



# Human Resources and Development COUNTY OF TULARE AGENDA ITEM

KUYLER CROCKER District One

PETE VANDER POEL District Two

AMY SHUKLIAN
District Three

J. STEVEN WORTHLEY
District Four

MIKE ENNIS
District Five

AGENDA DATE: April 10, 2018

SUBJECT:

Approval of the San Joaquin Valley Insurance Authority Participation

### Agreement

#### REQUEST(S):

That the Board of Supervisors:

- 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

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Agreement

**DATE:** April 10, 2018

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 SAN JOAQUIN VALLEY INSURANC AUTHORITY PARTICIP AGREEMENT	E , Resolution No
	)
UPON MOTION OF SUPERVIS	SOR, 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
* * * * * *	: * * * * * * * * *

### 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".

#### WITNESSETH:

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.** <u>SJVIA'S OBLIGATIONS</u>: 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.** <u>AUDITS AND INSPECTIONS:</u> 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).
  - **MOTICES:** 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, 14<sup>th</sup> 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. <u>TERMINATION</u>:

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	5.	COUNTERPARTS: This Agreement may be executed in one or more original counterparts, a	λII O
which too	ether	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:	COUNTY OF TULARE
By Pete Vander Poel SJVIA Board President	By Steven Worthley Chairman, Board of Supervisors
Date:	Date:
REVIEWED & RECOMMENDED FOR APPROVAL	L ATTEST:
By Paul Nerland SJVIA Manager	By Michael C. Spata, County Administrative Officer/Clerk of the Board of Supervisors
	APPROVED AS TO LEGAL FORM:
	By



# 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 <a href="https://www.healthreform.gov">www.healthreform.gov</a>.

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 Čare 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 For non-PPO Providers	None \$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 Non-PPO Providers The following do not apply to out-of-pocket maximums: non-covered expethe member remains responsible for non-PPO providers & other health ca	
Lifetime Maximum	Unlimited

Lifetime Maximum	Unlimited	
Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay <sup>1</sup>
Hospital Medical Services (subject to utilization review		
for inpatient services; waived for emergency admissions)  Semi-private room, meals & special diets,	10%	30%
& ancillary services	1070	(benefit limited to \$600/day)
Outpatient medical care, surgical services & supplies	10%	30%
(hospital care other than emergency room care)		(benefit limited to \$600/day)
Ambulatory Surgical Centers ➤ Outpatient surgery, services & supplies	10%	30%
2 Supularit surgery, services a supplies	1070	(benefit limited to \$350/day)
Skilled Nursing Facility (subject to utilization review)		
Semi-private room, services & supplies	10%	10%
(limited to 100 days/calendar year)		
Hospice Care (subject to utilization review) ➤ Inpatient or outpatient services	No сор	nav <sup>2</sup>
for member with up to one year life expectancy; family	110 00	, wy
bereavement services		

<sup>1</sup>The percentage copay for non-emergency services from non-Anthem Blue Cross PPO providers is based on the scheduled amount.

anthem.com/ca Anthem Blue Cross (P-NP) Effective 01/2017 Printed 11/28/2016

<sup>&</sup>lt;sup>2</sup> These providers are not represented in the Anthem Blue Cross PPO network.

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay <sup>1</sup>
Home Health Care (subject to utilization review) ➤ Services & supplies from a home health agency (limited to combined 100 prior authorized visits/calendar year,	10%	10% with authorization
one visit by a home health aide equals four hours or less; not covered while member receives hospice care)		
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 <sup>2</sup>	30%
<ul> <li>Hospital &amp; skilled nursing facility visits</li> </ul>	10%	30%
<ul> <li>Surgeon &amp; surgical assistant; anesthesiologist or anesthetist</li> </ul>	10%	30%
Drugs administered by a medical provider	10%	30%
(certain drugs are subject to utilization review)		
Diagnostic X-ray & Lab		
<ul> <li>MRI, CT scan, PET scan &amp; nuclear cardiac scan (subject to utilization review)</li> </ul>	10%	30%
➤ Other diagnostic x-ray & lab	No copay	30%
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%
<ul> <li>Speech Therapy</li> <li>Outpatient speech therapy following injury or organic disease</li> </ul>	\$20/visit	30%
Acupuncture		
<ul> <li>Services for the treatment of disease, illness or injury (limited to 20 visits/calendar year)</li> </ul>	\$25/visit <sup>8</sup>	\$25/visit <sup>g</sup>
Temporomandibular Joint Disorders		
Splint therapy & surgical treatment	10%	30%
Pregnancy & Maternity Care		
➤ Physician office visits	\$20/visit <sup>2</sup>	30%
<ul> <li>Prescription drug for elective abortion (mifepristone)</li> </ul>	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

<sup>&</sup>lt;sup>1</sup> The percentage copay for non-emergency services from non-Anthem Blue Cross PPO providers is based on the scheduled amount.

<sup>&</sup>lt;sup>2</sup> 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.

<sup>&</sup>lt;sup>3</sup> 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 <sup>1</sup>	
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	сорау	
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	сорау	
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 ,	10%	30%	
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-ri			
Related Outpatient Medical Services & Supplies			
<ul> <li>Ground or air ambulance transportation, services</li> <li>&amp; disposable supplies</li> </ul>	10	<b>%</b> <sup>2</sup>	
Blood transfusions, blood processing & the cost of unreplaced blood & blood products	10		
<ul> <li>Autologous blood (self-donated blood collection, testing, processing &amp; storage for planned surgery)</li> </ul>	10	<b>%</b> <sup>2</sup>	

<sup>&</sup>lt;sup>1</sup> The percentage copay for non-emergency services from non-Anthem Blue Cross PPO providers is based on the scheduled amount. <sup>2</sup> These providers are not represented in the Anthem Blue Cross PPO network.

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay <sup>1</sup>
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;	10%	30%
waived for emergency admissions)		(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 <sup>2</sup>	30%

<sup>&</sup>lt;sup>1</sup> The percentage copay for non-emergency services from non-Anthem Blue Cross PPO providers is based on the scheduled amount.

<sup>&</sup>lt;sup>2</sup> 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.

#### 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;
- at least 10% of its yearly budget must be spent on research not directly related to patient care:
- 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 FOC

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, liness, 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 *mcdically 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

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.

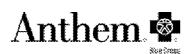
Lifestyle Programs. Programs to alter one's lifestyle which may include but are not limited to diet, exercise, imagery or nutrition. This exclusion will not apply to cardiac rehabilitation programs approved by us.

#### 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.

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# 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 <a href="https://www.healthreform.gov">www.healthreform.gov</a>.

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 Čare 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 For non-PPO Providers	None \$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 exp the member remains responsible for non-PPO providers & other health of			
lifetine Bassinesses	l Indianita d		

Lifetime Maximum	Unlimited	
Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay <sup>1</sup>
Hospital Medical Services (subject to utilization review		
for inpatient services; waived for emergency admissions)  > Semi-private room, meals & special diets,	10%	30%
& ancillary services	1070	(benefit limited to \$600/day)
<ul> <li>Outpatient medical care, surgical services &amp; supplies</li> </ul>	10%	30%
(hospital care other than emergency room care)		(benefit limited to \$600/day)
Ambulatory Surgical Centers	400/	200/
Outpatient surgery, services & supplies	10%	30% (benefit limited to \$350/day)
Skilled Nursing Facility (subject to utilization review)		
> Semi-private room, services & supplies	10%	10%
(limited to 100 days/calendar year)		
Hospice Care (subject to utilization review) ➤ Inpatient or outpatient services	No cor	oou?
for member with up to one year life expectancy; family	No сор	Jay <sup>2</sup>
bereavement services		

<sup>&</sup>lt;sup>1</sup>The percentage copay for non-emergency services from non-Anthem Blue Cross PPO providers is based on the scheduled amount.

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<sup>&</sup>lt;sup>2</sup> These providers are not represented in the Anthem Blue Cross PPO network.

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay <sup>1</sup>
Home Health Care (subject to utilization review) ➤ Services & supplies from a home health agency (limited to combined 100 prior authorized visits/calendar year,	10%	10% with authorization
one visit by a home health aide equals four hours or less; not covered while member receives hospice care)		
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 <sup>2</sup>	30%
<ul> <li>Hospital &amp; skilled nursing facility visits</li> </ul>	10%	30%
<ul> <li>Surgeon &amp; surgical assistant; anesthesiologist or anesthetist</li> </ul>	10%	30%
Drugs administered by a medical provider	10%	30%
(certain drugs are subject to utilization review)		
Diagnostic X-ray & Lab		
<ul> <li>MRI, CT scan, PET scan &amp; nuclear cardiac scan (subject to utilization review)</li> </ul>	10%	30%
Other diagnostic x-ray & lab	No copay	30%
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%
<ul> <li>Speech Therapy</li> <li>➤ Outpatient speech therapy following injury or organic disease</li> </ul>	\$20/visit	30%
Acupuncture		
<ul> <li>Services for the treatment of disease, illness or injury (limited to 20 visits/calendar year)</li> </ul>	\$25/visit <sup>3</sup>	\$25/visit <sup>6</sup>
Temporomandibular Joint Disorders		
➤ Splint therapy & surgical treatment	10%	30%
Pregnancy & Maternity Care		
➤ Physician office visits	\$20/visit <sup>2</sup>	30%
<ul> <li>Prescription drug for elective abortion (mifepristone)</li> </ul>	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

<sup>&</sup>lt;sup>1</sup> The percentage copay for non-emergency services from non-Anthem Blue Cross PPO providers is based on the scheduled amount.

<sup>&</sup>lt;sup>2</sup> 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.

<sup>&</sup>lt;sup>3</sup> 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 <sup>1</sup>	
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-ne.	10% twork)	30%	
Related Outpatient Medical Services & Supplies			
<ul> <li>Ground or air ambulance transportation, services</li> <li>&amp; disposable supplies</li> </ul>	10	<b>%</b> <sup>2</sup>	
Blood transfusions, blood processing & the cost of unreplaced blood & blood products		<b>%</b> 2	
Autologous blood (self-donated blood collection, testing, processing & storage for planned surgery)	10	% <sup>∠</sup>	

<sup>&</sup>lt;sup>1</sup> The percentage copay for non-emergency services from non-Anthem Blue Cross PPO providers is based on the scheduled amount. <sup>2</sup> These providers are not represented in the Anthem Blue Cross PPO network.

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay <sup>1</sup>
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;	10%	30%
waived for emergency admissions)	10.70	(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 <sup>2</sup>	30%

<sup>&</sup>lt;sup>1</sup> The percentage copay for non-emergency services from non-Anthem Blue Cross PPO providers is based on the scheduled amount.

<sup>&</sup>lt;sup>2</sup> 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.

#### 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;
- at least 10% of its yearly budget must be spent on research not directly related to patient care:
- 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, liness, 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 fool 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.

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# 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 <a href="https://www.healthreform.gov">www.healthreform.gov</a>.

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**

family bereavement services

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 exp		

member remains responsible for non-PPO providers & other health care providers, costs in excess of the covered expense

Lifetime Maximum

Unlimited

Lifetime Maximum	Unlimited	
Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay <sup>1</sup>
Hospital Medical Services (subject to utilization review		
for inpatient services; waived for emergency admissions)	COEOlodmingion : 200/	40%
<ul> <li>Semi-private room, meals &amp; special diets,</li> <li>&amp; ancillary services</li> </ul>	\$250/admission + 20%	(benefit limited to \$600/day)
<ul> <li>Outpatient medical care, surgical services &amp; supplies</li> </ul>	20%	40%
(hospital care other than emergency room care)		(benefit limited to \$600/day)
Ambulatory Surgical Centers		
<ul> <li>Outpatient surgery, services &amp; supplies</li> </ul>	\$125/surgery + 20%	40%
		(benefit limited to \$350/day)
Skilled Nursing Facility (subject to utilization review)		
Semi-private room, services & supplies	20%	20%
(limited to 100 days/calendar year)		
Hospice Care (subject to utilization review)		
Inpatient or outpatient services	No copay	2
for members with up to one year life expectancy;		

<sup>&</sup>lt;sup>1</sup> The percentage copay for non-emergency services from non-Anthem Blue Cross PPO providers is based on the scheduled amount. <sup>2</sup> These providers are not represented in the Anthem Blue Cross PPO network.

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Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay <sup>1</sup>
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 <sup>2</sup> (deductible waived)	40%
<ul> <li>Hospital &amp; skilled nursing facility visits</li> </ul>	20%	40%
<ul> <li>Surgeon &amp; surgical assistant; anesthesiologist or anesthetist</li> </ul>	20%	40%
<ul> <li>Drugs administered by a medical provider (certain drugs are subject to utilization review)</li> </ul>	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%
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.  Physical Therapy, Physical Medicine & Occupational	No copay (deductible waived)	40%
Therapy	(deductible waived)	
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)	<b>20%</b> <sup>3</sup>	<b>40%</b> <sup>3</sup>
Temporomandibular Joint Disorders  ➤ Splint therapy & surgical treatment	20%	40%
Pregnancy & Maternity Care  ➤ Physician office visits	\$35/visit <sup>2</sup> (deductible waived)	40%
<ul> <li>Prescription drug for elective abortion (milepristone)</li> <li>Normal delivery, cesarean section, complications of pregnancy</li> <li>abortion</li> </ul>	20%	Not covered
➤ 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)	<i>No copay</i>	Not covered
➤ Male Sterilization	20%	Not covered
> Family Planning counseling	\$35/visit (deductible waived)	Not covered

<sup>&</sup>lt;sup>1</sup>The percentage copay for non-emergency services from non-Anthem Blue Cross PPO providers is based on the scheduled amount.

<sup>&</sup>lt;sup>2</sup>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.

