to one room double occupancy & $100/day for duration of insured person's initial surgery stay for 4 days; other reasonable expenses limited to $25/day/person for 4 days/trip)*	No copay	
Diabetes Education Programs *(requires physician supervision)*		
➢ Teach insured persons & their families about the disease process, the daily management of diabetic therapy & self-management training	10%	50%

[1] Acupuncture services can be performed by a certified acupuncturist (C.A.), a doctor of medicine (M.D.), a doctor of osteopathy (D.O.), a podiatrist (D.P.M.), or a dentist (D.D.S.).

Covered Services	Traditional Health Coverage Insured Person Copay In-Network	Out-of-Network *(Insured is also responsible for charges in excess of covered expense.)*
Prosthetic Devices		
➢ Coverage for breast prostheses; prosthetic devices to restore a method of speaking; surgical implants; artificial limbs or eyes; the first pair of contact lenses or eyeglasses when required as a result of eye surgery; wigs for alopecia resulting from chemotherapy or radiation therapy; & therapeutic shoes & inserts for insured persons with diabetes	10%	10%
Durable Medical Equipment		
Rental or purchase of DME including dialysis equipment & supplies, home medical equipment, prosthetics/orthotics *(hearing aids benefit available for one hearing aid per ear every three years; breast pump and supplies are covered under preventive care at no charge for in-network)*	10%	10%
Related Outpatient Medical Services & Supplies		
➢ Ground or air ambulance transportation, services & disposable supplies	10%[1]	
➢ Blood transfusions, blood processing & the cost of unreplaced blood & blood products	10%[1]	
➢ Autologous blood *(self-donated blood collection, testing, processing & storage for planned surgery)*	10%[1]	
Emergency Care		
➢ Emergency room services & supplies	10%	10%
➢ Inpatient hospital services & supplies	10%	10%
➢ Physician services	10%	10%
Mental or Nervous Disorders and Substance Abuse		
Inpatient Care		
➢ Facility-based care *(subject to utilization review; waived for emergency admissions)*	10%	50% *(benefit limited to $350/day)*
➢ Inpatient physician visits	10%	50%
Outpatient Care		
➢ Facility-based care *(subject to utilization review; waived for emergency admissions)*	10%	50% *(benefit limited to $350/day)*
➢ Outpatient physician visits *(Behavioral Health treatment for Autism & Pervasive Disorder will be subject to pre-service review)*	10%	50%

[1] These providers are not represented in the Anthem Blue Cross PPO Network

Covered Services (For Outpatient Prescription Drugs)	Traditional Health Coverage Per Insured Person Copay for Each Prescription or Refill
Outpatient Prescription Drug Benefits *(Until the calendar year deductible is satisfied, the insured person pays the prescription drug ,maximum allowed amount and not the copays listed below.)*	
➢ Retail Pharmacy	
➢ Preventive immunizations administered by a retail pharmacy -	No copay *(deductible waived)*
➢ Female oral contraceptives generic and single source brand	No copay *(deductible waived)*
➢ Generic drugs	$7
➢ Brand name formulary drugs[1,2]	$25
➢ Self-administered injectable drugs, except insulin	$25
Home Delivery	
➢ Female oral contraceptives generic and single source brand	No copay
➢ Generic drugs	$14
➢ Brand name formulary drugs[1,2]	$50
➢ Self-administered injectable drugs, except insulin	$25
Specialty pharmacy drugs *(may only be obtained through the specialty pharmacy program)*	
➢ Generic drugs	$7
➢ Brand name formulary drugs[1]	$25
➢ Self-administered injectable drugs, except insulin	$25
Non-participating Pharmacies *(compound drugs & specialty pharmacy drugs not covered at retail participating pharmacies)*	*Insured person pays the above retail pharmacy copay plus:* 30% of the remaining prescription drug maximum allowed amount & costs in excess of the maximum amount allowed
Supply Limits[3]	
➢ Retail Pharmacy *(participating and non-participating)*	30-day supply; 60-day supply for federally classified Schedule II attention deficit disorder drugs that require a triplicate prescription form, but require a double copay; 6 tablets or units/30-day period for impotence and/or sexual dysfunction drugs (available only at retail pharmacies)
➢ Home Delivery	90-day supply
➢ Specialty Pharmacy	30-day supply

[1] *Mandatory Generic Substitution:* If an insured person requests a brand name drug when a generic drug substitution exists, the insured person pays the generic drug copay plus the difference in cost between the negotiated rate for the generic drug and the brand name drug, but not more than 50% of the cost of the prescription drug. Mandatory generic substitution does not apply when it has been determined that the brand name drug is medically necessary for the insured person.

[2] When the member's physician has specified "dispense as written" (DAW) for formulary brand drugs, the copay for brand name formulary drugs will apply. When the member's physician has not specified DAW for formulary brand drugs, the member pays the generic drug copay plus the difference in cost between the drug negotiated rate for the generic drug and the brand name formulary drug, but not more than 50% of the drug negotiated rate. Some drugs may also be subject to a review for Medical Necessity by Anthem Blue Cross Life and Health Insurance Company.

[3] Supply limits for certain drugs may be different. Please refer to the Certificate of Insurance for complete information.

The Outpatient Prescription Drug Benefit covers the following:

- Outpatient prescription drugs and medications which the law restricts to sale by prescription. Formulas prescribed by a physician for the treatment of phenylketonuria.
- Insulin
- Syringes when dispensed for use with insulin and other self-injectable drugs or medications
- Prescription oral contraceptives; contraceptive diaphragms. Contraceptive diaphragms are limited to one per year.
- Injectable drugs which are self-administered by the subcutaneous route (under the skin) by the patient or insured person. Drugs that have Food and Drug Administration (FDA) labeling for self-administration
- All compound prescription drugs that contain at least one covered prescription ingredient
- Diabetic supplies (i.e., test strips and lancets)
- Prescription drugs for treatment of impotence and/or sexual dysfunction are limited to organic (non-psychological) causes.
- Inhaler spacers and peak flow meters for the treatment of pediatric asthma.
- Smoking cessation products requiring a physician's prescription.
- Certain over-the-counter drugs approved by the Pharmacy and Therapeutics Committee to be included in the prescription drug formulary.

This Summary of Benefits is a brief review of benefits. Once enrolled, insured persons will receive a Certificate of Insurance, which explains the exclusions and limitations, as well as the full range of covered services of the plan in detail.

Lumenos HSA Plan — Exclusions and Limitations

Benefits are not provided for expenses incurred for or in connection with the following items.

Not Medically Necessary. Services or supplies that are not medically necessary, as defined.

Experimental or Investigative. Any experimental or investigative procedures or medication. But, if the insured person is denied benefits because it is determined that the requested treatment is experimental or investigative, the insured person may request an independent medical review as described in the Certificate.

Outside the United States. Services or supplies furnished and billed by a provider outside the United States, unless such services or supplies are furnished in connection with urgent care or an emergency.

Crime or Nuclear Energy. Conditions that result from (1) the insured person's commission of or attempt to commit a felony, as long as any injuries are not a result of a medical condition or an act of domestic violence, or (2) any release of nuclear energy, whether or not the result of war, when government funds are available for the treatment of illness or injury arising from the release of nuclear energy.

Not Covered. Services received before the insured person's effective date. Services received after the insured person's coverage ends, except as specified as covered in the Certificate.

Excess Amounts. Any amounts in excess of maximum amounts of the limited maximum.

Work-Related. Work-related conditions if benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation, employer's liability law or occupational disease law, whether or not the insured person claims those benefits. If there is a dispute or substantial uncertainty as to whether benefits may be recovered for those conditions pursuant to workers' compensation, we will provide the benefits of this plan for such conditions, subject to a right of recovery and reimbursement under California Labor Code Section 4903, as specified as covered in the Certificate.

Government Treatment. Any services the insured person actually receives that were provided by a state, local or federal government agency, except when payment under this plan is expressly required by federal or state law. We will not cover treatment for those services if the insured person is not required to pay for them or they are given to the insured person for free.

Services of Relatives. Professional services received from a person living in the insured person's home or who is related to the insured person by blood or marriage, except as specified as covered in the Certificate.

Voluntary Payment. Services for which the insured person has no legal obligation to pay, or for which no charge would be made in the absence of insurance coverage or other health plan coverage, except services received at a non-governmental charitable research hospital. Such a hospital must meet the following guidelines:

1. it must be internationally known as being devoted mainly to medical research;
2. at least 10% of its yearly budget must be spent on research not directly related to patient care;
3. at least one-third of its gross income must come from donations or grants other than gifts or payments for patient care;
4. it must accept patients who are unable to pay; and
5. two-thirds of its patients must have conditions directly related to the hospital's research

Not Specifically Listed. Services not specifically listed in the plan as covered services.

Private Contracts. Services or supplies provided pursuant to a private contract between the insured person and a provider, for which reimbursement under Medicare program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act.

Inpatient Diagnostic Tests. Inpatient room and board charges in connection with a hospital stay primarily for diagnostic tests which could have been performed safely on an outpatient basis.

Mental or Nervous Disorders. Academic or educational testing, counseling, and remediation. Mental or nervous disorders or substance abuse, including rehabilitative care in relation to these conditions, except as specified as covered in the Certificate.

Orthodontia. Braces, other orthodontic appliances or orthodontic services.

Dental Services or Supplies. Dental plates, bridges, crowns, caps or other dental prostheses, dental implants, dental services, extraction of teeth, treatment to the teeth or gums, or treatment to or for any disorders for the temporomandibular (jaw) joint, except as specified as covered in the Certificate. Cosmetic dental surgery or other dental services for beautification.

Hearing Aids or Tests. Hearing aids or routine hearing tests.

Optometric Services or Supplies. Optometric services, eye exercises including orthoptics. Routine eye exams and routine eye refractions, as specified as covered in the Certificate. Eyeglasses or contact lenses, except as specified as covered in the Certificate.

Outpatient Occupational Therapy. Outpatient occupational therapy, except by a home health agency, hospice, or home infusion therapy provider, as specified as covered in the Certificate.

Outpatient Speech Therapy. Outpatient speech therapy, except as specified as covered in the Certificate.

Cosmetic Surgery. Cosmetic surgery or other services performed solely for beautification or to alter or reshape normal (including aged) structures or tissues of the body to improve appearance. This exclusion does not apply to reconstructive surgery (that is, surgery performed to correct or repair abnormal structures of the body caused by congenital or developmental abnormalities, tumors, or injury for the purpose of improving bodily function or symptomatology or to create a normal appearance), including surgery performed to restore symmetry following mastectomy. Cosmetic surgery does not become reconstructive surgery because of psychological or emotional reasons.

Scalp Hair Prostheses. Scalp hair prostheses, including wigs or any form of hair replacement, except as specified as covered in the Certificate.

Commercial Weight Loss Programs. Weight loss programs, whether or not they are pursued under medical or physician supervision, unless specifically listed as covered in this plan.

This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

This exclusion does not apply to medically necessary treatments for morbid obesity or dietary evaluations and counseling, and behavioral modification programs for the treatment of anorexia nervosa or bulimia nervosa. Surgical treatment for morbid obesity is covered as described in the Certificate.

Sterilization Reversal.

Infertility Treatment. Any services or supplies furnished in connection with the diagnosis and treatment of infertility, including, but not limited to diagnostic tests, medication, surgery, artificial insemination, in vitro fertilization, sterilization reversal and gamete intrafallopian transfer.

Surrogate Mother Services. For any services or supplies provided to a person not covered under the plan in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

Orthopedic shoes and shoe inserts. This exclusion does not apply to orthopedic footwear used as an integral part of a brace, shoe inserts that are custom molded to the patient, or therapeutic shoes and inserts designed to treat foot complications due to diabetes, as specifically stated in the EOC.

Air Conditioners. Air purifiers, air conditioners or humidifiers.

Custodial Care or Rest Cures. Inpatient room and board charges in connection with a hospital stay primarily for environmental change or physical therapy. Custodial care or rest cures, except as specified as covered in the Certificate. Services provided by a rest home, a home for the aged, a nursing home or any similar facility. Services provided by a skilled nursing facility, except as specified as covered in the Certificate.

Health Club Memberships. Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment or facilities used for developing or maintaining physical fitness, even if ordered by a physician. This exclusion also applies to health spas.

Personal Items. Any supplies for comfort, hygiene or beautification.

Education or Counseling. Educational services or nutritional counseling, except as specified as covered in the Certificate. This exclusion does not apply to counseling for the treatment of anorexia nervosa or bulimia nervosa.

Food or Dietary Supplements. Nutritional and/or dietary supplements, except as provided in this plan or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written prescription or dispensing by a licensed pharmacist.

Telephone and Facsimile Machine Consultations. Consultations provided by telephone, except as specified as covered in the Certificate, or facsimile machine.

Routine Exams or Tests. Routine physical exams or tests which do not directly treat an actual illness, injury or condition, including those required by employment or government authority, except as specified as covered in the Certificate.

Acupuncture. Acupuncture treatment, except as specified as covered in the Certificate. Acupressure or massage to control pain, treat illness or promote health by applying pressure to one or more specific areas of the body based on dermatomes or acupuncture points.

Eye Surgery for Refractive Defects. Any eye surgery solely or primarily for the purpose of correcting refractive defects of the eye such as nearsightedness (myopia) and/or astigmatism. Contact lenses and eyeglasses required as a result of this surgery.

Physical Therapy or Physical Medicine. Services of a physician for physical therapy or physical medicine, except when provided during a covered inpatient confinement or as specified as covered in the Certificate.

Outpatient Prescription Drugs and Medications. Outpatient prescription drugs or medications and insulin, except as specified as covered in the Certificate. Non-prescription, over-the-counter patent or proprietary drugs or medicines, except as specified as covered in the Certificate. Cosmetics, health or beauty aids.

Specialty Pharmacy Drugs. Specialty pharmacy drugs that must be obtained from the specialty pharmacy program, but, which are obtained from a retail pharmacy, are not covered by this plan. Insured person will have to pay the full cost of the specialty pharmacy drugs obtained from a retail pharmacy that should have been obtained from the specialty pharmacy program.

Contraceptive Devices. Contraceptive devices prescribed for birth control except as specified as covered in the Certificate.

Diabetic Supplies. Prescription and non-prescription diabetic supplies except as specified as covered in the Certificate.

Private Duty Nursing. Inpatient or outpatient services of a private duty nurse.

Lifestyle Programs. Programs to alter one's lifestyle which may include but are not limited to diet, exercise, imagery or nutrition, except as specified as covered in the Certificate. This exclusion will not apply to cardiac rehabilitation programs approved by us.

Clinical Trials. Services and supplies in connection with clinical trials, except as specified as covered in the Certificate.

Lumenos HSA Rx Copay after Deductible Plan — Exclusions and Limitations (Continued)

Outpatient prescription drug services and supplies are not provided for or in connection with the following:

Immunizing agents, biological sera, blood, blood products or blood plasma

Hypodermic syringes (like needles, except when dispensed for use with insulin & other self-injectable drugs or medications

Drugs & medications used to induce spontaneous & non-spontaneous abortion

Drugs & medications dispensed or administered in an outpatient setting, including outpatient hospital facilities and physicians' offices

Professional charges in connection with administering, injecting or dispensing drugs

Drugs & medications that may be obtained without a physician's written prescription, except insulin or insulin for cholesterol lowering and certain over-the-counter drugs approved by the Pharmacy and Therapeutics Committee to be included in the prescription drug formulary.

Drugs & medications dispensed by or while confined in a hospital, skilled nursing facility, rest home, sanatorium, convalescent hospital or similar facility

Durable medical equipment, devices, appliances & supplies, even if prescribed by a physician, except contraceptive diaphragms, as specified as covered in the Certificate

Services or supplies for which the insured person is not charged

Oxygen

Cosmetics & health or beauty aids.

Drugs labeled "Caution, Limited by Federal Law to Investigational Use," or Non FDA approved investigational drugs. Any drugs or medications prescribed for experimental indications

Any expense for a drug or medication incurred in excess of the prescription drug maximum allowed amount

Drugs which have not been approved for general use by the State of California Department of Health Services or the Food and Drug Administration. This does not apply to drugs that are medically necessary for a covered condition.

Drugs to diminish or reduce dependency on, or addiction to, tobacco and tobacco products. This does not apply to medically necessary drugs that the insured person can only get with a prescription under state and federal law.

Drugs used primarily for cosmetic purposes (e.g., Retin-A for wrinkles). However, this will not apply to the use of this type of drug for medically necessary treatment of a medical condition other than one that is cosmetic.

Drugs used primarily to treat infertility (including, but not limited to, Clomid, Pergonal and Metrodin), unless medically necessary for another covered condition.

Anorectants and drugs used for weight loss, except when used to treat morbid obesity (e.g., diet pills & appetite suppressants)

Drugs obtained outside the U.S. unless they are furnished in connection with urgent care or an emergency

Allergy desensitization products or allergy serum

Infusion drugs, except drugs that are self-administered subcutaneously

Herbal supplements, nutritional and dietary supplements except for formulas for the treatment of phenylketonuria.

Prescription drugs with a non-prescription (over-the-counter) chemical and dose equivalent except insulin. This does not apply if an over-the-counter equivalent was tried and was ineffective.

Compound medications unless:

a. There is at least one component in it that is a prescription drug, and
b. It is obtained from other than a participating pharmacy, insured person will have to pay the full cost of the compound medications if insured person obtains drug at a non-participating pharmacy.

Specialty pharmacy drugs that must be obtained from the specialty pharmacy program, but, which are obtained from a retail pharmacy are not covered by this plan. Insured person will have to pay the full cost of the specialty pharmacy drugs obtained from a retail pharmacy that insured person should have obtained from the specialty pharmacy program

Third Party Liability – Anthem Blue Cross Life and Health Insurance Company is entitled to reimbursement of benefits paid if the insured person recovers damages from a legally liable third party.

Coordination of Benefits – The benefits of this plan may be reduced if the insured person has any other group health or dental coverage so that the services received from all group coverages do not exceed 100% of the covered expense.

Frequently Asked Questions

How do I find a participating network pharmacy?
You can use your EmpiRx Health ID card at over 66,000 pharmacies nationwide including all pharmacy chains. You can find a network pharmacy by logging onto www.empirxhealth.com or calling 877-262-7435.

What is a prior authorization and why is it necessary?
Certain medications require prior authorization (PA) because of their potential side effects, potentially harmful interactions with other prescription medications, or to confirm they are being prescribed in accordance with Food & Drug Administration (FDA) approved indications. This process is designed to help ensure your health and safety. If a PA is needed, EmpiRx Health will work directly with your physician to obtain the necessary information prior to fulfillment.