<sup>&</sup>lt;sup>3</sup>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 <sup>1</sup>
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/a	dmission + 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 сор	oay (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/a	dmission + 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)	<b>No со</b> р	oay (deductible waived)
Diabetes Education Programs (requires physician supervision) ➤ Teach members & their families about the disease	\$35/visit	40%
process, the daily management of diabetic therapy & self-management training	(deductible waived)	
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-		20%
Related Outpatient Medical Services & Supplies		
<ul> <li>Ground or air ambulance transportation, services</li> <li>&amp; disposable supplies</li> </ul>	<b>20%</b> <sup>2</sup>	
Blood transfusions, blood processing & the cost of unreplaced blood & blood products	<b>20%</b> <sup>2</sup>	
Autologous blood (self-donated blood collection, testing, processing & storage for planned surgery)	<b>20%</b> <sup>2</sup>	

<sup>&</sup>lt;sup>1</sup> The percentage copay for non-emergency services from non-Anthem Blue Cross PPO providers is based on the scheduled amount. <sup>2</sup> These providers are not represented in the Anthem Blue Cross PPO network.

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay <sup>1</sup>
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		
<ul> <li>Facility-based care (subject to utilization review; waived for emergency admissions)</li> </ul>	\$250/admission + 20%	40% (benefit limited to \$600/day)
> Inpatient physician visits	20%	40%
Outpatient Care		
<ul> <li>Facility-based care (subject to utilization review; waived for emergency admissions)</li> </ul>	20%	40% (benefit limited to \$600/day)
<ul> <li>Outpatient physician visits         (Behavioral Health treatment for Autism &amp; Pervasive</li> </ul>	\$35/visit³ (deductible waived)	40%
Disorder will be subject to pre-service review)		

<sup>&</sup>lt;sup>1</sup> The percentage copay for non-emergency services from non-Anthem Blue Cross PPO providers is based on the scheduled amount.

<sup>&</sup>lt;sup>3</sup> 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.

#### 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;
- at least 10% of its yearly budget must be spent on research not directly related to patient care;
- 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, liness, 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 *modically 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 hulimia 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.

#### Nigs.

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.

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# 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 Non-PPO Providers The following do not apply to out-of-pocket maximums: non-covered exp member remains responsible for non-PPO providers & other health care	

Unlimited

Lifetime Maximum	Uniimitea	
Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay <sup>1</sup>
Hospital Medical Services (subject to utilization review		
for inpatient services; waived for emergency admissions)  > Semi-private room, meals & special diets,	\$250/admission + 20%	40%
& ancillary services	000/	(benefit limited to \$600/day)
<ul> <li>Outpatient medical care, surgical services &amp; supplies (hospital care other than emergency room care)</li> </ul>	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)		

Lifatima Mavimum

Inpatient or outpatient services for members with up to one year life expectancy; family bereavement services

No copay2

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<sup>&</sup>lt;sup>1</sup> The percentage copay for non-emergency services from non-Anthem Blue Cross PPO providers is based on the scheduled amount. <sup>2</sup> These providers are not represented in the Anthem Blue Cross PPO network.

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay <sup>1</sup>
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 home health aide equals four hours or less; not covered while member receives hospice care)	20% ' a	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 <sup>2</sup> (deductible waived)	40%
Hospital & skilled nursing facility visits	20%	40%
<ul> <li>Surgeon &amp; surgical assistant; anesthesiologist or anesthetist</li> <li>Drugs administered by a medical provider (certain drugs are subject to utilization review)</li> </ul>	20% 20%	40% 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% <sup>3</sup>	<b>40%</b> <sup>3</sup>
Temporomandibular Joint Disorders ➤ Splint therapy & surgical treatment	20%	40%
Pregnancy & Maternity Care  ➤ Physician office visits	\$35/visit <sup>2</sup> (deductible waived)	40%
<ul> <li>Prescription drug for elective abortion (milepristone)</li> <li>Normal delivery, cesarean section, complications of pregnancy</li> <li>abortion</li> </ul>	20%	Not covered
<ul> <li>Inpatient physician services</li> <li>Hospital &amp; ancillary services</li> </ul>	20% \$250/admission + 20%	40% 40% (bonofit limited to \$600/day)
<ul> <li>Female Sterilization (including tubal ligation and counseling/consultation)</li> <li>Male Sterilization</li> <li>Family Planning counseling</li> </ul>	No copay 20% \$35/visit (deductible waived)	(benefit limited to \$600/day) Not covered Not covered Not covered

<sup>&</sup>lt;sup>1</sup>The percentage copay for non-emergency services from non-Anthem Blue Cross PPO providers is based on the scheduled amount.

<sup>&</sup>lt;sup>2</sup>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.

<sup>&</sup>lt;sup>3</sup>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.).

Cov	ered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay <sup>1</sup>
spe	gan & Tissue Transplants (subject to utilization review; ecified organ transplants covered only when performed a Center of Expertise [COE])	. ,	. ,
>	Inpatient services provided in connection with non-investigative organ or tissue transplants	\$250/a	admission + 20%
<b>&gt;</b>	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)	
nece	atric Surgery (subject to utilization review; medically essary surgery for weight loss, only for morbid obesity, ered only when performed at a Center of Expertise El)		
>	Inpatient services provided in connection with medically necessary surgery for weight loss, only for morbid obesity	\$250/a	admission + 20%
<u> </u>	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)	<b>No со</b> р	pay (deductible waived)
Diat	petes Education Programs (requires physician supervision) Teach members & their families about the disease	\$35/visit	40%
	process, the daily management of diabetic therapy & self-management training	(deductible waived)	
Pros	sthetic 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%
Dur	able Medical Equipment		
<i>&gt;</i>	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-ne	20% etwork)	20%
Rel	ated Outpatient Medical Services & Supplies		
<b>&gt;</b>	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)	<b>20%</b> <sup>2</sup>	

<sup>&</sup>lt;sup>1</sup> The percentage copay for non-emergency services from non-Anthem Blue Cross PPO providers is based on the scheduled amount. <sup>2</sup> These providers are not represented in the Anthem Blue Cross PPO network.

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay <sup>1</sup>
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		
<ul> <li>Facility-based care (subject to utilization review; waived for emergency admissions)</li> </ul>	\$250/admission + 20%	40% (benefit limited to \$600/day)
> Inpatient physician visits	20%	40%
Outpatient Care		
<ul> <li>Facility-based care (subject to utilization review; waived for emergency admissions)</li> </ul>	20%	40% (benefit limited to \$600/day)
<ul> <li>Outpatient physician visits</li> <li>(Behavioral Health treatment for Autism &amp; Pervasive</li> </ul>	\$35/visit <sup>3</sup> (deductible waived)	40%
Disorder will be subject to pre-service review)		

<sup>&</sup>lt;sup>1</sup> The percentage copay for non-emergency services from non-Anthem Blue Cross PPO providers is based on the scheduled amount.

<sup>&</sup>lt;sup>3</sup> 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.

#### 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;
- at least 10% of its yearly budget must be spent on research not directly related to patient care;
- 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 *modically 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 hulimia 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.

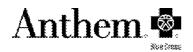
#### Wigs.

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 is the trade name of Blue Cross of California. Independent Licensee of the Blue Cross Association. 

ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association.



# 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 <a href="https://www.healthreform.gov">www.healthreform.gov</a>.

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 expens	e. After a member reaches the out-of-pocket maximum, the
member remains responsible for non-PPO providers & other health care pro	viders, costs in excess of the covered expense.

Lifetime Maximum	Unlimited	
Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay <sup>1</sup>
Hospital Medical Services (subject to utilization review		
for inpatient services; waived for emergency admissions)		
<ul><li>Semi-private room, meals &amp; special diets,</li></ul>	\$1,000/year <sup>2</sup> + 20%	50%
& ancillary services		(benefit limited to \$600/day)
Outpatient medical care, surgical services & supplies	20%	50%
(hospital care other than emergency room care)		(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	20%	20%
(limited to 100 days/calendar year)		
Hospice Care (subject to utilization review)		
Inpatient or outpatient services; for members	No copa	٧

<sup>&</sup>lt;sup>1</sup>The percentage copay for non-emergency services from non-Anthem Blue Cross PPO providers is based on the scheduled amount.

Bereavement services

with up to one year life expectancy; family

anthem.com/ca Anthem Blue Cross (P-NP) Effective 01/2017 Printed 11/28/2016

<sup>&</sup>lt;sup>2</sup> Applicable to the Annual Out-of-Pocket maximums.

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay <sup>1</sup>
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 <sup>2</sup> (deductible waived)	50%
<ul> <li>Hospital &amp; skilled nursing facility visits</li> </ul>	20%	50%
<ul><li>Surgeon &amp; surgical assistant; anesthesiologist or anesthetist</li></ul>	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 сорау	50%
Preventive Care Services  Preventive Care Services including*, physical exams, preventive screenings (including screenings for cancer, HPV, diabetes, cholesterd 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.	ol, No copay ( <i>deductible waived</i> )	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)	<b>20%</b> <sup>3</sup>	<b>50%</b> <sup>3</sup>
Temporomandibular Joint Disorders  ➤ Splint therapy & surgical treatment	20%	50%
Pregnancy & Maternity Care	2070	
Physician office visits	\$45/visit <sup>2</sup> (deductible waived)	50%
<ul> <li>Prescription drug for elective abortion (milepristone)</li> <li>Normal delivery, cesarean section, complications of pregnancy &amp; abortion</li> </ul>	20%	Not covered
Inpatient physician services	20%	50%
➤ Hospital & ancillary services	\$1,000/year <sup>4</sup> + 20%	50% (benefit limited to \$600/day)
Female Sterilization(including tubal ligation and counseling/consultation)		Not covered
Male Sterilization	20%	Not Covered
> Family planning counseling	\$45/visit (deductible waived)	Not covered

<sup>&</sup>lt;sup>1</sup>The percentage copay for non-emergency services from non-Anthem Blue Cross PPO providers is based on the scheduled amount.

<sup>&</sup>lt;sup>2</sup>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.

<sup>&</sup>lt;sup>3</sup>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.).

<sup>&</sup>lt;sup>4</sup> Applicable to the Annual Out-of-Pocket maximums

Cov	vered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay <sup>1</sup>
spe	gan & Tissue Transplants (subject to utilization review; ecified organ transplants covered only when performed a Center of Expertise [COE])		
۶	Inpatient services provided in connection with non-investigative organ or tissue transplants	\$1,000	/year <sup>3</sup> + 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 сор	oay (deductible waived)
песа	iatric Surgery (subject to utilization review; medically essary surgery for weight loss, only for morbid obesity, ered only when performed at a Center of Expertise E])		
>	Inpatient services provided in connection with medically necessary surgery for weight loss, only for morbid obesity	\$1,000	/year <sup>3</sup> + 20%
<b>&gt;</b>	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 сор	pay (deductible waived)
Dial	Detes 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%
Pro: ➤	sthetic 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%
	able Medical Equipment	5001	500
<u> </u>	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-net	50% work)	50%
	ated Outpatient Medical Services & Supplies		
>	Ground or air ambulance transportation, services & disposable supplies	<b>20%</b> <sup>2</sup>	
>	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)	<b>20%</b> <sup>2</sup>	

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

 $<sup>^2\,\</sup>mbox{These}$  providers are not represented in the Anthem Blue Cross PPO network.

<sup>&</sup>lt;sup>3</sup> Applicable to the Annual Out-of-Pocket maximums

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay <sup>1</sup>
Emergency Care		• •
Emergency room services & supplies (\$100 deductible waived if admitted)	20%	20%
Inpatient hospital services & supplies	\$1,000/year <sup>3</sup> + 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 <sup>3</sup> + 20%	50% (benefit limited to \$600/day)
> Inpatient physician visits	20%	50%
Outpatient Care		
<ul> <li>Facility-based care (subject to utilization review; waived for emergency admissions)</li> </ul>	20%	50% (benefit limited to \$600/day)
Outpatient physician visits (Behavioral Health treatment for Autism & Pervasive Disorder	\$45/visit <sup>2</sup> (deductible waived)	50%
will be subject to pre-service review)		

<sup>&</sup>lt;sup>1</sup> The percentage copay for non-emergency services from non-Anthem Blue Cross PPO providers is based on the scheduled amount.

<sup>&</sup>lt;sup>2</sup> 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.

<sup>&</sup>lt;sup>3</sup> Applicable to the Annual Out-of-Pocket maximums

#### 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;
- at least 10% of its yearly budget must be spent on research not directly related to patient care;
- 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 *modically 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).

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 hulimia 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.

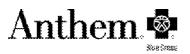
Lifestyle Programs. Programs to alter one's lifestyle which may include but are not limited to diet, exercise, imagery or nutrition. This exclusion will not apply to cardiac rehabilitation programs approved by us.

#### 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.

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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 <a href="https://www.healthreform.gov">www.healthreform.gov</a>.

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.

a actual charges, as their as any accustible a 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 exper	nse. After a member reaches the out-of-pocket maximum, the
member remains responsible for non-PPO providers & other health care p	

Lifetime Maximum	Unlimited	
Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay <sup>1</sup>
Hospital Medical Services (subject to utilization review		
for inpatient services, waived for emergency admissions)	04.0004 0 0004	500/
Semi-private room, meals & special diets,	\$1,000/year <sup>2</sup> + 20%	50%
& ancillary services	20%	(benefit limited to \$600/day) 50%
<ul> <li>Outpatient medical care, surgical services &amp; supplies (hospital care other than emergency room care)</li> </ul>	2076	(benefit limited to \$600/day)
		(benefit illimed to \$000/dby)
Ambulatory Surgical Centers  Outpatient surgery, services & supplies	\$250/ourgons + 200/	50%
Outpatient surgery, services & supplies	\$250/surgery + 20%	(benefit limited to \$350/visit)
Skillad Nursing Facility (cubiact to utilization ravious)		(Dettetti illimed to \$550/Visit)
Skilled Nursing Facility (subject to utilization review)  Semi-private room, services & supplies	20%	20%
(limited to 100 days/calendar year)	2070	2076
Hospice Care (subject to utilization review)	No sono	.,
Inpatient or outpatient services; for members	No copa	у

<sup>&</sup>lt;sup>1</sup>The percentage copay for non-emergency services from non-Anthem Blue Cross PPO providers is based on the scheduled amount.