How do I find out if a particular prescription is covered by my benefits?
Call 877-262-7435 to speak to a representative who can assist you with drug coverage questions or log onto www.empirxhealth.com for details.

How can I find out if generic or lower cost alternatives may be available to me?
Log into the member portal at www.empirxhealth.com and select "Drug Pricing." Search your medication and if there is a generic available, you will see the cost for both the brand as well as the generic. You can also call 877-262-7435 to speak to a representative who can assist you, or consult your physician or pharmacist to determine if generic equivalents are available for your prescription.

Why does my copay change from month to month?
The cost of medications changes regularly and prices are not all the same at each pharmacy. If your copay is based on a percentage rather than a fixed dollar amount then depending on the pharmacy you use and the cost of the medication at the time your prescription is filled, you may see a variation in your copay amount.

EmpiRx HEALTH

SJVIA
San Joaquin Valley Insurance Authority

SJVIA County of Tulare

Prescription Benefit Plan

EmpiRx Health Member Services
877-262-7435; TDD: 1-888-907-0020
24 hours a day, 7 days a week

Your Prescription Benefit Program

Annual Maximum Out of Pocket Amount

Your plan includes a $2,000 individual / $4,000 family annual maximum out of pocket amount.

Retail Pharmacy Copayment

You are responsible to pay the retail pharmacist the copayment per prescription which is listed below:

30-Day Supply	90-Day Supply
$10.00 for a Generic Medication	$20.00 for a Generic Medication
$20.00 for a Preferred Brand Medication	$40.00 for a Preferred Brand Medication
$35.00 for a Non-Preferred Brand Medication	$60.00 for a Non-Preferred Brand Medication

This is a Dispense As Written Plan (DAW), meaning your pharmacist must dispense the generic equivalent drug when one is available unless your physician specifically requests the brand be dispensed. If you request the brand name medication from your pharmacist, you are responsible for the difference in cost between the brand and the generic plus the copayment.

Retail quantities will be dispensed according to your physician's instructions written on the prescription up to a maximum of a 90-day supply.

Please Note: If the cost of your medication is less than your calculated copayment, you will only pay the cost of the medication.

Mail Order Pharmacy Copayment

Maintenance medications can be submitted to Benecard Central Fill, the EmpiRx Health mail order facility. Your plan allows for up to a 90-day supply with three (3) refills, according to your physician's instructions. Your co-pay amounts will be:

$20.00 for a Generic Medication
$40.00 for a Preferred Brand Medication
$60.00 for a Non-Preferred Brand Medication

Specialty Medication Copayment

Specialty medications are high-cost biotechnology drugs requiring special distribution, handling, and administration. These medications are typically designed to treat chronic diseases.

30% ($100 max) for a Generic Specialty Medication
30% ($100 max) for a Preferred Brand Specialty Medication
30% ($100 max) for a Non-Preferred Brand Specialty Medication

Specialty medications can be filled one (1) time at a retail pharmacy. All future prescriptions must be obtained at Benecard Central Fill's Specialty Pharmacy. Please note that specialty medications are limited to a 30-day supply.

Online Member Tools

Maximize your benefit and find out how you can save on your out-of-pocket costs with our valuable member resource tools online at www.empirxhealth.com including:

- Plan coverage details and copay information
- Network pharmacy finder
- Mail service access to request refills and check order status
- Updated preferred medication list
- Drug comparison pricing tool to identify lower cost alternatives
- Drug information
- Recent personal drug utilization history including the amount you have paid and what the plan has paid on your behalf. This is helpful for year-end tax purposes

Registration is easy! Along with your EmpiRx Health ID card, you will need basic member information, a phone number and an email address. Refer to our website periodically for the most recent pharmacy network finder and preferred medication list.

EmpiRx HEALTH

Powered by

Preferred Medication List

The Preferred Medication List is a guide for selecting clinically and therapeutically appropriate medications. It should not take the place of a physician's or pharmacist's judgment with regard to a patient's pharmaceutical care. Refer to www.empirxhealth.com for the most recent version of the Preferred Medication List.

Exclusions

Your prescription program covers most Medically Necessary, Federal Legend, State Restricted and Compounded Medications which, by law, may not be dispensed without a prescription.

Be sure to present your EmpiRx Health ID card at a participating network pharmacy to receive a discount off the retail price of medications that may not be covered.

Retail Pharmacy Network

Your EmpiRx Health prescription benefit program provides you with access to an extensive national pharmacy network, including all chain pharmacies and most independents. This plan allows for a 90-day supply of maintenance medications. Your ID card provides all the information your pharmacist will need to process your prescription through EmpiRx Health. To locate a participating network pharmacy, log onto www.empirxhealth.com or call EmpiRx Health Member Services toll-free at 877-262-7435 (TDD: 1-888-907-0020).

Mail Order Pharmacy

The EmpiRx Health mail service pharmacy, Benecard Central Fill, is an option for you to obtain maintenance medications. Typically, prescriptions filled through mail service include medications used to treat chronic conditions and are written for up to a 90-day supply, plus refills. Prescriptions that you need to use right away should always be taken to your local pharmacy. You do have the option to obtain 90-day supplies through the retail network.

For your first order, complete the enclosed Mail Service Order Form and mail it along with your original prescription using the pre-addressed envelope provided to Benecard Central Fill. You can also have your physician submit your prescription electronically to Benecard Central Fill or fax your prescription to 1-888-907-0040. Be sure that your physician includes the cardholder name, ID number, shipping address, and patient's date of birth. Only prescriptions faxed from a doctor's office will be accepted via fax.

To order refills you have three options:

- **Internet:** Visit www.empirxhealth.com. If you have not yet registered, click on Register. If you are a registered user, log in and select Mail Order.
- **Phone:** Call Member Services toll-free, 877-262-7435, 24 hours a day, 7 days a week and use the prompts to order your refills. Have your identification number and credit card information ready.
- **Mail:** Send the Refill Request Order Form provided with your last shipment back to Benecard Central Fill mail service in the pre-addressed envelope

EmpiRx Health does NOT automatically refill your prescriptions.

To avoid delays, always include the appropriate copayment (if applicable) when your order is placed. Visa, MasterCard, Discover, or American Express and debit cards are accepted. You may also pay by check or money order made payable to Benecard Central Fill. Please do not send cash. Please allow up to two (2) weeks for delivery. Emergency prescriptions can be expedited at an additional charge.

Specialty Pharmacy

Specialty pharmaceuticals are typically produced through biotechnology, administered by injection, and/or require special handling and patient monitoring.

Through the Specialty Pharmacy, you receive personalized attention to help you manage your medical condition including one-on-one counseling with our team of pharmacists and trained medical professionals.

Our clinical team partners with you and your prescribing doctor to ensure you understand:

- How to manage your condition
- What medications you have been prescribed
- How to take your medication
- What lower cost options may be available
- How to coordinate delivery of your medication
- How to safely handle and store your medication

Shipments will arrive in secure, temperature-controlled packaging (if necessary) and will include everything you will need to take your medication. Due to the sensitive nature of specialty medications, some packages may require a signature.

Where Can I Ship My Medications?

We offer the convenience you need. Your medication can be shipped directly to:

- Your home
- Your work
- Your doctor's office
- Or a convenient location of your choice

Save with Generic Medications

Generic equivalent drugs must meet the same Food & Drug Administration (FDA) standards for purity, strength, and safety as brand name drugs. They also must have the same active ingredients and identical absorption rate within the body as the brand name version. If you wish to take advantage of this savings opportunity, speak with your physician about the use of generics. You may also consult with your pharmacist regarding generic drug options that may be available to you.

ID Cards

If your ID card is lost, you may print a temporary card online at www.empirxhealth.com. If there is an emergency and you need a prescription filled, call Empirx Health Member Services toll-free at 877-262-7435 (TDD: 1-888-907-8020) and we will provide your pharmacist with the required information to facilitate processing the claim.

Direct Member Reimbursement

If you must pay out-of-pocket for your medication which is covered by your plan, submit a Direct Member Reimbursement Form, which is available online at www.empirxhealth.com. You will need to provide an itemized receipt showing: the amount charged, prescription number, medication dispensed, manufacturer, dosage form, strength, quantity, and date dispensed. Your pharmacist can assist you if you do not have a detailed receipt. Direct reimbursement is based upon your plan benefits and the amount reimbursed may be significantly lower than the retail price you paid; therefore, always try to use a participating network pharmacy and present your ID card to reduce any unnecessary out-of-pocket expenses.

Disclosure Form

339375 SIVIA-COUNTY OF TULARE

Principal Benefits for
Kaiser Permanente Traditional Plan (1/1/18—12/31/18)

Health Plan believes this coverage is a "grandfathered health plan" under the Patient Protection and Affordable Care Act. If you have questions about grandfathered health plans, please call our Member Service Contact Center.

Accumulation Period

The Accumulation Period for this plan is 1/1/18 through 12/31/18 (calendar year).

Out-of-Pocket Maximum(s) and Deductible(s)

For Services that apply to the Plan Out-of-Pocket Maximum, you will not pay any more Cost Share for the rest of the Accumulation Period once you have reached the amounts listed below.

Amounts Per Accumulation Period	Self-Only Coverage (a Family of one Member)	Family Coverage Each Member in a Family of two or more Members	Family Coverage Entire Family of two or more Members
Plan Out-of-Pocket Maximum	$1,500	$1,500	$3,000
Plan Deductible	None	None	None
Drug Deductible	None	None	None

Professional Services (Plan Provider office visits)	You Pay
Most Primary Care Visits and most Non-Physician Specialist Visits	$25 per visit
Most Physician Specialist Visits	$25 per visit
Routine physical maintenance exams, including well-women exams	No charge
Well-child preventive exams (through age 23 months)	No charge
Family planning counseling and consultations	No charge
Scheduled prenatal care exams	No charge
Routine eye exams with a Plan Optometrist	No charge
Urgent care consultations, evaluations, and treatment	$25 per visit
Most physical, occupational, and speech therapy	$25 per visit

Outpatient Services	You Pay
Outpatient surgery and certain other outpatient procedures	$25 per procedure
Allergy injections (including allergy serum)	$8 per visit
Most immunizations (including the vaccine)	No charge
Most X-rays and laboratory tests	No charge
Covered individual health education counseling	No charge
Covered health education programs	No charge

Hospitalization Services	You Pay
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	$250 per admission

Emergency Health Coverage	You Pay
Emergency Department visits	$100 per visit

Note: This Cost Share does not apply if you are admitted directly to the hospital as an inpatient for covered Services (see "Hospitalization Services" for inpatient Cost Share).

Ambulance Services	You Pay
Ambulance Services	$50 per trip

Prescription Drug Coverage	You Pay
Covered outpatient items in accord with our drug formulary guidelines:	
Most generic items at a Plan Pharmacy or through our mail-order service	$10 for up to a 100-day supply
Most brand-name items at a Plan Pharmacy or through our mail-order service	$20 for up to a 100-day supply
Most specialty items at a Plan Pharmacy	$20 for up to a 30-day supply

Durable Medical Equipment (DME)	You Pay
DME items in accord with our DME formulary guidelines	20% Coinsurance

Mental Health Services	You Pay
Inpatient psychiatric hospitalization	$250 per admission
Individual outpatient mental health evaluation and treatment	$25 per visit
Group outpatient mental health treatment	$12 per visit

Substance Use Disorder Treatment	You Pay
Inpatient detoxification	$250 per admission
Individual outpatient substance use disorder evaluation and treatment	$25 per visit
Group outpatient substance use disorder treatment	$5 per visit
Home Health Services	**You Pay**
Home health care (up to 100 visits per Accumulation Period)	No charge
Other	**You Pay**
Eyeglasses or contact lenses every 24 months	Amount in excess of $150 Allowance
Skilled nursing facility care (up to 100 days per benefit period)	No charge
Prosthetic and orthotic devices	No charge
Covered fertility Services	50% Coinsurance
Hospice care	No charge

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Share, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Share amounts. For a complete explanation, please refer to the EOC. Please note that we provide all benefits required by law (for example, diabetes testing supplies).

229275 SJVIA-COUNTY OF TULARE

Principal Benefits for
Kaiser Permanente Deductible HMO Plan (1/1/18—12/31/18)

Accumulation Period

The Accumulation Period for this plan is 1/1/18 through 12/31/18 (calendar year).

Out-of-Pocket Maximum(s) and Deductible(s)

For Services that apply to the Plan Out-of-Pocket Maximum, you will not pay any more Cost Share for the rest of the Accumulation Period once you have reached the amounts listed below.

For Services that are subject to the Plan Deductible or the Drug Deductible, you must pay Charges for covered Services you receive during the Accumulation Period until you reach the deductible amounts listed below. All payments you make toward your deductible(s) apply to the Plan Out-of-Pocket Maximum amounts listed below.

Amounts Per Accumulation Period	Self-Only Coverage (a Family of one Member)	Family Coverage Each Member in a Family of two or more Members	Family Coverage Entire Family of two or more Members
Plan Out-of-Pocket Maximum	$3,000	$3,000	$6,000
Plan Deductible	$1,000	$1,000	$2,000
Drug Deductible	None	None	None

Professional Services (Plan Provider office visits)	You Pay
Most Primary Care Visits and most Non-Physician Specialist Visits	$20 per visit (Plan Deductible doesn't apply)
Most Physician Specialist Visits	$20 per visit (Plan Deductible doesn't apply)
Routine physical maintenance exams, including well-woman exams	No charge (Plan Deductible doesn't apply)
Well-child preventive exams (through age 23 months)	No charge (Plan Deductible doesn't apply)
Family planning counseling and consultations	No charge (Plan Deductible doesn't apply)
Scheduled prenatal care exams	No charge (Plan Deductible doesn't apply)
Routine eye exams with a Plan Optometrist	No charge (Plan Deductible doesn't apply)
Urgent care consultations, evaluations, and treatment	$20 per visit (Plan Deductible doesn't apply)
Most physical, occupational, and speech therapy	$20 per visit after Plan Deductible

Outpatient Services	You Pay
Outpatient surgery and certain other outpatient procedures	20% Coinsurance after Plan Deductible
Allergy injections (including allergy serum)	No charge after Plan Deductible
Most immunizations (including the vaccine)	No charge (Plan Deductible doesn't apply)
Most X-rays and laboratory tests	$10 per encounter after Plan Deductible
Preventive X-rays, screenings, and laboratory tests as described in the EOC	No charge (Plan Deductible doesn't apply)
MRI, most CT, and PET scans	$50 per procedure after Plan Deductible
Covered individual health education counseling	No charge (Plan Deductible doesn't apply)
Covered health education programs	No charge (Plan Deductible doesn't apply)

Hospitalization Services	You Pay
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	20% Coinsurance after Plan Deductible

Emergency Health Coverage	You Pay
Emergency Department visits	20% Coinsurance after Plan Deductible

Note: This Cost Share does not apply if you are admitted directly to the hospital as an inpatient for covered Services (see "Hospitalization Services" for inpatient Cost Share).

Ambulance Services	You Pay
Ambulance Services	$150 per trip after Plan Deductible

Prescription Drug Coverage	You Pay
Covered outpatient items in accord with our drug formulary guidelines:	
Most generic items at a Plan Pharmacy	$10 for up to a 30-day supply (Plan Deductible doesn't apply)
Most generic refills through our mail-order service	$20 for up to a 100-day supply (Plan Deductible doesn't apply)
Most brand-name items at a Plan Pharmacy	$30 for up to a 30-day supply (Plan Deductible doesn't apply)
Most brand-name refills through our mail-order service	$60 for up to a 100-day supply (Plan Deductible doesn't apply)

(continues)

Most specialty items at a Plan Pharmacy	$30 for up to a 30-day supply (Plan Deductible doesn't apply)

Durable Medical Equipment (DME)	You Pay
DME items in accord with our DME formulary guidelines	20% Coinsurance (Plan Deductible doesn't apply)

Mental Health Services	You Pay
Inpatient psychiatric hospitalization	20% Coinsurance after Plan Deductible
Individual outpatient mental health evaluation and treatment	$10 per visit (Plan Deductible doesn't apply)
Group outpatient mental health treatment	$10 per visit (Plan Deductible doesn't apply)

Substance Use Disorder Treatment	You Pay
Inpatient detoxification	20% Coinsurance after Plan Deductible
Individual outpatient substance use disorder evaluation and treatment	$20 per visit (Plan Deductible doesn't apply)
Group outpatient substance use disorder treatment	$5 per visit (Plan Deductible doesn't apply)

Home Health Services	You Pay
Home health care (up to 100 visits per Accumulation Period)	No charge (Plan Deductible doesn't apply)

Other	You Pay
Skilled nursing facility care (up to 100 days per benefit period)	20% Coinsurance after Plan Deductible
Prosthetic and orthotic devices	No charge (Plan Deductible doesn't apply)
Covered fertility Services	50% Coinsurance (Plan Deductible doesn't apply)
Hospice care	No charge (Plan Deductible doesn't apply)

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Share, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Share amounts. For a complete explanation, please refer to the EOC. Please note that we provide all benefits required by law (for example, diabetes testing supplies).

39189 SJVIA-COUNTY OF TULARE

Principal Benefits for Kaiser Permanente Senior Advantage (HMO) with Part D (1/1/18—12/31/18)

Plan Out-of-Pocket Maximum	
For Services subject to the maximum, you will not pay any more Cost Share for the rest of the calendar year if the Copayments and Coinsurance you pay for those Services add up to one of the following amounts:	
For any one Member	$1,500 per calendar year
Plan Deductible	**None**
Professional Services (Plan Provider office visits)	**You Pay**
Most Primary Care Visits and most Non-Physician Specialist Visits	$15 per visit
Most Physician Specialist Visits	$15 per visit
Annual Wellness visit and the "Welcome to Medicare" preventive visit	No charge
Routine physical exams	No charge
Routine eye exams with a Plan Optometrist	$15 per visit
Urgent care consultations, evaluations, and treatment	$15 per visit
Physical, occupational, and speech therapy	$15 per visit
Outpatient Services	**You Pay**
Outpatient surgery and certain other outpatient procedures	$15 per procedure
Allergy injections (including allergy serum)	$3 per visit
Most immunizations (including the vaccine)	No charge
Most X-rays and laboratory tests	No charge
Manual manipulation of the spine	$15 per visit
Hospitalization Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	$200 per admission
Emergency Health Coverage	**You Pay**
Emergency Department visits	$50 per visit
Ambulance Services	**You Pay**
Ambulance Services	$50 per trip
Prescription Drug Coverage	**You Pay**
Covered outpatient items in accord with our drug formulary guidelines:	
Most generic items	$10 for up to a 100-day supply
Most brand-name items	$25 for up to a 100-day supply
Durable Medical Equipment (DME)	**You Pay**
Covered durable medical equipment for home use	20 percent Coinsurance
Mental Health Services	**You Pay**
Inpatient psychiatric hospitalization	$200 per admission
Individual outpatient mental health evaluation and treatment	$15 per visit
Group outpatient mental health treatment	$7 per visit

(continues)

Substance Use Disorder Treatment	You Pay
Inpatient detoxification	$200 per admission
Individual outpatient substance use disorder evaluation and treatment	$16 per visit
Group outpatient substance use disorder treatment	$5 per visit

Home Health Services	You Pay
Home health care (part-time, intermittent)	No charge

Other	You Pay
Eyeglasses or contact lenses every 24 months	Amount in excess of $150 Allowance
Skilled nursing facility care (up to 100 days per benefit period)	No charge
External prosthetic and orthotic devices	20 percent Coinsurance
Ostomy and urological supplies	20 percent Coinsurance

This chart does not explain benefits, Cost Share, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Share amounts. For more information, please refer to the *Summary of Benefits* booklet enclosed.