Bereavement services

with up to one year life expectancy; family

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<sup>&</sup>lt;sup>2</sup> Applicable to the Annual Out-of-Pocket maximums.

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay <sup>1</sup>
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 <sup>2</sup> (deductible waived)	50%
<ul> <li>Hospital &amp; skilled nursing facility visits</li> </ul>	20%	50%
<ul> <li>Surgeon &amp; surgical assistant; anesthesiologist or anesthetist</li> </ul>	20%	50%
<ul> <li>Drugs administered by a medical provider (certain drugs are subject to utilization review)</li> </ul>	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 сорау	50%
Preventive Care Services  Preventive Care Services including*, physical exams, preventive screenings (including screenings for cancer, HPV, diabetes, cholesterd 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.	ol, No copay ( <i>deductible waived</i> )	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)	<b>20%</b> <sup>3</sup>	<b>50%</b> <sup>3</sup>
Temporomandibular Joint Disorders  ➤ Splint therapy & surgical treatment	20%	50%
Pregnancy & Maternity Care		
Physician office visits	\$45/visit <sup>2</sup> (deductible waived)	50%
<ul> <li>Prescription drug for elective abortion (milepristone)</li> <li>Normal delivery, cesarean section, complications of pregnancy &amp; abortion</li> </ul>	20%	Not covered
> Inpatient physician services	20%	50%
➤ Hospital & ancillary services	\$1,000/year <sup>4</sup> + 20%	50% (benefit limited to \$600/day)
> Female Sterilization(including tubal ligation and counseling/consu	ltation) No copay	Not covered
Male Sterilization	20%	Not Covered
> Family planning counseling	\$45/visit (deductible waived)	Not covered

<sup>&</sup>lt;sup>1</sup>The percentage copay for non-emergency services from non-Anthem Blue Cross PPO providers is based on the scheduled amount.

<sup>&</sup>lt;sup>2</sup>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.

<sup>&</sup>lt;sup>3</sup>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.).

<sup>&</sup>lt;sup>4</sup> Applicable to the Annual Out-of-Pocket maximums

Cov	ered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay <sup>1</sup>
spe	gan & Tissue Transplants (subject to utilization review; ecified organ transplants covered only when performed a Center of Expertise [COE])	. ,	. ,
>	Inpatient services provided in connection with non-investigative organ or tissue transplants	\$1,000	/year <sup>3</sup> + 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 сор	ay (deductible waived)
песа	iatric Surgery (subject to utilization review; medically essary surgery for weight loss, only for morbid obesity, ered only when performed at a Center of Expertise F1)		
>	Inpatient services provided in connection with medically	\$1,000	/year <sup>3</sup> + 20%
<b>A</b>	necessary surgery for weight loss, only for morbid obesity 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 сор	ay (deductible waived)
	petes Education Programs (requires physician supervision)	Φ454.:-:t	500/
<i>&gt;</i>	Teach members & their families about the disease process, the daily management of diabetic therapy & self-management training	\$45/visit (deductible waived)	50%
	Sthetic Devices	500/	500/
<b>&gt;</b>	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%
	able Medical Equipment	E00/	500/
>	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% rk)	50%
Rel	ated Outpatient Medical Services & Supplies		
>	Ground or air ambulance transportation, services & disposable supplies	<b>20%</b> <sup>2</sup>	
>	Blood transfusions, blood processing & the cost of unreplaced blood & blood products	<b>20%</b> <sup>2</sup>	
	Autologous blood (self-donated blood collection, testing, processing & storage for planned surgery)	<b>20%</b> <sup>2</sup>	

<sup>The percentage copay for non-emergency services from non-Anthem Blue Cross PPO providers is based on the scheduled amount.
These providers are not represented in the Anthem Blue Cross PPO network.
Applicable to the Annual Out-of-Pocket maximums</sup> 

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

<sup>&</sup>lt;sup>1</sup> The percentage copay for non-emergency services from non-Anthem Blue Cross PPO providers is based on the scheduled amount.

<sup>&</sup>lt;sup>2</sup> 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.

<sup>&</sup>lt;sup>3</sup> Applicable to the Annual Out-of-Pocket maximums

## 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;
- at least 10% of its yearly budget must be spent on research not directly related to patient care;
- 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 *modically 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).

**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 hulimia 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.

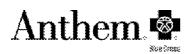
#### Wigs.

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.

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## 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 <a href="https://www.healthreform.gov">www.healthreform.gov</a>.

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
- 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)

\$2,500/individual insured person \$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

Anthem Blue Cross Life and Health Insurance Company (P-NP)

Effec

Covered Services	Traditional Health	
	Insured Perso	on Copay 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)		
<ul> <li>Semi-private room, meals &amp; special diets,</li> <li>&amp; ancillary services</li> </ul>	10%	50% up to \$580 plan payment per day
<ul> <li>Outpatient medical care, surgical services &amp; supplies (hospital care other than emergency room care)</li> </ul>	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 service	10% es	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%
<ul> <li>Surgeon &amp; surgical assistant; anesthesiologist or anesthetist</li> </ul>	10%	50%
<ul> <li>Drugs administered by a medical provider (certain drugs are subject to utilization review)</li> </ul>	10%	50%
Diagnostic X-ray & Lab		
<ul> <li>MRI, CT scan, PET scan &amp; nuclear cardiac scan (subject to utilization review)</li> </ul>	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, cholest 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.	, No copay (deductible waived)	50%
*This list is not exhaustive. This benefit includes all Preventive Care Services required by federal and state law.		
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 Cov Insured Person C In-Network		verage Copay 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%	
<ul> <li>Prescription drug for elective abortion (mifepristone)</li> </ul>	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%	

<sup>&</sup>lt;sup>1</sup> 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	
	insurea In-Network	Out-of-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	10%	10%
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)		
Related Outpatient Medical Services & Supplies		
<ul> <li>Ground or air ambulance transportation, services</li> <li>&amp; disposable supplies</li> </ul>	1	10%1
<ul> <li>Blood transfusions, blood processing &amp; the cost of unreplaced blood &amp; blood products</li> </ul>	1	10%1
Autologous blood (self-donated blood collection, testing, processing & storage for planned surgery)	1	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)
<ul> <li>Outpatient physician visits         (Behavioral Health treatment for Autism &amp; Pervasive Disorder         will be subject to pre-service review)</li> </ul>	10%	50%

<sup>&</sup>lt;sup>1</sup>These providers are not represented in the Anthem Blue Cross PPO Network.

## 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.)

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> 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 drugs¹,²	\$25
<ul> <li>Self-administered injectable drugs, except insulin</li> </ul>	\$25
Home Delivery	
Female oral contraceptives generic and single source brand	No copay
➤ Generic drugs	\$14
➤ Brand name formulary drugs¹,²	\$50
➤ Self-administered injectable dru <i>g</i> s, except insulin	\$25
Specialty pharmacy drugs (may only be obtained through the specialty pharmacy program)	
Generic drugs	\$7
➢ Brand name formulary drugs¹	\$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 <sup>3</sup>	
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

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.

### 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.

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.

<sup>3</sup> Supply limits for certain drugs may be different. Please refer to the Certificate of Insurance for complete information

## **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;
- 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, liness, 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 *modically 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:

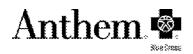
- a. There is at least one component in it that is a prescription drug; and
- It is obtained from other than a participating pharmacy. Insured person will have to pay the full cost of the compound medications if insured person obtains drug at a non-participating pharmacy.

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.

Lumenos plans provided by Anthem Blue Cross Life and Health Insurance Company. Independent licensee of the Blue Cross Association. ® ANTHEM and LUMENOS are registered trademarks of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association.



## 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 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
- 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)

\$2,500/individual insured person \$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

Anthem Blue Cross Life and Health Insurance Company (P-NP)

Effo

Covered Services	Traditional Health	
	Insured Perso	on Copay 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)		
<ul> <li>Semi-private room, meals &amp; special diets,</li> <li>&amp; ancillary services</li> </ul>	10%	50% up to \$580 plan payment per day
<ul> <li>Outpatient medical care, surgical services &amp; supplies (hospital care other than emergency room care)</li> </ul>	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)		<u> </u>
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%
<ul> <li>Surgeon &amp; surgical assistant; anesthesiologist or anesthetist</li> </ul>	10%	50%
<ul> <li>Drugs administered by a medical provider (certain drugs are subject to utilization review)</li> </ul>	10%	50%
Diagnostic X-ray & Lab		
<ul> <li>MRI, CT scan, PET scan &amp; nuclear cardiac scan (subject to utilization review)</li> </ul>	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, cholester 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.	ol, No copay (deductible waived)	50%
*This list is not exhaustive. This benefit includes all Preventive Care Services required by federal and state law.		
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	4001	5001
> Outpatient speech therapy following injury or organic disease	10%	50%

Covered Services	Traditional Health Cov Insured Person C In-Network		verage Copay Out-of-Network	
	III Notilion		(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%	
<ul> <li>Prescription drug for elective abortion (mifepristone)</li> </ul>	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%	

<sup>&</sup>lt;sup>1</sup> 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	10%	10%
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)		
Related Outpatient Medical Services & Supplies		
<ul> <li>Ground or air ambulance transportation, services</li> <li>&amp; disposable supplies</li> </ul>	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%
<ul> <li>Inpatient hospital services &amp; supplies</li> </ul>	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)
<ul> <li>Outpatient physician visits         (Behavioral Health treatment for Autism &amp; Pervasive Disorder         will be subject to pre-service review)</li> </ul>	10%	50%

<sup>&</sup>lt;sup>1</sup> These providers are not represented in the Anthem Blue Cross PPO Network.

## **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.)

the prescription drug ,maximum allowed	amount and not the sopays listed belowly
> 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 drugs¹,²	\$25
<ul> <li>Self-administered injectable drugs, except insulin</li> </ul>	\$25
Home Delivery	
Female oral contraceptives generic and single source brand	No copay
➤ Generic drugs	\$14
➤ Brand name formulary drugs¹,²	\$50
<ul> <li>Self-administered injectable drugs, except insulin</li> </ul>	\$25
Specialty pharmacy drugs (may only be obtained through the specialty pharmacy program)	
➤ Generic drugs	\$7
➤ Brand name formulary drugs¹	\$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 <sup>3</sup>	
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

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.

### 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.

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.

<sup>3</sup> Supply limits for certain drugs may be different. Please refer to the Certificate of Insurance for complete information

## **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;
- 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 *modically 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
- 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.

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## **Prescription Drug Copays**

30 Day Supply:		<u>Mail</u>	
Generic	\$10	Generic	\$20
Formulary	\$20	Formulary	\$40
Non-Formulary	\$35	Non-Formulary	\$60
DAW 1 - No Cost Diff	ferential	DAW 1 - No Cost Diff	erential

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.\*\*

## Annual Out-of-Pocket Maximum

DAW 2 - Non-Formulary + Cost Difference

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)

**Family Coverage** 

Entire Family of two or more

Members

\$3,000

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)

**Amounts Per Accumulation Period** 

Plan Out-of-Pocket Maximum

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.

Self-Only Coverage

(a Family of one Member)

\$1,500

Family Coverage

Each Member in a Family of

two or more Members

\$1,500

Plan Deductible	None	None	None
Drug Deductible	None	None	None
Professional Services (Plan Provider of	fice visits)	You Pay	
Most Primary Care Visits and most Non-P Most Physician Specialist Visits	luding well-woman exams	\$25 per visitNo chargeNo chargeNo chargeNo chargeNo chargeNo chargeNo charge	
Outpatient Services		You Pay	
Outpatient surgery and certain other outpatient surgery and certain other outpatients (including allergy serum Most immunizations (including the vaccine Most X-rays and laboratory tests	)		
Hospitalization Services	You Pay	You Pay	
		10a lay	
Room and board, surgery, anesthesia, X-	ays, laboratory tests, and drugs		
Room and board, surgery, anesthesia, X-	ays, laboratory tests, and drugs	\$250 per admission	
Room and board, surgery, anesthesia, X-Emergency Health Coverage  Emergency Department visits	ou are admitted directly to the hos		ed Services (see
Room and board, surgery, anesthesia, X-Emergency Health Coverage  Emergency Department visits  Note: This Cost Share does not apply if you "Hospitalization Services" for inpatient Combulance Services	ou are admitted directly to the hosost Share).		ed Services (see
Room and board, surgery, anesthesia, X-Emergency Health Coverage  Emergency Department visits  Note: This Cost Share does not apply if you "Hospitalization Services" for inpatient Combulance Services  Ambulance Services	ou are admitted directly to the hosost Share).	\$250 per admission You Pay  \$100 per visit  pital as an inpatient for cover  You Pay  \$50 per trip	ed Services (see
Room and board, surgery, anesthesia, X-Emergency Health Coverage  Emergency Department visits	ou are admitted directly to the hosost Share).		ed Services (see
Room and board, surgery, anesthesia, X-Emergency Health Coverage  Emergency Department visits  Note: This Cost Share does not apply if you "Hospitalization Services" for inpatient Combulance Services  Ambulance Services	ou are admitted directly to the hosest Share).  ur drug formulary guidelines: or through our mail-order service.		ay supply ay supply
Room and board, surgery, anesthesia, X-Emergency Health Coverage  Emergency Department visits	ou are admitted directly to the hosest Share).  ur drug formulary guidelines: or through our mail-order service.		ay supply ay supply
Room and board, surgery, anesthesia, X-Emergency Health Coverage  Emergency Department visits	ou are admitted directly to the hosest Share).  ur drug formulary guidelines: or through our mail-order service	\$250 per admission You Pay  \$100 per visit pital as an inpatient for cover You Pay  \$50 per trip You Pay  \$10 for up to a 100-centric service \$20 for up to a 30-date You Pay	ay supply ay supply
Room and board, surgery, anesthesia, X-Emergency Health Coverage  Emergency Department visits  Note: This Cost Share does not apply if your "Hospitalization Services" for inpatient Contained Services  Ambulance Services  Ambulance Services  Prescription Drug Coverage  Covered outpatient items in accord with our Most generic items at a Plan Pharmacy Most brand-name items at a Plan Pharmacy Most specialty items at a Plan Pharmacy Durable Medical Equipment (DME)	ou are admitted directly to the hosest Share).  ur drug formulary guidelines: or through our mail-order service	\$250 per admission You Pay  \$100 per visit pital as an inpatient for cover You Pay  \$50 per trip You Pay  \$10 for up to a 100-centric service \$20 for up to a 30-date You Pay	ay supply ay supply

Disclosure Form	(continued)
Chemical Dependency Services	You Pay
Inpatient detoxification	\$25 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	No charge No charge 50% Coinsurance

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-

Member Services 1-800-464-4000 Home Region: Northern California

## Principal benefits for Kaiser Permanente Deductible HMO Plan

(1/1/17 - 12/31/17)

Family Coverage

Entire Family of two or more

Members

\$6,000

\$2,000

(continues)

#### **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)

**Amounts Per Accumulation Period** 

Plan Out-of-Pocket Maximum

Plan Deductible

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.