Plan Benefit Highlights for: COUNTY OF TULARE
Group No: 18128

DELTA DENTAL PPO

BENEFIT HIGHLIGHTS

Eligibility	Primary enrollee, spouse and eligible dependent children to the end of the month dependent turns age 26			
Deductibles	Delta Dental PPO dentists: None Non-Delta Dental PPO dentists: $25 per person / $75 per family each calendar year			
Deductibles waived for Diagnostic & Preventive (D & P)?	Delta Dental PPO dentists: None Non-Delta Dental PPO dentists: Yes			
Maximums	$1,000 per person each calendar year			
Waiting Period(s)	Basic Benefits None	Major Benefits None	Prosthodontics None	Orthodontics None

Benefits and Covered Services*	**Delta Dental PPO dentists****	**Non-Delta Dental PPO dentists****
Diagnostic & Preventive Services (D & P) Exams, cleaning and x-rays	100 %	100 %
Basic Services Fillings and simple tooth extractions	80 %	80 %
Endodontics (root canals) Covered Under Basic Services	80 %	80 %
Periodontics (gum treatment) Covered Under Basic Services	80 %	80 %
Oral Surgery Covered Under Basic Services	80 %	80 %
Major Services Crowns, inlays, onlays and cast restorations	50 %	50 %
Prosthodontics Bridges, dentures and implants	50 %	50 %
Orthodontic Benefits Adults and dependent children	50 %	50 %
Orthodontic Maximums	$1,500 Lifetime	$1,500 Lifetime
Dental Accident Benefits	100 % (separate $1,000 maximum per person per calendar year)	100 % (separate $1,000 maximum per person per calendar year)

* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.

** Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and program allowance for non-Delta Dental dentists.

Delta Dental of California
100 First St.
San Francisco, CA 94105

Customer Service
800-765-6003

Claims Address
P.O. Box 997330
Sacramento, CA 95899-7330

deltadentalins.com

This benefit information is not intended or designed to replace or serve as the plan's Evidence of Coverage or Summary Plan Description. If you have specific questions regarding the benefits, limitations or exclusions for your plan, please consult your company's benefits representative.

SCHEDULE A

Description of Benefits and Copayments

The Benefits shown below are performed as deemed appropriate by the attending Contract Dentist subject to the limitations and exclusions of the Program. Please refer to *Schedule B* for further clarification of Benefits. **Enrollees should discuss all treatment options with their Contract Dentist prior to services being rendered.**

Text that appears in italics below is specifically intended to clarify the delivery of Benefits under the DeltaCare USA Program and is not to be interpreted as CDT-2016 procedure codes, descriptors or nomenclature that are under copyright by the American Dental Association. The American Dental Association may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.

CODE	DESCRIPTION	ENROLLEE PAYS
D0100-D0999	**I. DIAGNOSTIC**	
D0120	Periodic oral evaluation - established patient	No Cost
D0140	Limited oral evaluation - problem focused	No Cost
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No Cost
D0150	Comprehensive oral evaluation - new or established patient	No Cost
D0160	Detailed and extensive oral evaluation - problem focused, by report	No Cost
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	No Cost
D0171	Re-evaluation - post-operative office visit	No Cost
D0180	Comprehensive periodontal evaluation - new or established patient	No Cost
D0190	Screening of a patient	No Cost
D0191	Assessment of a patient	No Cost
D0210	Intraoral - complete series of radiographic images - *limited to 1 series every 24 months*	No Cost
D0220	Intraoral - periapical first radiographic image	No Cost
D0230	Intraoral - periapical each additional radiographic image	No Cost
D0240	Intraoral - occlusal radiographic image	No Cost
D0250	Extraoral - 2D projection radiographic image created using a stationary radiation source, and detector	No Cost
D0251	Extraoral posterior dental radiographic image	No Cost
D0270	Bitewing - single radiographic image	No Cost
D0272	Bitewings - two radiographic images	No Cost
D0273	Bitewings three radiographic images	No Cost
D0274	Bitewings - four radiographic images - *limited to 1 series every 6 months*	No Cost
D0277	Vertical bitewings - 7 to 8 radiographic images	No Cost
D0330	Panoramic radiographic image	No Cost
D0415	Collection of microorganisms for culture and sensitivity	No Cost
D0425	Caries susceptibility tests	No Cost
D0460	Pulp vitality tests	No Cost
D0470	Diagnostic casts	No Cost
D0472	Accession of tissue, gross examination, preparation and transmission of written report - *available only when performed in conjunction with a covered biopsy*	No Cost
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report - *available only when performed in conjunction with a covered biopsy*	No Cost
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report - *available only when performed in conjunction with a covered biopsy*	No Cost
D0601	Caries risk assessment and documentation, with a finding of low risk - *limited to children age 3 to 19, 1 every 3 years*	No Cost
D0602	Caries risk assessment and documentation, with a finding of moderate risk - *limited to children age 3 to 19, 1 every 3 years*	No Cost
D0603	Caries risk assessment and documentation, with a finding of high risk - *limited to children age 3 to 19, 1 every 3 years*	No Cost
D0999	Unspecified diagnostic procedure, by report - *includes office visit, per visit (in addition to other services)*	No Cost
D1000-D1999	**II. PREVENTIVE**	
D1110	Prophylaxis *cleaning* - adult - *1 per 6 month period*	No Cost
D1110	*Additional prophylaxis cleaning - adult (within the 6 month period)*	$45.00

D1120	*Prophylaxis cleaning - child - 1 per 6 month period*	No Cost
D1120	*Additional prophylaxis cleaning - child (within the 6 month period)*	$35.00
D1206	Topical application of fluoride varnish - *1 D1206 or D1208 per 6 month period*	No Cost
D1208	Topical application of fluoride - excluding varnish - *1 D1206 or D1208 per 6 month period*	No Cost
D1310	Nutritional counseling for control of dental disease	No Cost
D1320	Tobacco counseling for the control and prevention of oral disease	No Cost
D1330	Oral hygiene instructions	No Cost
D1351	Sealant - per tooth - *limited to permanent molars through age 15*	No Cost
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth - *limited to permanent molars through age 15*	No Cost
D1353	Sealant repair - per tooth - *limited to permanent molars through age 15*	No Cost
D1354	Interim caries arresting medicament application - *1 per 6 month period*	No Cost
D1510	Space maintainer - fixed - unilateral	No Cost
D1515	Space maintainer - fixed - bilateral	No Cost
D1520	Space maintainer - removable - unilateral	No Cost
D1525	Space maintainer - removable - bilateral	No Cost
D1550	Re-cement or re-bond space maintainer	No Cost
D1555	Removal of fixed space maintainer	No Cost

D2000-D2999 III. RESTORATIVE

- Includes polishing, all adhesives and bonding agents, indirect pulp capping, bases, liners and acid etch procedures.
- When there are more than six crowns in the same treatment plan, an Enrollee may be charged an additional $125.00 per crown, beyond the 6th unit.
- Replacement of crowns, inlays and onlays requires the existing restoration to be 5+ years old.
** Name brand, laboratory processed or in-office processed crowns/pontics produced through specialized technique or materials are material upgrades. The Contract Dentist may charge an additional fee not to exceed $125.00 in addition to the listed Copayment. Refer to Limitation of Benefits #4 for additional information.*

D2140	Amalgam - one surface, primary or permanent	No Cost
D2150	Amalgam - two surfaces, primary or permanent	No Cost
D2160	Amalgam - three surfaces, primary or permanent	No Cost
D2161	Amalgam - four or more surfaces, primary or permanent	No Cost
D2330	Resin-based composite - one surface, anterior	No Cost
D2331	Resin-based composite - two surfaces, anterior	No Cost
D2332	Resin-based composite - three surfaces, anterior	No Cost
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	No Cost
D2390	Resin-based composite crown, anterior	No Cost
D2391	Resin-based composite - one surface, posterior	$25.00
D2392	Resin-based composite - two surfaces, posterior	$30.00
D2393	Resin-based composite - three surfaces, posterior	$35.00
D2394	Resin-based composite - four or more surfaces, posterior	$40.00
D2510	Inlay - metallic - one surface	No Cost
D2520	Inlay - metallic - two surfaces	No Cost
D2530	Inlay - metallic - three or more surfaces	No Cost
D2542	Onlay - metallic - two surfaces	No Cost
D2543	Onlay - metallic - three surfaces	No Cost
D2544	Onlay - metallic - four or more surfaces	No Cost
D2610	Inlay - porcelain/ceramic - one surface*	$50.00
D2620	Inlay - porcelain/ceramic - two surfaces*	$60.00
D2630	Inlay - porcelain/ceramic - three or more surfaces*	$65.00
D2642	Onlay - porcelain/ceramic - two surfaces*	$55.00
D2643	Onlay - porcelain/ceramic - three surfaces*	$65.00
D2644	Onlay - porcelain/ceramic - four or more surfaces*	$70.00
D2650	Inlay - resin-based composite - one surface	$15.00
D2651	Inlay - resin-based composite - two surfaces	$20.00
D2652	Inlay - resin-based composite - three or more surfaces	$30.00
D2662	Onlay - resin-based composite - two surfaces	$25.00
D2663	Onlay - resin-based composite - three surfaces	$35.00
D2664	Onlay - resin-based composite - four or more surfaces	$60.00
D2710	Crown - resin-based composite (indirect)	No Cost

D2712	Crown - ¾ resin-based composite (indirect)	No Cost
D2720	Crown - resin with high noble metal	$90.00
D2721	Crown - resin with predominantly base metal	$15.00
D2722	Crown - resin with noble metal	$20.00
D2740	Crown - porcelain/ceramic substrate*	$85.00
D2750	Crown - porcelain fused to high noble metal*	$70.00
D2751	Crown - porcelain fused to predominantly base metal	$55.00
D2752	Crown - porcelain fused to noble metal	$60.00
D2780	Crown - ¾ cast high noble metal	$70.00
D2781	Crown - ¾ cast predominantly base metal	$55.00
D2782	Crown - ¾ cast noble metal	$60.00
D2783	Crown - ¾ porcelain/ceramic*	$70.00
D2790	Crown - full cast high noble metal	$70.00
D2791	Crown - full cast predominantly base metal	$55.00
D2792	Crown - full cast noble metal	$60.00
D2794	Crown - titanium	$70.00
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	No Cost
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	No Cost
D2920	Re-cement or re-bond crown	No Cost
D2921	Reattachment of tooth fragment, incisal edge or cusp *(anterior)*	No Cost
D2929	Prefabricated porcelain/ceramic crown - primary tooth - *anterior*	No Cost
D2930	Prefabricated stainless steel crown - primary tooth	No Cost
D2931	Prefabricated stainless steel crown - permanent tooth	No Cost
D2932	Prefabricated resin crown - *anterior primary tooth*	No Cost
D2933	Prefabricated stainless steel crown with resin window - *anterior primary tooth*	No Cost
D2940	Protective restoration	No Cost
D2941	Interim therapeutic restoration - primary dentition	No Cost
D2949	Restorative foundation for an indirect restoration	No Cost
D2950	Core buildup, including any pins when required	No Cost
D2951	Pin retention - per tooth, in addition to restoration	No Cost
D2952	Post and core in addition to crown, indirectly fabricated - *includes canal preparation*	No Cost
D2953	Each additional indirectly fabricated post - same tooth - *includes canal preparation*	No Cost
D2954	Prefabricated post and core in addition to crown - *base metal post; includes canal preparation*	No Cost
D2955	Post removal	No Cost
D2957	Each additional prefabricated post - same tooth - *base metal post; includes canal preparation*	No Cost
D2960	Labial veneer (resin laminate) - chairside - *limited to replacement of significant tooth structure loss due to caries or fracture*	$245.00
D2961	Labial veneer (resin laminate) - laboratory - *limited to replacement of significant tooth structure loss due to caries or fracture*	$295.00
D2962	Labial veneer (porcelain laminate) - laboratory - *limited to replacement of significant tooth structure loss due to caries or fracture*	$345.00
D2971	Additional procedures to construct new crown under existing partial denture framework	$14.00
D2980	Crown repair necessitated by restorative material failure	No Cost
D2981	Inlay repair necessitated by restorative material failure	No Cost
D2982	Onlay repair necessitated by restorative material failure	No Cost
D2983	Veneer repair necessitated by restorative material failure	No Cost
D2990	Resin infiltration of incipient smooth surface lesions - *limited to permanent molars through age 19*	No Cost

D3000-D3999 IV. ENDODONTICS

D3110	Pulp cap - direct (excluding final restoration)	No Cost
D3120	Pulp cap - indirect (excluding final restoration)	No Cost
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	No Cost
D3221	Pulpal debridement, primary and permanent teeth	No Cost
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	No Cost
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	No Cost
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	No Cost

D3310	*Root canal* - endodontic therapy, anterior tooth (excluding final restoration)	$20.00
D3320	*Root canal* - endodontic therapy, bicuspid tooth (excluding final restoration)	$40.00
D3330	*Root canal* - endodontic therapy, molar (excluding final restoration)	$60.00
D3331	Treatment of root canal obstruction; non-surgical access	$40.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$40.00
D3333	Internal root repair of perforation defects	$40.00
D3346	Retreatment of previous root canal therapy - anterior	$35.00
D3347	Retreatment of previous root canal therapy - bicuspid	$50.00
D3348	Retreatment of previous root canal therapy - molar	$95.00
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$55.00
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)	$45.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	$45.00
D3410	Apicoectomy - anterior	No Cost
D3421	Apicoectomy - bicuspid (first root)	No Cost
D3425	Apicoectomy - molar (first root)	No Cost
D3426	Apicoectomy (each additional root)	No Cost
D3427	Periradicular surgery without apicoectomy	No Cost
D3430	Retrograde filling - per root	No Cost
D3450	Root amputation - per root	No Cost
D3920	Hemisection (including any root removal), not including root canal therapy	No Cost

D4000-D4999 V. PERIODONTICS

- Includes preoperative and postoperative evaluations and treatment under a local anesthetic.

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	No Cost
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	No Cost
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	No Cost
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	No Cost
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	No Cost
D4245	Apically positioned flap	$45.00
D4249	Clinical crown lengthening - hard tissue	$45.00
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	$75.00
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	$50.00
D4263	Bone replacement graft - first site in quadrant	$125.00
D4264	Bone replacement graft - each additional site in quadrant	$45.00
D4266	Guided tissue regeneration - resorbable barrier, per site	$100.00
D4267	Guided tissue regeneration - nonresorbable barrier, per site (includes membrane removal)	$140.00
D4270	Pedicle soft tissue graft procedure	$125.00
D4273	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft	$75.00
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)	No Cost
D4275	Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft	$115.00
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft	$125.00
D4278	Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant, or edentulous tooth position in same graft site	$125.00
D4283	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) - each additional contiguous tooth, implant or edentulous tooth position in same graft site	$45.00
D4285	Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) - each additional contiguous tooth, implant or edentulous tooth position in same graft site	$69.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	No Cost

D4342	Periodontal scaling and root planing - one to three teeth per quadrant - *limited to 4 quadrants during any 12 consecutive months*	No Cost
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis - *limited to 1 treatment in any 12 consecutive months*	No Cost
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth - *for each of the first two teeth treated within a quadrant following root planing or periodontal maintenance*	$60.00
D4381	*Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth - for an additional tooth treated in the same quadrant following root planing or periodontal maintenance*	No Cost
D4910	Periodontal maintenance - *limited to 1 treatment each 6 month period*	No Cost
D4910	*Additional periodontal maintenance (within the 6 month period)*	$55.00
D4921	Gingival irrigation - per quadrant	No Cost

D5000-D5899 VI. PROSTHODONTICS (removable)

- For all listed dentures and partial dentures, Copayment includes after delivery adjustments and tissue conditioning, if needed, for the first six months after placement. The Enrollee must continue to be eligible, and the service must be provided at the Contract Dentist's facility where the denture was originally delivered.
- Rebases, relines and tissue conditioning are limited to 1 per denture during any 12 consecutive months.
- Replacement of a denture or a partial denture requires the existing denture to be 5+ years old.

D5110	Complete denture - maxillary	$75.00
D5120	Complete denture - mandibular	$75.00
D5130	Immediate denture - maxillary	$85.00
D5140	Immediate denture - mandibular	$85.00
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	$80.00
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	$80.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$95.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$95.00
D5221	Immediate maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	$80.00
D5222	Immediate mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	$80.00
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$95.00
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$95.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	$195.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	$195.00
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth)	$80.00
D5410	Adjust complete denture - maxillary	No Cost
D5411	Adjust complete denture - mandibular	No Cost
D5421	Adjust partial denture - maxillary	No Cost
D5422	Adjust partial denture - mandibular	No Cost
D5510	Repair broken complete denture base	No Cost
D5520	Replace missing or broken teeth - complete denture (each tooth)	No Cost
D5610	Repair resin denture base	No Cost
D5620	Repair cast framework	No Cost
D5630	Repair or replace broken clasp - per tooth	No Cost
D5640	Replace broken teeth - per tooth	No Cost
D5650	Add tooth to existing partial denture	No Cost
D5660	Add clasp to existing partial denture - per tooth	No Cost
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	$65.00
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	$65.00
D5710	Rebase complete maxillary denture	$30.00
D5711	Rebase complete mandibular denture	$30.00
D5720	Rebase maxillary partial denture	$30.00
D5721	Rebase mandibular partial denture	$30.00
D5730	Reline complete maxillary denture (chairside)	No Cost
D5731	Reline complete mandibular denture (chairside)	No Cost
D5740	Reline maxillary partial denture (chairside)	No Cost
D5741	Reline mandibular partial denture (chairside)	No Cost