Self-Only Coverage

(a Family of one Member)

\$3,000

\$1,000

Family Coverage

Each Member in a Family of

two or more Members

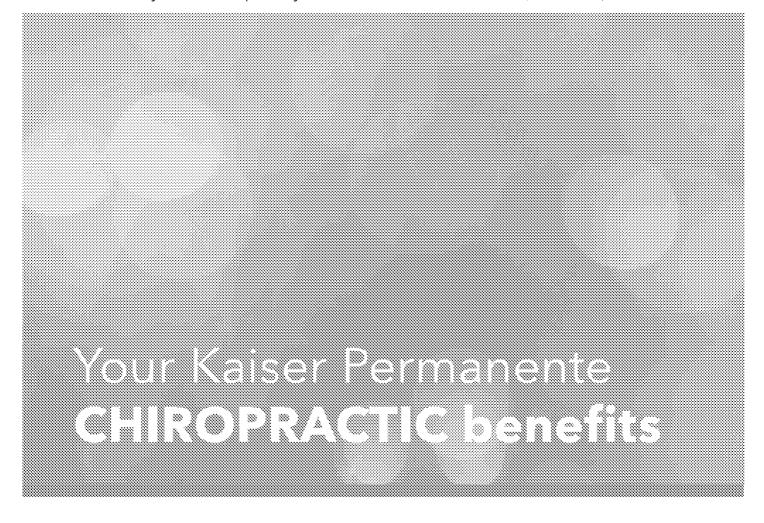
\$3,000

\$1,000

T IATT Deductible	Ψ1,000	Ψ1,000	Ψ2,000		
Drug Deductible	None	None	None		
Professional Services (Plan Provider of	You Pay	You Pay			
Most Primary Care Visits and most Non-Pl Most Physician Specialist Visits	uding well-woman exams 23 months) ons st d treatment		eductible doesn't apply) uctible doesn't apply)		
Outpatient surgery and certain other outpa	tient procedures	•	er Plan Deductible		
Allergy injections (including allergy serum) Most immunizations (including the vaccine Most X-rays and laboratory tests	)	No charge after Plan No charge (Plan Ded	Deductible uctible doesn't apply)		
Preventive X-rays, screenings, and laborat	ory tests as described in the E	OC No charge (Plan Ded	uctible doesn't apply)		
MRI, most CT, and PET scans					
Covered individual health education couns Covered health education programs					
Hospitalization Services		You Pay			
Room and board, surgery, anesthesia, X-r	ays, laboratory tests, and drugs	20% Coinsurance aft	er Plan Deductible		
Emergency Health Coverage		You Pay			
Emergency Department visits	u are admitted directly to the ho	20% Coinsurance aft			
Ambulanca Carriaca		You Pay			
Ambulance Services		\$150 per trip after Pla	an Deductible		
Prescription Drug Coverage		You Pay	You Pay		
Covered outpatient items in accord with ou					
Most generic items at a Plan Pharmacy.		\$10 for up to a 30-da doesn't apply)	y supply (Plan Deductible		
Most generic refills through our mail-order service		\$20 for up to a 100-d doesn't apply)			
Most brand-name items at a Plan Pharmacy		\$30 for up to a 30-da doesn't apply)			
Most brand-name refills through our mail-order service					
Wood State Hame to the day of the	l-order service		ay supply (Plan Deductible		

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 per visit (Plan Deductible doesn't apply)
Chemical Dependency Services	You Pay
Inpatient detoxification	. \$20 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)	No charge (Plan Deductible doesn't apply) 50% Coinsurance (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).



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.)





## 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. انصل برقم 1-9133-878-800 (رقم هاتف الصم والمكم: 1-2746-257-877).

ՈՒՇԱԴՐՈՒԹՑՈՒՆ` Եթե խոսում եք հայերեն, ապա ձեզ անվձար կարող են տրամադրվել լեզվական աջակցության ծառայություններ։ Զանգահարեք 1-800-678-9133 (TTY (հեռատիպ)`1-877-257-2746)։

**نوجه**: اگر به زبان فارسی گفتگو می کنید، شهپلات زبانی بصنورت رابگان برای شما فراهم می باشد. با -1 :TTY) -9133-678-800-1 (877-257-2746 نماس بگیرید

ध्यानदें: 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。

թանը։ անձանայոնատա տումաց, սաժանգամայատու տումանանուայա փաստուածաննայու - ար ջոնդ 1-800-678-9133 (ТТҮ: 1-877-257-2746)-ո

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

Dir baa ako ninizin: Dir saad bee yandti 'go Dine Biznad', saad bee öka 'anida 'awo 'dee', t 'aa jiik 'eh, er aa holo, koji 'hodirlaih - 1-800-678-9133 (TTY: 1-877-257-2746).

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ 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 (телетайл: 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 kang Tagalog, maaari kang gumamit ng mga serbisvo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-678-9133 (TTY: 1-877-257-2746).

เงิดน: ล้าอุลกูทลภาษาใกออุลเกรบางสร้องวิสางต่อยเหลือกางภาษาให้ทั้ง โกร 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)。

CHỦ 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 PPOsm\* 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	<ul> <li>Freedom to choose any licensed dentist</li> <li>No referral required for specialty care</li> </ul>	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	<ul> <li>Coverage is provided only for treatment started and completed after your effective date of coverage under the Delta Dental plan</li> </ul>	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)	<ul> <li>Covers new enrollees who, on the effective date of their coverage, are in active treatment started under their previous employer-sponsored dental plan</li> <li>Enrollees are responsible for all copayments and fees subject to the provisions of their prior dental plan</li> </ul>
Authorization for specialty care treatment	<ul> <li>Preauthorization is not required</li> </ul>	<ul> <li>Preauthorization is required for treatment provided by a specialist</li> <li>Your DeltaCare USA dentist will coordinate your specialty care treatment authorization</li> </ul>
Out-of-area coverage	<ul> <li>Visit any licensed dentist</li> </ul>	Limited to emergency care provision
Deductibles and maximums	<ul> <li>Deductibles and annual maximums apply to most plan designs</li> </ul>	No annual deductible or annual dollar maximums
Claims	Deita 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	<ul> <li>No claim forms required</li> <li>You only need to pay the specified copayment at the time of your visit</li> </ul>

## Delta Dental PPO<sup>™</sup> — Benefit highlights



Greatest potential savings when you visit a Delta Dental PPO dentist

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:

#### **OUT-OF-POCKET COSTS**

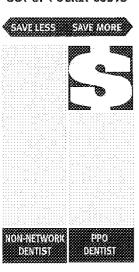


illustration showing sample enrollee share of cost for information purposes only. Actual dentist fees and contract allowances will very by region, procedure and by group contract.

AMOUNT YOU **SAVE** 

AMOUNT YOU PAY

- 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.

<sup>\*</sup> In Texas, Delta Dental Insurance Company offers a Dental Provider Organization (DPO) plan.

Plan Benefit Highlights for: COUNTY OF TULARE

Group No: 16128

listeration.	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

	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

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<sup>SM</sup> 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 flome 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 Deltal 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 anyfees 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

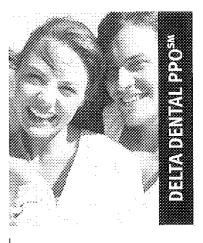
To access some services, you'll need to log in: simply enter your user name and password in the designated boxes and submit. If you are visiting our website for the first time, you'll need to complete a quick one-time registration process by clicking the "Register Today" link.

## 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 ctaims 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 toil-free during business hours.



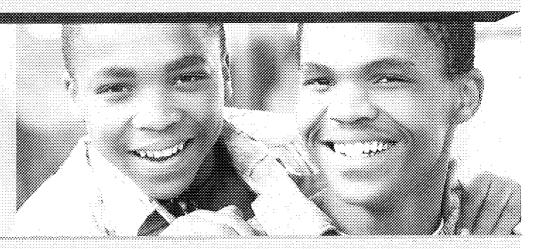


Find all of our dental health resources, including risk assessment quizzes, articles, videos and a free newsletter subscription at: mysmileway.com.

<sup>\*</sup>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

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

EMBOLLEE

### 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	NROLLEE PAYS
D0100-		2-device-de
	Periodic oral evaluation - established patient	No Cost
D0120		No Cost
D0140		
D0143		
D0160		
D0100		
D0170	Re-evaluation - post-operative office visit	
D0177	transport to the contract of t	
D0190		
D0191	Assessment of a patient	
D0210		
D0210		
D0230		
D0230		
D0250		
D0250	Extraoral posterior dental radiographic image	
D0231		
D0270		
D0273		
D0274		
D0277		
D0330		
D0415		
D0425		
D0460		
D0470		
D0472		
0,01,2	performed in conjunction with a covered biopsy	No Cost
D0473		
	available only when performed in conjunction with a covered biopsy	, No Cost
D0474		
	of disease, preparation and transmission of written report - available only whon performed in conjunction with a	
	covered bicpsy	. No Cost
D0601	Carles 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	
D0603	Caries risk assessment and documentation, with a finding of high risk - limited to children age 3 to 19, 1 every 3 years	
D0999	Unspecified diagnostic procedure, by report - includes office visit, per visit (in addition to other services)	. No Cost
D1000-	-D1999 II. PREVENTIVE	
D111.0	Prophylaxis cleaning - adult - 1 per 6 month period	
D1110		

Plai	n CA42N DeltaCare USA Description of Benefits a	ind Copayments
J12712	Crown - ¾ resin-based composite (indirect)	Na Gost
	Crown - resin with high noble:metal	
	Crown - resin with predominantly base metal	
	Crown - resin with noble metal	
	Crown - porcelain/ceramic substrate*	
	Crown - porcelain fused to high noble metal*	
	Crown - porcetain fused to predominantly base metal	
	Crown - porcelain fused to noble metal	
	Crown - 3/2 cast high noble metal	
	Crown - 3/4 cast predominantly base metal	
	Crown - ¾ cast noble metal	the contract of the contract o
	Crown - ¾ porcelain/ceramic*	
	Crown - full cast high noble metal	
	Crown - full cast predominantly base metal	
	! Crown - full cast noble metal	
	Crown - tifanium	
	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	
	Re-cement or re-bond indirectly fabricated or prefabricated post and core	
	Re-cement or re-bond crown	
D2921		No Cost
D2929		No Cost
D2930		
	Prefabricated stainless steel crown - permanent tooth	
	Prefabricated resin crown - anterior primary tooth	
	Prefabricated stainless steel crown with resin window - anterior primary tooth	
D2940		
D2941		
D2949	•	
D2950		
D2951		
D2952		
D2953		
D2954		
	5 Post removal	
	Each additional prefabricated post - same tooth - base metal post; includes canal preparation	
	Labial veneer (resin laminate) - chairside - limited to replacement of significant tooth structure loss de or fracture	ue to caries
D2961	andra and the first of the contract of the con	
	or fracture	\$295.00
D2962	Labial veneer (porcelain laminate) - laboratory - limited to replacement of significant tooth structure k	oss due to
	caries or fracture	
D2971	2 ( 1 mm m - 1 mm - 1 m	
D2980		
D2981		
D2982		
D2983		
D2990	Resin infiltration of incipient smooth surface lesions - limited to permanent molars through age 15	No Cost
D3000	0-D3999 IV. ENDODONTICS	
D3110	Pulp cap - direct (excluding final restoration)	No Cost
D3120	and the first and the control of the	
D3220		junction and
D3221	• •	
D3221		
D3230		
D3240		

Plai	n CA42N DeltaCare USA Description of Benefits and Copay	yments
D3310	Root canal - endodontic therapy, anterior tooth (excluding final restoration)	\$20.00
D3320	Root canal - endodontic therapy, bicuspid tooth (excluding final restoration)	
D3330	Root canal - endodontic therapy, molar (excluding final restoration)	
D3331	Treatment of root canal obstruction; non-surgical access	
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	
D3333	Internal root repair of perforation defects	
D3346	Retreatment of previous root canal therapy - anterior	\$35.00
D3347	Retreatment of previous root canal therapy - bicuspid	
D3348	Retreatment of previous root canal therapy - molar	
D3351 D3352		
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of	
	perforations, root resorption, etc.),	\$45.00
D3410	Apicoectomy - anterior	
D3421	Apicoectomy - bicuspid (first root)	
D3425	Apicoectomy - molar (first root)	
	Apicoectomy (each additional root)	No Cost
D3427	Periradicular surgery without apicoectomy	
D3430	Retrograde filling - per root	
D3450 D3920	Root amputation - per root	
2 2 12 12 12		140-0006
	D4999 V. PERIODONTICS	
	es preoperative and postoperative evaluations and treatment under a local anesthelic.	No Cont
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	
D4211 D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	
D4240	Gingive crown or gringivo plasty to allow access for restorative procedure, per tooth ounded spaces per quadrant	
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	
D4245	Apically positioned flap	
D4249	Clinical crown lengthening - hard tissue	
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	\$60.00
D 4000	bounded spaces per quadrant	
D4263 D4264	Bone replacement graft - each additional site in quadrant	
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	
D4273	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft	
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)	No Cost
D4275	edentulous tooth position in graft	. \$115.00
D4277	Free soft tissue graft procedure (including recipient and doner surgical sites) first tooth, implant, or edentulous tooth position in graft	, \$125.00
D4278	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

19434 Perconsial sealing and root planing- one to tince beth por quadrant-limited to if quadrants during any 12 consecutive months are substituted to a substitute or another present the months of the plant of the control of the plant of the plant of the control of the plant of the control of the plant of the control of the plant of	Plai	n CA42N DeltaCare USA Description of Benefits and Copa	yments
DA355 Full mouth debridment to enable comprehensive evaluation and diagnosis - limited to 1 treatment in any 12 consecutive imorbits - localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevioular tissue, per tooth - for each of the files (two teeth treated with a quadrant following not planing or perforted imbitinesses. \$60.00 Localized delivery of artimicrobial segants via a controlled release vehicle into diseased crevious fresses, per tooth - for en additional tooth treated in the same quadrant following not planing or periodiatal maintenance. No Cost 19419 Periodiatal periodorial maintenance - limited to 1 treatment election of month period).  SS00-DE921 Ginghell irrigation - per quadrant.  No Cost 19500-DE999 VI. PROSTHODONTICS (removable)  Propositional periodorial maintenance / within the 6 month period).  SS00-DE999 VI. PROSTHODONTICS (removable)  Propositional distribus, Cooperant industribus, Cooperant	D4342		No Cost
toth - for each of the first two teeth first dwith its quadrant following not planing or periodoctal maintenance \$60.00 (2014)  Localized cellulary of antimicrobials agents via a controlled release vehicle into diseased crevicular tissue, per coth - for an additional look frested in the same quadrant following reor planing or periodoctal maintenance. No Cost 19410 Periodottal maintenance - Introduct of treatment each 6 month period productal maintenance. No Cost 19410 Periodottal maintenance - Introduct of treatment each 6 month period productal maintenance. No Cost 19410 Periodottal maintenance - Introduction of the month period product of the periodottal maintenance - Introduction of the month period product of the periodottal maintenance - Introduction of the month period production of the periodottal maintenance - Introduction of the month period production of the Periodottal maintenance - Introduction of the month period production of the periodottal maintenance - Introduction of the month period production of the periodottal maintenance - Introduction of the months after placement. The Emolize must continue to be eligible, and the service must be provided at the Controct Demists feelilly where no doctrue was originally dishered.  **The production of the periodottal maintenance - Introduction of the periodottal maintenance - Introduction of the periodottal maintenance - Introduction of the eligible, and the service must be provided at the Controct Demists feelilly where the doctrum was originally dishered.  **The periodottal of the Controct Demists feelilly where the doctrum or an putful demuter requires the existing duritum to be 51 years old.  **Str. 100 11-10 Competed cellulary - manifolding demuter - maintenance - manifolding - maintenance - maintenance - manifolding - maintenance -	D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis - limited to 1 treatment in any 12	
Localized delivery of antimicrobial agents via a controlled relatives valide into diseased drevioular tissue, per solit for an additional cost freested in the same quadrant following rout planing ar periodontal maintenance. No Cost 19410   Periodontal maintenance - limited to 1 treatment each 6 month period)   \$5.50	D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per	
D4910 Periodortal maintenance - Imited to 1 treatment each 6 month period	D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per	
D4910 Additional periodontal maintenance (within the 6 month period).  \$65.00  D4921 Gingheit irrigation - per quadrant.  No Cost  D5000-D5399 VI. PROSTHODONTICS (removable)  - For all listed deniures and partial deniures, Copayment includes after delivery adjustments and issue conditioning, if needed, for the first kin months after placement. The Emotice must continue to be eligible, and the service must be provided at the Contract Demissis facilities in months after placement. The Emotice must continue to be eligible, and the service must be provided at the Contract Demissis facilities in months after a partial deniure or a partial deniure requires the existing deniure to the 5+ years old.  \$75.00  D5110 Complete denture - maxillary  \$86.00  D5110 Complete denture - maxillary as the existing deniure to the 5+ years old.  \$75.00  D5110 Complete denture - maxillary  \$86.00  D5111 Maxillary partial denture - resis base (including any conventional clasps, rests and teeth) \$80.00  D5111 Maxillary partial denture - resis base (including any conventional clasps, rests and teeth) \$80.00  D5121 Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) \$80.00  D5121 Immediate maxillary partial denture - resis base (including any conventional clasps, rests and teeth) \$80.00  D5121 Immediate maxillary partial denture - resis base (including any conventional clasps, rests and teeth) \$80.00  D5221 immediate maxillary partial denture - resis base (including any conventional clasps, rests and teeth) \$80.00  D5221 immediate maxillary partial denture - resis base (including any conventional clasps, rests and teeth) \$80.00  D5222 immediate maxillary partial denture - resis mase (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) \$80.00  D5224 Immediate maxillary partial denture - cast metal framework with resin	D4910		
D5000-D5899 VI. PROSTHODONTICS (removable)  For all listed darknes and partial dentures. Copayment includes after delivery adjustments and tissue conditioning, if needed, for the first six months after placement. The Empirice must continue to be eligible, and the service must be provided at the Contract Demist's feelity where the definitive was originally delivered.  Febbases, rebres and tissue conditioning are limited to 1 per denture during any 12 consecutive menths.  Feliplecement of a delution or a partial delution requires the existing duriture to be 51 years old.  S75,00  D5110 Complete denture - maxillary.  \$75,00  D5121 Complete denture - maxillary.  \$86,00  D5131 Maxillary partial denture - resir base (including any conventional clasps, rests and teeth).  \$80,00  D5131 Maxillary partial denture - resir base (including any conventional clasps, rests and teeth).  \$80,00  D5131 Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).  \$80,00  D5212 Immediate maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).  \$80,00  D5221 Immediate maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).  \$80,00  D5221 Immediate maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).  \$80,00  D5222 Immediate maxillary partial denture - cast metal framework with resin denture bases (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).  \$80,00  D5224 Immediate maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).  \$80,00  D5226 Maxillary partial denture - maxillary and partial denture - maxillary and partial dentur		Additional periodontal maintenance (within the 6 month period)	\$55.00
D5004-D5890 VI. PROSTHODONTICS (remiovable) - For all listed definitives and partial dentitives, Copyanism includes after delivery adjustments and lissue conditioning, if needed, for the first six months after placement. The Eminities must contitive to be eligible, and the service must be provided at the Contract Dentitis's facility where the dentitive was originally delivered to the dentitive was originally delivered Replacement of a dentitive or a partial dentitive requires the obtaining dentities must be provided at the Contract Dentitis's facility where the dentitive experiment of the dentitive or a partial dentitive requires the obtaining dentities must be \$4.000 Replacement of a dentitive or a partial dentities requires the obtaining dentities or partial dentities Replacement of a dentities or maxillary must be provided at the contract of the partial dentities Replacement of a dentities or maxillary must be provided at the contract of the partial dentities Replacement of a dentities or maxillary maxillar partial dentities or resis hase (including any conventional clasps, rests and teeth) Section 1921. Mandibular partial dentities or east metal framework with resin dentities bases (including any conventional clasps, rests and teeth) Section 1922. Immediate maxillary partial dentities - resin base (including any conventional clasps, rests and teeth) Section 1922. Immediate maxillary partial dentities - resin base (including any conventional clasps, rests and teeth) Section 1922. Immediate maxillary partial dentities - resin base (including any conventional clasps, rests and teeth) Section 1922. Immediate maxillary partial dentities - resin base (including any conventional clasps, rests and teeth) Section 1922. Immediate maxillary partial dentities - resin these (including any conventional clasps, rests and teeth) Section 1922. Adjust partial dentities - cast metal framework with resin dentities bases (including any conventional clasps, rests and teeth) Section 1922. Ad			
For all listed deniums and partial deniums, Copagnami includes after delivery adjustments and listue conditioning, if necoded, for the first immorths after placement. The Empilee must continue to be eligible, and the service must be provided at the Contract Denius's feality where the denture was originally delivered.  Replacement of a denture or a partial denture requires the existing denture to be 5+ years old.  576.00  5710 Complete denture - maxillary	Denno		
D5120 Complete denture - mandibular \$75.00   D5130 Immediate denture - mandibular \$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) \$80.00   D5214 Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) \$95.00   D5214 Mandibular partial denture - resin base (including any conventional clasps, rests and teeth) \$95.00   D5222 Immediate maxillary 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) \$80.00   D5224 Immediate maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) \$80.00   D5225 Maxillary partial denture - fiexible base (including any clasps, rests and teeth) \$95.00   D5226 Mandibular partial denture - fiexible base (including any clasps, rests and teeth) \$195.00   D5226 Mandibular partial denture - fiexible base (including any clasps, rests and teeth) \$195.00   D5226 Maxillary partial denture - fiexible base (including any clasps, rests and teeth) \$195.00   D5227 Maxillary partial denture - fiexible base (including any clasps, rests and teeth) \$195.00   D5228 Removable unilateral partial denture - the partial denture dent	- For all six mon where to - Rebas - Replac	listed dentures and partial dentures. Copayment includes after delivery adjustments and tissue conditioning, if needed, f ths after placement. The Enrollee must continue to be eligible, and the service must be provided at the Contract Dentist's the denture was originally delivered. es, relines and tissue conditioning are limited to 1 per denture during any 12 consecutive months. The cement of a denture or a partial denture requires the existing denture to be 5+ years old.	s facility
D5140 Immediate denture - maxillary \$85.00 D5140 Immediate denture - maxillary \$86.00 D5141 Maxillary partial denture - resin base (including any conventional clasps, rests and teeth) \$80.00 D5212 Maxillary 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) \$80.00 D5214 Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) \$95.00 D5214 Mandibular partial denture - resin base (including any conventional clasps, rests and teeth) \$95.00 D5224 Immediate maxillary partial denture - resin base (including any conventional clasps, rests and teeth) \$80.00 D5225 Immediate maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) \$80.00 D5226 Immediate maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) \$80.00 D5226 Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) \$95.00 D5227 Maxillary partial denture - lexible base (including any clasps, rests and teeth) \$95.00 D5280 Mandibular partial denture - lexible base (including any clasps, rests and teeth) \$95.00 D5281 Removable unilateral partial denture - one plece cast metal (including clasps and teeth) \$80.00 D5281 Adjust complete denture - maxillary No Cost D5282 Replace missing or broken teeth - complete denture (each toolh) No Cost D5283 Repair contenture - maxillary (each toolh) No Cost D5380 Repair or replace broken clasp - per tooth No Cost D5380 Repair or replace broken clasp - per tooth No Cost D5880 Add tooth to existing partial denture - per tooth No Cost D5880 Add clasp to existing partial denture - per tooth No Cost D5880 Add clasp to existing partial denture - per tooth No Cost D5880 Replace all teeth and			
D5140 Immediate denture - mandibular	D5120		
D5211 Maxiltary partial denture - resin base (including any conventional clasps, rests and teeth) \$80.00 D5212 Mandibular 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 D5214 Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) \$95.00 D5221 Immediate maxilitary partial denture - resin base (including any conventional clasps, rests and teeth) \$95.00 D5222 Immediate maxilitary partial denture - resin base (including any conventional clasps, rests and teeth) \$80.00 D5223 Immediate maxilitary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) \$85.00 D5224 Immediate mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) \$95.00 D5225 Maxiltary partial denture - flaxible base (including any clasps, rests and teeth) \$95.00 D5226 Mandibular partial denture - flaxible base (including any clasps, rests and teeth) \$195.00 D5227 Maxiltary partial denture - maxillary \$95.00 D528 Maxiltary partial denture - maxillary \$95.00 D529 Maxiltary partial denture - maxillary \$95.00 D520 Maxiltary partial denture - maxillary \$95.00 D520 Maxiltary partial denture - maxillary \$95.00 D521 Repair cast framework \$95.00 D522 Replace missing or broken teeth - complete denture (each tooth) \$95.00 D523 Replace missing or broken teeth - complete denture (each tooth) \$95.00 D524 Repair cast framework \$95.00 D525 Replace missing partial denture - per tooth \$95.00 D526 Replace booken clasp - per tooth \$95.00 D527 Replace and acrylic on cast metal framework (maxillary) \$95.00 D528 Replace and acrylic on cast metal framework (maxillary) \$95.00 D529 Rebase complete maxillary denture \$95.00 D529 Rebase maxillary partial denture	D5130	· ·	
D5212 Maxiliary partial denture - resin base (including any conventional clasps, rests and teeth).  Sept. Maxiliary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).  Sept. Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).  Sept. Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).  Sept. Maxiliary partial denture - resin base (including any conventional clasps, rests and teeth).  Sept. Maxiliary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).  Sept. Maxiliary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth).  Sept. Maxiliary partial denture - lexible base (including any casps, rests and teeth).  Sept. Maxiliary partial denture - flexible base (including any clasps, rests and teeth).  Sept. Maxiliary partial denture - lexible base (including any clasps, rests and teeth).  Sept. Maxiliary partial denture - maxiliary.  Maxiliary partial denture - maxiliary.  Maxiliary partial denture - maxiliary.  No Cost D5281 Removable unifiateral partial denture - one piece cast metal (including clasps and teeth).  Sept. Maxiliary partial denture - maxiliary.  No Cost D5412 Adjust partial denture - mandibular.  No Cost D5412 Adjust partial denture - mandibular.  No Cost Replace missing or broken teeth - complete denture (each footh).  No Cost Replace missing or broken teeth - complete denture (each footh).  No Cost Replace missing or broken teeth - complete denture (each footh).  No Cost Replace in teeth and acrylic on cast metal framework (maxiliary).  Sept. Replace all leeth and acrylic on cast metal framework (maxiliary).  Sept. Replace all leeth and acrylic on cast metal framework (maxiliary).  Sept. Replace complete maxiliary denture.  Sept. Replace complete maxiliary			
DS213   Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)   \$95.00			
rests and teeth)			\$80.00
rests and teeth) \$95.00 D5221 Immediate maxillary partial denture - resin base (including any conventional clasps, rests and teeth) \$80.00 D5222 Immediate maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) \$95.00 D5223 Immediate maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) \$95.00 D5224 Immediate maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth) \$95.00 D5226 Maxillary partial denture - flexible base (including any clasps, rests and teeth) \$195.00 D5227 Maxillary partial denture - flexible base (including any clasps, rests and teeth) \$195.00 D5228 Removable unilateral partial denture - one piece cast metal (including clasps and teeth) \$195.00 D5281 Adjust complete denture - maxillary No Cost D5410 Adjust complete denture - maxillary No Cost D5411 Adjust partial denture - maxillary No Cost D5412 Adjust partial denture - maxillary No Cost D5412 Adjust partial denture - maxillary No Cost D5510 Repair broken complete denture base No Cost D5510 Repair rosin denture base No Cost D5610 Repair rosin denture base No Cost D5610 Repair rosin denture base No Cost D5610 Repair or replace broken clasp - per tooth No Cost D5610 Repair or replace broken clasp - per tooth No Cost D5610 Replace all teeth and acrylic on cast metal framework (maxillary) \$65.00 D5710 Rebase complete maxillary denture  \$30.00 D5711 Rebase complete mandibular denture  \$30.00 D5721 Rebase complete mandibular denture  \$30.00 D5730 Reline complete mandibular denture (chairside) No Cost D5730 Reline complete mandibular denture (chairside) No Cost D5730 Reline complete mandibular denture (chairside) No Cost	D5213	rests and teeth)	. \$95,00
D5222 Immediate mandibular partial denture - resin base (including any conventional clasps, rests and teeth)   \$80.00	D5214		\$95.00
Immediate maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	D5221	Immediate maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	. \$80.00
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D5640 Replace broken teeth - per tooth	D5620	Repair cast framework	. No Cost
D5650 Add tooth to existing partial denture	D5630	Repair or replace broken clasp - per tooth	. No Cost
D5660 Add clasp to existing partial denture - per tooth D5670 Replace all teeth and acrylic on cast metal framework (maxillary) D5671 Replace all teeth and acrylic on cast metal framework (mandibular) D5710 Rebase complete maxillary denture D5711 Rebase complete mandibular denture D5720 Rebase maxillary partial denture D5721 Rebase mandibular partial denture D5730 Reline complete maxillary denture (chairside) D5731 Reline complete mandibular denture (chairside) D5740 Reline maxillary partial denture (chairside) D5740 Reline maxillary partial denture (chairside) No Cost	D5640	Replace broken teeth - 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	D5650	Add tooth to existing partial denture	. No Cost
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D5721 Rebase mandibular partial denture	D5711	Rebase complete mandibular denture	. \$30.00
D5730 Reline complete maxillary denture (chairside)	D5720		
D5731 Reline complete mandibular denture (chairside)	D5721		
D5740 Reline maxillary partial denture (chairside)	D5730		
	D5731		
D5741 Reline mandibular partial denture (chairside)	D5740		