D5750	Reline complete maxillary denture (laboratory)	$25.00
D5751	Reline complete mandibular denture (laboratory)	$25.00
D5760	Reline maxillary partial denture (laboratory)	$25.00
D5761	Reline mandibular partial denture (laboratory)	$25.00
D5820	Interim partial denture (maxillary) - *limited to 1 in any 12 consecutive months*	No Cost
D5821	Interim partial denture (mandibular) - *limited to 1 in any 12 consecutive months*	No Cost
D5850	Tissue conditioning, maxillary	No Cost
D5851	Tissue conditioning, mandibular	No Cost

D5900-D5999 VII. MAXILLOFACIAL PROSTHETICS - Not Covered

D6000-D6199 VIII. IMPLANT SERVICES - Not Covered

D6200-D6999 IX. PROSTHODONTICS, fixed (each retainer and each pontic constitutes a unit in a fixed partial denture [bridge])

- When a crown and/or pontic exceeds six units in the same treatment plan, an Enrollee may be charged an additional $125.00 per unit, beyond the 6th unit.
- Replacement of a crown, pontic, inlay, onlay or stress breaker requires the existing bridge to be 5+ years old.
** Name brand, laboratory processed or in-office processed crowns/pontics produced through specialized technique or materials are material upgrades. The Contract Dentist may charge an additional fee not to exceed $325.00 in addition to the listed Copayment. Refer to Limitation of Benefits #4 for additional information.*

D6205	Pontic - indirect resin based composite	$30.00
D6210	Pontic - cast high noble metal	$70.00
D6211	Pontic - cast predominantly base metal	$55.00
D6212	Pontic - cast noble metal	$60.00
D6214	Pontic - titanium	$70.00
D6240	Pontic - porcelain fused to high noble metal*	$70.00
D6241	Pontic - porcelain fused to predominantly base metal	$55.00
D6242	Pontic - porcelain fused to noble metal	$60.00
D6245	Pontic - porcelain/ceramic*	$70.00
D6250	Pontic - resin with high noble metal	$30.00
D6251	Pontic - resin with predominantly base metal	$15.00
D6252	Pontic - resin with noble metal	$20.00
D6600	Retainer inlay - porcelain/ceramic, two surfaces	$60.00
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces	$65.00
D6602	Retainer inlay - cast high noble metal, two surfaces	$70.00
D6603	Retainer inlay - cast high noble metal, three or more surfaces	$70.00
D6604	Retainer inlay - cast predominantly base metal, two surfaces	No Cost
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces	No Cost
D6606	Retainer inlay - cast noble metal, two surfaces	$60.00
D6607	Retainer inlay - cast noble metal, three or more surfaces	$60.00
D6608	Retainer onlay - porcelain/ceramic, two surfaces	$65.00
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces	$65.00
D6610	Retainer onlay - cast high noble metal, two surfaces	$70.00
D6611	Retainer onlay - cast high noble metal, three or more surfaces	$70.00
D6612	Retainer onlay - cast predominantly base metal, two surfaces	No Cost
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	No Cost
D6614	Retainer onlay - cast noble metal, two surfaces	$60.00
D6615	Retainer onlay - cast noble metal, three or more surfaces	$60.00
D6710	Retainer crown - indirect resin based composite	$30.00
D6720	Retainer crown - resin with high noble metal	$30.00
D6721	Retainer crown - resin with predominantly base metal	$15.00
D6722	Retainer crown - resin with noble metal	$20.00
D6740	Retainer crown - porcelain/ceramic*	$70.00
D6750	Retainer crown - porcelain fused to high noble metal*	$70.00
D6751	Retainer crown - porcelain fused to predominantly base metal	$55.00
D6752	Retainer crown - porcelain fused to noble metal	$60.00
D6780	Retainer crown - ¾ cast high noble metal	$70.00
D6781	Retainer crown - ¾ cast predominantly base metal	$55.00

D6782	Retainer crown - ¾ cast noble metal	$60.00
D6783	Retainer crown - ¾ porcelain/ceramic*	$70.00
D6790	Retainer crown - full cast high noble metal	$70.00
D6791	Retainer crown - full cast predominantly base metal	$50.00
D6792	Retainer crown - full cast noble metal	$60.00
D6794	Retainer crown - titanium	$70.00
D6930	Re-cement or re-bond fixed partial denture	No Cost
D6940	Stress breaker	No Cost
D6980	Fixed partial denture repair necessitated by restorative material failure	No Cost

D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY

- Includes preoperative and postoperative evaluations and treatment under a local anesthetic.

D7111	Extraction, coronal remnants - deciduous tooth	No Cost
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	No Cost
D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$10.00
D7220	Removal of impacted tooth - soft tissue	$15.00
D7230	Removal of impacted tooth - partially bony	$25.00
D7240	Removal of impacted tooth - completely bony	$35.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$50.00
D7250	Surgical removal of residual tooth roots (cutting procedure)	No Cost
D7251	Coronectomy - intentional partial tooth removal	$50.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$35.00
D7280	Surgical access of an unerupted tooth	$25.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	$25.00
D7283	Placement of device to facilitate eruption of impacted tooth	No Cost
D7286	Incisional biopsy of oral tissue - soft - *does not include pathology laboratory procedures*	No Cost
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	No Cost
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	No Cost
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	No Cost
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	No Cost
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	No Cost
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	No Cost
D7471	Removal of lateral exostosis (maxilla or mandible)	No Cost
D7472	Removal of torus palatinus	No Cost
D7473	Removal of torus mandibularis	No Cost
D7510	Incision and drainage of abscess - intraoral soft tissue	No Cost
D7960	Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure	No Cost
D7970	Excision of hyperplastic tissue - per arch	No Cost
D7971	Excision of pericoronal gingiva	No Cost

D8000-D8999 XI. ORTHODONTICS

- The listed Copayment for each phase of orthodontic treatment (limited, interceptive or comprehensive) covers up to 24 months of active treatment. Beyond 24 months, an additional monthly fee, not to exceed $125.00, may apply.
- The Retention Copayment includes adjustments and/or office visits up to 24 months.

Pre and post orthodontic records include:

	The benefit for pre-treatment records and diagnostic services includes:	$200.00
D0210	Intraoral - complete series of radiographic images	
D0322	Tomographic survey	
D0330	Panoramic radiographic image	
D0340	2D cephalometric radiographic image - acquisition, measurement and analysis	
D0350	2D oral/facial photographic images obtained intraorally or extraorally	
D0351	3D photographic image	
D0470	Diagnostic casts	
	The benefit for post-treatment records includes:	$70.00
D0210	Intraoral - complete series of radiographic images	
D0470	Diagnostic casts	

D8010	Limited orthodontic treatment of the primary dentition	$725.00
D8020	Limited orthodontic treatment of the transitional dentition - *child or adolescent to age 19*	$725.00
D8030	Limited orthodontic treatment of the adolescent dentition - *adolescent to age 19*	$725.00
D8040	Limited orthodontic treatment of the adult dentition - *adults, including covered dependent adult children*	$925.00
D8050	Interceptive orthodontic treatment of the primary dentition	$725.00
D8060	Interceptive orthodontic treatment of the transitional dentition	$725.00
D8070	Comprehensive orthodontic treatment of the transitional dentition - *child or adolescent to age 19*	$1,700.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition - *adolescent to age 19*	$1,700.00
D8090	Comprehensive orthodontic treatment of the adult dentition - *adults, including covered dependent adult children*	$1,900.00
D8660	Pre-orthodontic treatment examination to monitor growth and development	$25.00
D8670	Periodic orthodontic treatment visit - *included in comprehensive case fee*	No Cost
D8680	Orthodontic retention (removal of appliances, construction and placement of *removable* retainers)	$275.00
D8681	Removable orthodontic retainer adjustment	No Cost
D8693	Re-bond or re-cement fixed retainer - *limited to 2 per 6 month period*	No Cost
D8694	Repair of fixed retainers, includes reattachment - *limited to 2 per 6 month period*	No Cost
D8999	Unspecified orthodontic procedure, by report - *includes treatment planning session*	$100.00

D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES

D9110	Palliative (emergency) treatment of dental pain - minor procedure	No Cost
D9211	Regional block anesthesia	No Cost
D9212	Trigeminal division block anesthesia	No Cost
D9215	Local anesthesia in conjunction with operative or surgical procedures	No Cost
D9219	Evaluation for deep sedation or general anesthesia	No Cost
D9223	Deep sedation/general anesthesia - each 15 minute increment	$80.00
D9243	Intravenous moderate (conscious) sedation/analgesia - each 15 minute increment	$80.00
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	No Cost
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	No Cost
D9440	Office visit - after regularly scheduled hours	$20.00
D9450	Case presentation, detailed and extensive treatment planning	No Cost
D9932	Cleaning and inspection of removable complete denture, maxillary	No Cost
D9933	Cleaning and inspection of removable complete denture, mandibular	No Cost
D9934	Cleaning and inspection of removable partial denture, maxillary	No Cost
D9935	Cleaning and inspection of removable partial denture, mandibular	No Cost
D9940	Occlusal guard, by report - *limited to 1 in 3 years*	$75.00
D9943	Occlusal guard adjustment	$10.00
D9951	Occlusal adjustment, limited	No Cost
D9952	Occlusal adjustment, complete	No Cost
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays - *limited to one bleaching tray and gel for two weeks of self-treatment*	$125.00
D9986	Missed appointment - *without 24 hour notice - per 15 minutes of appointment time - up to an overall maximum of $40.00*	$10.00
D9987	Canceled appointment - *without 24 hour notice - per 15 minutes of appointment time - up to an overall maximum of $40.00*	$10.00

If services for a listed procedure are performed by the assigned Contract Dentist, the Enrollee pays the specified Copayment. Listed procedures which require a Dentist to provide Specialist Services, and are referred by the assigned Contract Dentist, must be authorized by Delta Dental. The Enrollee pays the Copayment specified for such services.