Plan CA4	2N DeltaCare USA Description of Benefits and Copayn	nents
D5751 Reline D5760 Reline D5761 Reline D5820 Interim D5821 Interim D5850 Tissue	complete mandibular denture (laboratory)  maxillary partial denture (laboratory)  mandibular partial denture (laboratory)  partial denture (maxillary) - limited to 1 in any 12 consecutive months  partial denture (mandibular) - limited to 1 in any 12 consecutive months  conditioning, maxillary  N  conditioning, mandibular	\$25,00 \$25,00 o Cost o Cost o 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 dent [bridge])	ure
beyond the 6th in Replacement of Name brand, li material upgrad Limitation of Bei	and/or pontic exceeds six units in the same treatment plan, an Enrollee may be charged an additional \$125.00 per unit. of a crown, pontic, inlay, onlay or stress breaker requires the existing bridge to be 5+ years old. aboratory processed or in-office processed crowns/pontics produced through specialized technique or materials are es. The Contract Dentist may charge an additional fee not to exceed \$325.00 in addition to the listed Copayment. Repetits #4 for additional information.	efer to
		\$30.00
		\$70,00 \$55.00
		\$60.00
		\$70.00
		\$70.00
		\$55.00
		\$60.00
	<b>)</b>	\$70.00
		\$30.00
		\$15.00
	the many at that the state of t	\$20.00
		\$60,00
		\$65.00
D6602 Retain		\$70.00
		\$70.00
	er inlay - cast predominantly base metal, two surfaces	
	er inlay - cast predominantly base metal, three or more surfaces	
	er inlay - cast noble metal, two surfaces	
	er inlay - cast noble metal, three or more surfaces	
		\$55.00
		\$65.00
	··· ··································	\$70.00
	ner onlay - cast high noble metal, three or more surfaces	\$70.00
	per onlay - cast predominantly base metal, two surfaces	
	ier onlay - cast predominantly base metal, three or more surfaces	
		\$60.00
D6615 Retain	er onlay - cast noble metal, three or more surfaces	\$60.00
D6710 Retain	ner crown - indirect resin based composite	\$30.00
D6720 Retain	ner crown - resin with high noble metal	\$30.00
		\$15.00
		\$20.00
		\$70.00
	· · · · · · · · · · · · · · · · · · ·	\$70.00
D6751 Retain	of alami, have a breaking the breaking the control of the control	\$55.00
		\$60.00
	and the same training the same training to the same training tr	\$70.00
D6781 Retain	ner crown - ¾ cast predominantly base metal	\$55.00

Pla	n CA42N DeltaCare USA Description of Benefits and Gopay	/ments
D6782	Retainer crown - ¾ cast noble metal	\$60.00
	Retainer crown - ¾ porcelain/ceramic*	
D6790	Retainer crown - full cast high noble metal	\$70.00
D6791	Retainer crown - full cast predominantly base metal	
D6792	Retainer grown - full cast noble metal	\$60.00
D6794	Retainer crown - titanium	
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-		
- Include	es preoperative and postoperative evaluations and treatment under a local anesthetic.	
D7111	Extraction, coronal remnants - deciduous tooth	
	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	thán co
	mucoperiosteal flap if indicated	\$10.00
D7220	Removal of impacted tooth - soft tissue	
D7230	Removal of impacted tooth - partially bony	\$25.00 eac.oc
D7240	Removal of impacted tooth - completely bony	
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	
D7250	Surgical removal of residual tooth roots (cutting procedure)	
D7251	Coronectomy - Intentional partial tooth removal	
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	
D7280	Surgical access of an unerupted tooth	
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	
D7283	Placement of device to facilitate eruption of impacted tooth	
D7286	Incisional biopsy of oral tissue - soft - does not include pathology laboratory procedures	
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	
D7450 D7451	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	
	Removal of lateral exestosis (maxilla or mandible)	
D7471	Removal of torus palatinus	
	Removal of torus mandibularis	
D7473		
D7960	Frenulectomy ~ also known as frenectomy or frenotomy - separate procedure not incidental to another procedure	No Cost
	Excision of hyperplastic tissue - per arch	
	Excision of pericoronal gingiva	
		140,0031
D8000-	F-14-14-14-14-14-14-14-14-14-14-14-14-14-	of antivo
treatme	sted Copayment for each phase of orthodontic treatment (limited, interceptive or comprehensive) covers up to 24 months nt. Beyond 24 months, an additional monthly fee, not to exceed \$125.00, may apply. etention Copayment includes adjustments and/or office visits up to 24 months.	u, acuve
	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	
	Tomographic survey	
	Panoramic radiographic image	
D0340		
D0350		
D0351		
D0470	Diagnostic casts	
	The benefit for post-treatment records includes:	\$70.00
D0210	Intracral - complete series of radiographic images	T
	Diagnostic casts	
23170	——————————————————————————————————————	

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D8010	Limited orthodontic treatment of the primary dentition
D8020	Limited orthodontic treatment of the transitional dentition - child or adolescent to age 19
D8030	Limited orthodontic treatment of the adolescent dentition - adolescent to age 19
D8040	Limited orthodontic treatment of the adult dentition - adults, including covered dependent adult children\$925.00
D8050	Interceptive orthodontic treatment of the primary dentition
D8060	Interceptive orthodontic treatment of the transitional dentition
D8070	Comprehensive orthodontic treatment of the transitional dentition - child or adolescent to age 19
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
D8680	Orthodontic retention (removal of appliances, construction and placement of removable retainers)
D8681	Removable orthodontic retainer adjustment
D8693	Re-bond or re-cement fixed retainer - limited to 2 per 6 month period
D8694	Repair of fixed retainers, includes reattachment - limited to 2 per 6 month period
D8999	Unspecified orthodontic procedure, by report - includes treatment planning session\$100.00
CACIGARAGA	Gitsberniër hundering brosedtie'r 73 Jeholf - wordoos godeneir british 8 coppos ( 1111111111111111111111111111
D9000-	
D9110	Palliative (emergency) treatment of dental pain - minor procedure
D9211	Regional block anesthesia
D9212	Trigeminal division block anesthesia
D9215	Local anesthesia in conjunction with operative or surgical procedures
D9219	Evaluation for deep sedation or general anesthesia
D9223	Deep sedation/general anesthesia - each 15 minute increment
D9243	Intravenous moderate (conscious) sedation/analgesia - each 15 minute increment
D9310	
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed
D9440	Office visit - after regularly scheduled hours
D9450	Case presentation, detailed and extensive treatment planning
D9932	
D9933	Cleaning and inspection of removable complete denture, mandibular
D9934	Cleaning and inspection of removable partial denture, maxillary
D9935	Cleaning and inspection of removable partial denture, mandibular
D9940	Occlusal guard, by report - limited to 1 in 3 years\$75.00
D9943	Occlusal guard adjustment
D9951	Occlusal adjustment, limited
D9952	
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays - limited to
20010	one bleaching tray and gel for two weeks of self-treatment
D9986	Missed appointment - without 24 hour notice - per 15 minutes of appointment time - up to an overall maximum
20000	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

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

- The frequency of certain Benefits is limited. All frequency limitations are listed in Schedule A, Description of Benefits and Copayments.
- 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.
- 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.
- 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.
- Lost or stolen appliances including, but not limited to, full or partial denfures, 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.
- Prescription drugs.

# Limitations and Exclusions of Benefits

- 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 theraples, 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

Quality Convenience Predictable Costs

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



Select a DelfaCare USA dentist



Receive your welcome kit



Schedule an appointment



Receive dental care



Pay only your copayment directly to dentist

No paperwork. No hassie.

# Save money with a DeltaCare® USA

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

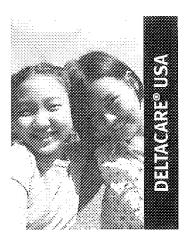
On our website, you can:

- · 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 toil-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.

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

facebook.com/deltadentalins twitter.com/deltadentalins youtube.com/deltadentalins

Delta Dental PPOSS is underwritten by Delta Dental Insurance Company in At. DC, FL, GA, IA, MS, MT, NY and UT and by not-for-profit dental service companies in these states: CA -- Delta Dental of California, PA, MD -- Delta Dental of Pennsylvania, NY -- Delta Dental of New York, Inc., DE -- Delta Dental of Delaware, Inc., WV -- Delta Dental of West Virginia. In Texas, Delta Dental insurance Company provides a Dental Provider Organization (DPO) plan.

DettaCare® USA is underwritten in these states by these entities: AL — Alpha Dental of Alabama, Inc.; CA — Delta Dental of California; AR, CO, IA, MI, OR, RI, SC, WA, WI, WY — Dentegra Insurance Company: DE, FI, GA, KS, TN, WY and Washington, D.C. — Delta Dental Insurance Company; HI, ID, IN, KY, MD, MO, NI, TX — Alpha Dental Programs, Inc.; UT — Alpha Dental of Utah, Inc.; NY — Delta Dental of New York, Inc.; PA — Delta Dental of Virginia. Delta Dental insurance Company, acts as the DeltaCare USA administrator in all these states. These companies are financially responsible for their own products.

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 RO. Box 1803 Alpharetta, GA 30023



deltadentalins.com

# 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

### 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 van.com or call 800,877,7195 for more details on your vision. coverage and evolutive savings and promotions for VSP members.

<sup>1</sup>Brands/Promotion subject to change.

\*2014 Vision Service Plan. All rights reserved. VSP, VSP Vision care for life, and WellVision Exam are registered trademarks of Vision Service Plan. Flexon is a registered trademark of Marchon Eyewear, Inc. All other company names and brands are trademarks or registered trademarks of their respective owners.



	Your Coverage with a VSP Provider	
WellVision Exam	Focuses on your eyes and overall wellness     Every 12 months	\$10
Prescription Gla	sses	\$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 Prescriptior Glasses
Lenses	<ul> <li>Single vision, lined bifocal, and lined trifocal lenses</li> <li>Polycarbonate lenses for dependent children</li> <li>Every 12 months</li> </ul>	Included in Prescriptior 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	<b>\$</b> O
Primary Eyecare	<ul> <li>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.</li> <li>As needed</li> </ul>	\$20
	Glasses and Sunglasses  Extra \$20 to spend on featured frame by vsp.com/specialoffers for details.  20% savings on additional glasses and including lens enhancements, from any within 12 months of your last WellVision.	sunglasses,
Extra Savings	Retinal Screening     No more than a \$39 copay on routine roas an enhancement to a WellVision Example.	
	Laser Vision Correction     Average 15% off the regular price or 5% promotional price; discounts only availad contracted facilities	

Visit vsp.com for details, if you plan to see a provider other than a VSP network provider.

Examup to \$45	Lineal Talkanal Langua men #CF
Frame up to \$70	Lined Trifocal Lensesup to \$65 Progressive Lensesup to \$50 Contactsup to \$105
Single Vision Lensesup to \$30	Contracts Lensesup to \$50
Lined Bifocal Lensesup to \$50	Contactsup 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
<u>Kaiser</u>				
Kaiser HMO	\$805.20	\$1,586.43	\$1,437.98	\$2 <b>,</b> 367.67
Kaiser DHMO	\$625.56	\$1,227.16	\$1,112.86	\$1,828.77
Kaiser Senior Advantage Rates				+000.05
Subscriber with Medicare				\$303.25
Subscriber with Medicare + Spouse Non-Medicare				\$1,084.48
Subscriber with Non-Medicare + Spouse with Medica	ire			\$1,084.49
Subscriber with Medicare + Spouse with Medicare Subscriber with Medicare + Child Non-Medicare				\$582.54
Subscriber with Medicare + Child Non-Medicare Subscriber with Medicare + Children Non-Medicare				\$936.03
	Child New Medices	_		\$936.03
Subscriber with Medicare + Spouse with Medicare +				\$1,363.79
Subscriber with Medicare + Spouse with Non-Medica Subscriber with Non-Medicare + Spouse with Medica				\$1,865.73 \$1,865.74
Subscriber with Medicare + Spouse with Medicare +				\$1,003.74 \$1,363.79
Subscriber with Medicare + Spouse With Medicare + Subscriber with Medicare + Spouse Non-Medicare +				\$1,365.79
Subscriber with Medicare + Spouse Non-Medicare + Subscriber with Non-Medicare + Spouse with Medica				\$1,865.74 \$1,865.74
Subscriber with Non-Medicare + Spouse with Medica	ire + Cilliaren Non-	Medicare		\$1,605.74
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 21, 2018 SJVIA County of Tulare Custom Classic 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 plon can preserve certain basic health coverage that was afreedy in effect when that law was enacted. Being a grandiathered 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 sharms. However, grandfathered health plans must comply with consin other consumer presections in the Affordable Care Act, for exemple, the elimination of lifetime limits on benefits.

Questions regarding which protections of the Affordable Care Act apply and which proteotions 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 banefits administrator if you do not have an identification card. For ERISA plans, you may also contact the Employee Renefits Gecurity Administration, U.S. Department of Labor at 1–866–444-3272 or www.doi.gov/ebea/hesithreform. 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.treathretonn.gov.

In addition to dollar and percentage copays, members are responsible for deductibles, as described below. Please review the deductible information to know it a deductible applies to a specific covered service. Certain Covered Services have meximum visit and/or day limits per year. The number of visits audior 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 traites. 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, copsyment or coinsurance. Participating Providers. The rate the provider has agreed to accept as relimbursement for covered services. Members are not responsible for the difference between the provider's usual changes & the maximum allowed amount.

Non-Participating Providers & Other Health Care Providers (includes those not represented in the PPO provider network)-Relimbursement 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 bitled charges. For Medical Emergency care matered by a Non-Participating Provider or Non-Contracting Hospital, relimbursement 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.

For PPO Providers & Other Health Providers For non-PPO Providers Deductible for non-Anthem Blue Cross PPO hospital or	None \$500/mamber; \$1,000/ None	family		
residential treatment center				
Deductible for non-Anthem Blue Cross PPO hospital or residential treatment center if utilization review not obtained	\$250/admission (waive }	\$250/admission (waived for amargancy admission)		
Deductible for emergency room services	\$100/visit (walved if adi	mitted 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-cove the member remains responsible for non-PPO providers & other	\$2,000/member/year; i \$8,000/member/year; i grad expense. After a mambor raach health care providers, costs in exce	\$10,000/damily/year nes the cut-of-pocket maximum,		
Lifetime Maximum	Unlimited			
Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay <sup>1</sup>		
Hospital Medical Services (subject to utilization review for inpatient services, waived for emergency admissions)  — Semi-private room, meals & special diets,	16%	30%		
<ul> <li>&amp; ancillary services</li> <li>Outpatient medical pare, surgical services &amp; supplies (nospital care other than emergency room care)</li> </ul>	10%	(benefit limited to \$600/day) 30% (benefit limited to \$600/day)		
Ambulatory Surgical Centers  Outpatient surgery, services & supplies	10%	30%		
		(benefit limited to \$350/day)		
Skillied Nursing Pacility (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 outcationt services for member with up to one year life expectancy, family bereavement services	No co;	oay <sup>;</sup>		

<sup>&</sup>quot;The demantings coping for in examinations sorvices from non-Aribum Blos Cross PFO providers is hased on the scheduled amount.

These providers see not represented in the Anthem Blue Cross PPO network.

Covered Services	PPO: Per Member Copay	Non-PPO: Fer Member Capay <sup>i</sup>	
tome Health Care (subject to utilization review)			
<ul> <li>Services &amp; supplies from a home health agency (invited to combined 100 prior outhorized visits/calendar year, one visit by a home health side equals from hours or less; not covered while member receives hospice care;</li> </ul>	10%	10% with authorization	
loma Infusion Tharapy (subject to utilization review)	**		
<ul> <li>Includes medication, antillary services &amp; amplies; caregiver inhibing &amp; visits by provider to monitor liverapy; durable medical equipment; lab services</li> </ul>	10%	18%	
hysician Medical Services			
Ciffice & home visits	\$20/visit2	30%	
Hospital & skilled nursing facility visits	10%	30%	
Surgeon & surgical assistent; anesthesiologist or aneathatist	10%	30%	
<ul> <li>Drugs administered by a medical provider (certain drugs are subject to utilization review)</li> </ul>	10%	30%	
Diagnostic X-ray & Lab			
<ul> <li>MRI, CT scan, PET scan &amp; nuclear cerdiae scan (subject to utilization reverse)</li> </ul>	10%	30%	
P Other diagnostic x-ray & lab	No copay	30%	
Principitive Care Services including*, physical exams, jareventive largerings (including screenings for cancer, HPV, diabeties, cliclesterol, liked pressure, familing and vision immunizations, familin education, intervention services; HIV testing), and additional preventive care or 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%	
hysical Therapy, Physical Medicine & Occupational herapy	\$25/visit	30%	
Chiroprectic Services (up to 12 visits/calendar year, additional risks may be approved, if medically necessary)	\$25/visii	30%	
špeech Therapy			
<ul> <li>Outpatient spacen therapy following injury or organic disease</li> </ul>	\$20/visi:	30%	
Acupuncture			
<ul> <li>Services for the treatment of discesse, illness or injury (limited to 20 visits/balandar year)</li> </ul>	\$25/visiP	\$26/v/sii?	
Cemporomandibular Jeint Disorders			
Splint therapy & surgicel treatment	10%	30%	
Pregnancy & Maternity Care			
<ul> <li>Physician office visits</li> </ul>	\$20/visit8	30%	
<ul> <li>Prescription drug for elective abortion (milepolatone)</li> </ul>	10%	Not covered	
Normal delivery, cesarean section, complications of pregnancy Rabortion			
<ul> <li>Inpatient physician services</li> </ul>	10%	30%	
→ Hospital & ancillary services	10%	30% (benefit (mited to \$600/day)	
<ul> <li>Family planning counseling</li> </ul>	\$20/vish	Noi covered	

<sup>\*</sup>The percentage copyr for non-americancy services from the Archesti Blob Cross PPO providers is based on the scheduled arrount,

The deterropsy applies only to the yield local. An additional 19% copey applies our any services performed in office (i.e., X.my, i.b., surgery), after any applicable distinctions.

Acaponeous condess can be performed by a condition acaponeously (C.A.), a declar of medicine (M.C.), a declar of estemplishy (D.C.), a podiatrish (C.E.M.), or a denied (C.O.S.).

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay <sup>1</sup>
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	0%
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 cosch airfare, hotel limited to 1 room double occupancy & \$180/day for 21 days/trip, other expenses limited to \$25/day/person for 21 days/trip, donor fransportation limited to 1 trips/episode & \$250 for round-trip coach airfare; hotel limited to \$100/day for 7 days, other expenses limited to \$25/day for 7 days.	N	o copay
Barlatric 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))		
<ul> <li>Inpatient services provided in connection with medically necessary surgery for weight loss, only for morbid obesity</li> </ul>	1	0%
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/persondrip for 3 trips (pre-surgical visit, initial surgery & one follow-up visit); one companion's transportation to & from CME limited to \$130/persondrip for 2 trips (lititial 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/critic reasonable expenses limited to \$25/day/person for 4 days/critic).	•	io copay
Disbates Education Programs (requires physician supervision)	V 86.61 : 11	0.70
Teach members & their iamilies about the disease process, the daily management of diabetic therapy & self-management training	\$20/visit	30%
Prosthelic 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	L #10"	2231
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-n	10% elwork)	39%
Related Outpatient Medical Services & Supplies		
<ul> <li>Ground or air ambulance transportation, services</li> <li>&amp; disposable supplies</li> </ul>		0%\$
Blood transfusions, blood processing & the cost of unreplaced blood & blood products	1	0%/
Autologous blood (self-donated blood collection, testing, processing & storage for planned surgery)	1	0%3

<sup>3</sup> The percentage copay for concentragency sendors from non-Anthem Blue Gross PPO previders is based on the subsidited embant.

<sup>§</sup> These providers are not represented in the Archem Blue Cross PPO seswork.

Co	vered Services	PPQ Per Member Copay	Non-PPO: Per Member Copay <sup>s</sup>
ξn	sargency Care		
W.	Emergency room services & supplies (\$100 deductible waived if admitted)	10%	10%
30	inpatient hospital services & supplies	10%	10%
×	Physician services	10%	10%
350	ntal or Narvous Disorders and Substance Abuse		
inp	ration) Care		
è	Facility-based care (subject to utilization myles; weited for emergancy admissions)	10%	30% (benefit imited to \$600/day)
≫	Inpetient physicien visits	10%	30%
Ou	tpatient Care		
Ž.	Facility-based care (mitigat to utilization review; waived for emergancy admissions)	10%	30% (benefit limited to \$600/day)
۶	Outpatient physicien visits (Behavioral Health treatment for Autism & Pervisive disorder will be subject to pre-vervice review)	\$20/visit <sup>a</sup>	30%

The parcentage copsy for non-emergency services from non-Anthem Blue Cross PPO providers is hased on the scheduled smount.

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 datail.

The deliar copey applies only to the visit lines. An additional 10% copey applies for any services performed in office (i.e., X-ray, leb. surgery), after any application deductible.

### Classic PPO Exclusions and Limitations

Not Madically Nacassary. Lamidas or supplies that are not medically recessary, as defined Experimental or investigative. Any experimental or investigative procedure or medication. But it monitor in depend sometic perceive its determined that the requested treatment in apparamental or ferrologistics, this mender may request an independent medical review, as described in the Evidence of Courtings (COC).

Outside the United States, Services or supplies tempoled and labed by a provision addictithe United States, listens such services or supplies are fundabled in connuction with urgent case or supplies are fundabled in connuction with urgent case or supplies.

Oriente or Mischadt Energy, Confelieus that result from (1) the member's controlesion of or stangel to commit a february as long as any injuries manned a moult of a medical condition or an fact of february by internal or (2) any releases of medical energy, whether or on the result of wax, when construct burds are available for the treatment of thoses or latery anality from the releases of medical energy.

Wirk Covered, Services received before the member's effective date. Services received effect the member's coveregy rade, except as specified as covered in the ECK.

Expensión Amounts. Any amounts in expensión covered expense en line Malisea maximum

Where Related, Work mineral amplificant if broselic and randoment or can be recovered, either by adjustmedim, sentented or otherwise, under any southers' nompensation, employer's faibility law or occupational disease law, whether or not the esember delime brose benefits, it there is a dispute of adjustmedia incombinity as in whether consider may be recovered for three conditions pursuant to workers' compensation, we will provide the benefits of take provide provide any delimited pursuant provides and reinforcement index California Libur Carle Section 4915, as specified as provided in the PPC.

Continuous Freetment, Any services the member solucity reneived that were presided by a total, state or Arter's government agency, emby when payment than this plan is expressly required by Enforce or state tax. We will not rower payment for these services in the member is not regulated to pay to them or that are given to the magnitude for the.

Services at Refetives. Professional services received from a person living in the member's from an except as specified in the member by blood or moviege, except as specified he governd to the Professional Research.

Voluntary Payment, Services to which the member has no legal obligation to pay, or for which we change would be made in the absence of insurance overage or other health plan coverage, except services received at a non-governmental charlable research buspital. Such a hospital must receive and otherway gradulinus:

- 1. If must be internationally known as being devoted mainly to medical research,
- all tears, 10% of its yearly burger must be spect on research and directly retained to patient dans.
- attieves one discircities gross incomes must come from beneficies or general plate than gifts or travments for patient grass.
- 4. If must except potents who are unable to pay, and
- 5. Two trinds of its patients must have conditions disortly related to the hospital's research.

Net Specifically Listed, Ferduce and specifically lated in the plan as creared services.