Procedures not listed above are not covered, however, may be available at the Contract Dentist's "filed fees." "Filed fees" mean the Contract Dentist's fees on file with Delta Dental. Questions regarding these fees should be directed to the Customer Service department at 800-422-4234.

SCHEDULE B

Limitations of Benefits

1. The frequency of certain Benefits is limited. All frequency limitations are listed in *Schedule A, Description of Benefits and Copayments.*
2. If the Enrollee accepts a treatment plan from the Contract Dentist that includes any combination of more than six crowns, bridge pontics and/or bridge retainers, the Enrollee may be charged an additional $100.00 above the listed Copayment for each of these services after the sixth unit has been provided.
3. General anesthesia and/or intravenous sedation/analgesia is limited to treatment by a contracted oral surgeon and in conjunction with an approved referral for the removal of one or more partial or full bony impactions. (Procedures D7230, D7240, and D7241).
4. Benefits provided by a pediatric Dentist are limited to children through age seven following an attempt by the assigned Contract Dentist to treat the child and upon prior authorization by Delta Dental, less applicable Copayments. Exceptions for medical conditions, regardless of age limitation, will be considered on an individual basis.
5. The cost to an Enrollee receiving orthodontic treatment whose coverage is canceled or terminated for any reason will be based on the Contract Orthodontist's usual fee for the treatment plan. The Contract Orthodontist will prorate the amount for the number of months remaining to complete treatment. The Enrollee makes payment directly to the Contract Orthodontist as arranged.
6. Orthodontic treatment in progress is limited to new DeltaCare USA Enrollees who, at the time of their original effective date, are in active treatment started under their previous employer sponsored dental plan, as long as they continue to be eligible under the DeltaCare USA Program. Active treatment means tooth movement has begun. Enrollees are responsible for all Copayments and fees subject to the provisions of their prior dental plan. Delta Dental is financially responsible only for amounts unpaid by the prior dental plan for qualifying orthodontic cases.

Exclusions of Benefits

1. Any procedure that is not specifically listed under *Schedule A, Description of Benefits and Copayments.*
2. Any procedure that in the professional opinion of the Contract Dentist:
   a. has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, or
   b. is inconsistent with generally accepted standards for dentistry.
3. Services solely for cosmetic purposes, with the exception of procedure D9975 (External bleaching for home application, per arch), or for conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel, except for the treatment of newborn children with congenital defects or birth abnormalities.
4. Porcelain crowns, porcelain fused to metal, cast metal or resin with metal type crowns and fixed partial dentures (bridges) for children under 16 years of age.
5. Lost or stolen appliances including, but not limited to, full or partial dentures, space maintainers, crowns and fixed partial dentures (bridges).
6. Procedures, appliances or restoration if the purpose is to change vertical dimension, or to diagnose or treat abnormal conditions of the temporomandibular joint (TMJ).
7. Precious metal for removable appliances, metallic or permanent soft bases for complete dentures, porcelain denture teeth, precision abutments for removable partials or fixed partial dentures (overlays, implants, and appliances associated therewith) and personalization and characterization of complete and partial dentures.
8. Implant-supported dental appliances and attachments, implant placement, maintenance, removal and all other services associated with a dental implant.
9. Consultations for non-covered benefits.
10. Dental services received from any dental facility other than the assigned Contract Dentist, a preauthorized dental specialist, or a Contract Orthodontist except for *Emergency Services* as described in the Contract and/or Evidence of Coverage.
11. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.
12. Prescription drugs.

13. Dental expenses incurred in connection with any dental or orthodontic procedure started before the Enrollee's eligibility with the DeltaCare USA Program. Examples include: teeth prepared for crowns, root canals in progress, full or partial dentures for which an impression has been taken and orthodontics unless qualified for the orthodontic treatment in progress provision.

14. Lost, stolen or broken orthodontic appliances.

15. Changes in orthodontic treatment necessitated by accident of any kind.

16. Myofunctional and parafunctional appliances and/or therapies, with the exception of procedure D9940 (occlusal guard, per report).

17. Composite or ceramic brackets, lingual adaptation of orthodontic bands and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances.

18. Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services.

Your Vision Benefits Summary

Get the best in eye care and eyewear with COUNTY OF TULARE and VSP® Vision Care.

Using your VSP benefit is easy.

- **Create an account at vsp.com.** Once your plan is effective, review your benefit information.
- **Find an eye care provider who's right for you.** The decision is yours to make—choose a VSP doctor, a participating retail chain, or any out-of-network provider. To find a VSP provider, visit vsp.com or call 800.877.7195.
- **At your appointment, tell them you have VSP.** There's no ID card necessary. If you'd like a card as a reference, you can print one on vsp.com.

That's it! We'll handle the rest—there are no claim forms to complete when you see a VSP provider.

Primary Eye Care

As a VSP member, you can visit your VSP doctor for medical and urgent eye care. Your VSP doctor can diagnose, treat, and monitor common eye conditions like pink eye, and more serious conditions like sudden vision loss, glaucoma, diabetic eye disease, and cataracts. Ask your VSP doctor for details.

Choice in Eyewear

From classic styles to the latest designer frames, you'll find hundreds of options. Choose from featured frame brands like bebe®, Calvin Klein, Cole Haan, Flexon®, Lacoste, Nike, Nine West, and more†. Visit vsp.com to find a Premier Program location that carries these brands. Prefer to shop online? Check out all of the brands at Eyeconic.com, VSP's online eyewear store.

Plan Information

VSP Coverage Effective Date: 01/01/2018
VSP Provider Network: VSP Choice

SAN JOAQUIN VALLEY INSURANCE AUTHORITY and VSP provide you with an affordable eyecare plan.

	You Pay	You Get
You Coverage with a VSP Provider		
WellVision Exam	• Focuses on your eyes and overall wellness • Every 12 months	$10
Prescription Glasses		$25
Frame	• $130 allowance for a wide selection of frames • $150 allowance for featured frame brands (see 'Extra Savings' below) • 20% savings on the amount over your allowance • $70 Costco® frame allowance • Every 24 months	Included in Prescription Glasses
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children • Every 12 months	Included in Prescription Glasses
Lens Enhancements	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 20-25% on other lens enhancements • Every 12 months	$55 $65 - $105 $150 - $175
Contacts (instead of glasses)	• $120 allowance for contacts and contact lens exam (fitting and evaluation) • 15% savings on a contact lens exam (fitting and evaluation) • Every 12 months	$0
Primary Eyecare	• Treatment and diagnosis of eye conditions like pink eye, vision loss and monitoring of cataracts, glaucoma and diabetic retinopathy. Limitations and coordination with medical coverage may apply. Ask your VSP doctor for details. • As needed	$20
Extra Savings	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. Go to vsp.com/specialoffers for details. • 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam. **Retinal Screening** • No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam **Laser Vision Correction** • Average 15% off the regular price or 5% off the promotional price, discounts only available from contracted facilities	
You Coverage with Out-of-Network Providers		

Visit vsp.com for details, if you plan to see a provider other than a VSP network provider.

Exam	up to $45	Lined Trifocal Lenses	up to $65
Frame	up to $70	Progressive Lenses	up to $50
Single Vision Lenses	up to $30	Contacts	up to $105
Lined Bifocal Lenses	up to $50		

[redacted]

Details/Information subject to change.

Exhibit B **January 1, 2018 - December 31, 2018**

San Joaquin Valley Insurance Authority
County of Tulare
January 1, 2018 - December 31, 2018

	Employee	Employee & Spouse	Employee & Child(ren)	Family
Anthem $0 PPO	$907.65	$1,814.33	$1,656.20	$2,750.68
Anthem $500 PPO	$683.47	$1,367.63	$1,252.58	$2,157.08
Anthem $1000 PPO	$600.38	$1,199.91	$1,100.99	$1,829.16
Anthem $2500 PPO	$569.01	$1,137.12	$1,043.39	$1,733.50
Kaiser HMO	$805.20	$1,586.43	$1,437.98	$2,367.67
Kaiser DHMO	$625.56	$1,227.16	$1,112.86	$1,828.77
Delta Dental PPO	$35.43	$61.42	$69.60	$103.32
Delta Dental DHMO	$26.38	$45.27	$45.58	$65.70
VSP Vision	$4.86	$8.20	$8.68	$12.93

Kaiser Senior Advantage	
Subscriber with Medicare	$303.25
Subscriber with Medicare/Sp non-Medicare	$1,084.48
Subscriber non-Mediare/Sp Medicare	$1,084.49
Subscriber with Medicare/Sp with Medicare	$582.54
Subscriber with Medicare/Child(ren) non-Medicare	$936.03
Subscriber with Medicare/Sp with Medicare/Child non-Medicare	$1,363.79
Subscriber Medicare/Sp non-Medicare/Child non-Medicare	$1,865.73
Subscriber non Medicare/Sp with Medicare/Child non-Medicare	$1,865.74
Subscriber with Medicare/Sp with Medicare/Children non-Medicare	$1,363.79
Subscriber with Medicare/Sp non-Medicare/Children non-Medicare	$1,865.73
Subscriber non Medicare/Sp with Medicare/Children non-Medicare	$1,865.74