Private Contracts. Services or supplies provided possumit to a private project between the members and a precision for which relationsement ender leadingse program is prohibited, as specified in Section 1809 (40 U.S.C. 1885s) of File XVIII of the Societ Remain Aut.

kapations Diagnossia Taesa, Inpuliari racin and poard chuspe in comercion with a kospind stay primaria for diagnosiis tesis which could be a been performed salay on an ordporent basis.

Mential of Mercenia Disarriers, Academic or obscational lesting, counseling, and remodiation, Mentid or nervous disorders or subscence about, including rehobilitative uses in relation to flose scraditions, recopi as specified as concered in the ECC.

Official entitle. Enaces, other orthodoctic applicances or orthodoctic services.

Cental Services or Seggilles, treated printes, briuges, process, cups or other contal prostheses, doubt implants, derible survices, extraction of resit, treatment in the Seeth or gurrer, or treatment to or for any disordiers for the temporomismostibular (grey joint, excupt us specified as decerted in the ECC. Contrator related suppry or other frostel services for beautifaction.

Heating Alde or Yeats

Optiomatchi Sanviosa or Sapplilas, Optionetrio servicas, eyo exercisas bichiding enhopsios. Routine eye axema und qualna aya ratiaciona, sa spanified na comend ni the ECC. Exertasses se contest kersing school os spanified us covaged in the ECC.

Outpatiant Occupational Therapy, Outpolient recupational therapy, except by a forma health against Lespine, or borne intention than only provider, we specified an exceed to the ECIO.

Ordpatent Sheesa Thurspy, Outpuboid sheeth dienary, except de sponifiad as apvered in the ECC.

Cosmetto Surgery. Cosmetic sergery or other services performed colely for becoffination or to eliter or makene council (eccleding aged) structures or fissues of the bridy to improve appearance. This evolution their not apply to reconstructive surgery (first to, surgery performed to correct usefrunities caused by congenital or developmental abnormalities, Bures, or injury for the purpose of improving boddly isostom or symptomoleticity or to create a correct appearance), including surgery performed to unknown symptomoleticity or to create a correct appearance), including surgery performed to unknown symptomoleticity or population of psychological processors. Consecus corporations and become records under surgery because of psychological or psychianter research.

Commercial Weight Leas Programs, Weight less programs, shelter or out her are pursued under medical or physicism symposisms, unless specifically load as created in this public

This is ublished wighters, but is not limited to, commontal weight has programs (Weight Weighers, Jeres) CA Weight Least and Jacquey programs.

This perfection does not apply to medically necessary treatments for market already or distant activations are premished, and principle and mathipation programs for the realization of accretion premise or taking provides. Surgical mathment for probled moustly is covered as described in the Existence of Coverage (EOC).

Sterification Several

fortertifity Treatment. Any services or oxygities (urnished in non-vention with the degensis and freement of security, including, but as limited to diagnostic tests, medication, surgery, addicial insemination, in vitro fartitation, stedistation revents and gernete inhalatopise transfer,

Starragate Statister Services. For any services or supplies provided to a person risk november the plan in connection with a surragate program y finisheding, but not finished to, the bearing of a child by profiler women for or industrie propiet.

Officiand is shown and show inserts. This exclusion does not apply to utilized individual used as an etagration of a brook, show mostly find an outsign motivate to be policial, or Berapaulo show and inserts designed to treat fool complications due to distalent, as specifically stand to the 5000.

Air Consistencero. Air punitare, air conditionero or transidificas,

Constantial Care or Rost Curve. Impater i room and hourd charges in consention with a hospital clay primarily for environmental charge or physical therapy. Services provided by a resi home, a home for the agest, a runding home or any station toolity, frencions provided by a stiffed running hosfitty or cyclodise care or root curve, accord as specified as copered to the HOC.

Health Clais Monderships, Health chip memberships, exercise apriprient, charges from a physicist foreign restriction or personal habor, or any other charges on establish, againment or habities used for developing or matrialising physicist floress, even if ordered by a physicist. This exalters also applies to health space.

Personal items. Any supplier for contail, hygione or beautification.

Education or Causeadian. Educational services in outritional counseling, except as specified as unrested in the ECC. This enduction time only apply to counseling for the restment of anomalia narrows as technical partners.

Food or Distary Supplierments, fibritisms and/or dickey supplierments, aspect as provided in this plan or as remained by law. This exclusion leutides, but is not limited, those multilensi formation and distance supplierments that can be parchased over the country, which by law to not requirement other a written prescription or disponenting by a figuresial observacion.

Yalophopa and Pacsimila Blachtne Consultations. Consultations provided by telephone or facsimila machine.

Routine Events of Yests, finaline propries example historists which do not directly had an ecoal disease, interly or condition, including those required by emmayment or government enhancy, except as specified as ordered in the ECC.

Adapant (ura, Adapantina healmini, recept as specified as covered in the EOC, Adapantants of massings to control poin, that defeate to promise health by applying precious to the of motal specific onset of the body healed on demonstrates or adapantants project.

Eye Burgery for MeBactive Detecta. Any eye surgery colety or primarily for the propose of correction; self-active defends of the number of correction; self-active defends of the number of correction colors of myopid, and or setigmatism. Contest to see and eyestesses required as a result or this everyary.

Physical Thorapy or Physical Medicine, Society of a physical for object library or physical resolution, except when provided during a covered inpatroid confinement or as opacified as covered in the ECC.

Cultipations Prescription Drugs and Madicultions, Cultipations pursonplain utings or mediculous and insulin, except as specified as covered in the ECC. Any par-prescription, ever-the-counter patient or progradary array or medicine. Controller, beauty and

Specially Pharmary Drugs, Specially marrises stuge that read be obtained from the operatly pharmary program, but, which are obtained from a retail stromacy, one not present by this plan thanker with last a to pay the full cost of the epoclatry pharmacy drugs outsined from a restal pharmary that should have been obtained from the epoclatry pharmary program.

Contropoptivo Devisors, Com aceptive devices prescribed for bith commi except as specified an experted in the ECC.

Distriction Supplies. Presoription and non-prescription district supplies except as specified as covered in the EOC.

Private Daty Marking, inpulant or adpollent services of a private duly norse.

Effective Programs: Programs in other one's bleetive which may include but are not finded to dist, axercase, the gary or mobilism. This controller will not apply to contact vehablication programs agreemed by us.

Cigs.

Triand Parity Crability — Anthere Blue Cress is antitred to relinducement of benefits paid if the market recovers dramages from a regarly fiable third perfet.

Coordination of Benefits — The benefits of this plan may be recorded the marriner has any other group health or destal coverages of that the services received from all group coverages do not exceed 160% of the covered aspense.

Anthom Stoc Cross is the trade ment of Stoc Cross of Colferings, Independent Liceanse of the Blue Cross Association, & ANTHEM in a registered reasoners of Anthom Instrumes Companies, Sec. The Stoc Cross nente and symbol are registered meres of the Stoc Cross Association.

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## SJVIA County of Tulare Custom Classic PPO 500/35/80/60

Anthem believes this plan is a "grandfathered health plan" under the Patient Proteotion 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 isealth plan means that this plan may not include cartain 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 ideline 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.dot.gcv/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.tocalthreform.gov

in addition to dollar and percentage copays, members are responsible for deductibles, as described below. Prease 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 obsis 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 & actual charges, as well as any deductible & percenta		ence between the covered expense
Calendar year deductible for all providers	\$500/member; \$1,000/far	nily
Deductible for non-Anthem Blue Cross PPO hospital or residential treatment center	r \$250/admission (walved f	or emergency admission)
Deductible for non-Anthem Blue Cross PPO hospital or residential treatment center if utilization review not obt		or emergency admission)
Deductible for emergency room services	\$100/visit (walved if admit	ted 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: nor member remains responsible for non-PPO providers & other	\$3,000/member/year; \$6, \$10,000/member/year; \$: -covered expense. After a member reaches ar health care providers, costs in excess of t	20,000%amily/year silic out-of-pocket maximum, the
Lifetime Maximum	Unimited	
Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copsy <sup>1</sup>
Hospital Medical Services (subject to utilization review for inpatient services, waived for emergency admissions)  > Semi-private room, meals & special diets, & ancillary services  > Outpatient medical care, surgical services & supplies (hospital care other than emergency room care)	\$250/adm/ssion + 20% 20%	40% (benefit limited to \$600/day) 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 more, services & supplies (limited to 100 days/calender year)	20%	20%
Hospice Čare (subject to utilization review)		
Inpatient or outpatient services for members with up to one year life expectancy; family bereavement services	No copay	¢.

<sup>\*</sup>This assertings capsy for non-entringently scretces from our Aelptem Plan Cross FPC providers is based on the subedular amount. \* These providers are trill represented in the Arthura Blue Cross PPC person.

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Coy	ered Services	PPO: Per Member Copay	Non-PPO: Per Member Copsy <sup>1</sup>
ion V	ne Health Care (subject to utilization roview). Services & supplies from a home hoalth agency. filmified to combined 100 prior authorized visitivisate day year, one visit by a frome health pide equals from hours or less, not rovered. white member receives hospice care).	20%	20% will) authorization
:3n	ne infusion Therapy (subject to utilization review)		
in a	Includes medication, anditary services & supplies; caregiver training & visits by provider to monitor therapy; durable medical equipment lab services	20%	20%
Phy	sician Medica: Services		
مو	Citice & home visits	\$35/visii? (doduotibie waivod)	4(%
K,	Hospital & skilled nursing facility visits	20%	40%
6	Surgeon & surgical assistant, anesthesiologist or anesthetist	20%	40%
ja	Drugs administered by a medical provider (cortain drugs are subject to utilization review)	<u> </u>	40%
Ois	gnostic X-ray & Cab		
\$	MRI, CT scan, PET scan & reclear cardiac scan (subject to utilization review)	20%	49% 
	Other diagnostic x-ray & lab	No copay	<b>4</b> (%,
, Sec	ventive Care Services		
sors blue inte for s Res *Thi	ventive Care Services including*, physical exams, preventive senings (including screenings for cancer, HFV, distrates, cholesterol, ad pressure, bearing and vision immunistrations, basilib education, remilion services. HfV testing), and additional preventive care gamen provided for in the guidelines appointed by the Neath curses and Services Administration. Is list to not extraoritive. This benefit includes all Preventive Care vices required by federal and state law.	No copay (deductible waived)	40%
Phy	isical Therapy, Physical Medicine & Occupational	3-25/visit (deductible weived)	40%
	rapy	\$25/85ft	49%
visit	roprautic Services (up to 12 visita/celender year, editional s may be approved, if modically recoscary)	(deductible stolved)	40 k
Sp.	ech Therapy	AA	100
<i>‰</i> 	Outpatient appeals therapy following injury or organic disease	\$25(visit (deductible walved)	40%
<b>&gt;</b>	opuncture Services for the treatment of disease, litness or injury (limited to 20 visito/calandar year)	20%3	40%3
: 9n	operomandibulist Joint Disorders		
7:-	Splint therapy & surgical treatment	20%	46%
ŗç	griancy & Maternity Care		
ja e	Physician office visits	\$36/vist? (deductible walved)	48%
	Prescription drug for elective abortion (mifeoristone) mel delivery, ceserean section, complications of pregnancy bortion	20%	Not covered
, i	Inpatient physician services	26%	40%
حتى	Hospital & ancillary services	\$250/admission + 20%	40% (benelli limited to \$600May)
, in	Female Staribization (including liubal ligation and counseling/consultation)	ya cabak	विको स्टब्स्टर्स
· ~	Male Sterilization	20%	Not covered
See	Family Planning counsoling	\$35/vieit (deduciible walved)	Not covered

The percentage papay for any a maganay existent hand such Ashari Blac Canal PPO providers in based on the catedylad amount.

This defer copy applies only to the visit data. An obstance Data copy applies for any someter pullbrand in office (i.e., Kiny, lab, surgery), after any applicable democratic personalise services are be parliament by a cardies a ruphino dis (C.A.), a decide (A.D.), a decide of estection (C.O.), a position (C.P.M.), or a decide (C.D.).

evos	red Services	PPO: Per Member Copay	Non-PPO: Per Member Copay <sup>1</sup>
Spac	en & Tissue Transplants (subject to utilization review; died enjun transplants covered only when performed Center of Expentise (COEI)		
jis .	Impatient services provided in connection with con-investigative organ or lessue transplants	\$250/8	admission + 20%
>	Transplant iravel expense for an authorized, specified iransplant at a COE, precipient & compenses transportation imited to 8 trips/epicode & \$250/person/rip for round-hip coach atifare. Indet imited to 1 room double overplancy & \$100/day for 21 days/rip, other expenses limited to \$25/day/junten for 21 days/rip, donor transportation fimited in 1 trip/epicode & \$250 for round-trip coach sidare, noted limited to \$100/day for 1 days, other expenses limited to \$25/day for 7 days)	No cop	aay (deduclihki walved)
over ecer	dric Surgery (subject to utilization review, medically isery surgery for accipit loss, eally for morbid obasity, ed only when performed at a Center of Experiise		
COE	## Inpallent services provided in connection with mediculty necessary surgery for weight loss, only for morbid chasily	\$250/	admission + 20%
	Bariatric travel expense when member's home is 50 miles or more from the nearest Bariatric CMF (member's transportation to & from CME kinded to \$130/personality for 3 trins (pre-surgical visit, indial surgery & erie follow up visit), one companion's transportation to & from CME limited to \$130/personario for 2 trips (initial surgery & one follow-up visit), hotel fin member & one ranguation limited to one room double occupancy & \$100/day for 2 days/trip, or as medically necessary, for pre-surgical & failow-up visit, hotel for one companion limited to one room double occupancy & \$100/day for duration of member's with surgery stay for 4 days, other maximable expenses finited to \$25/day/person for 4 days; other maximable expenses	No 00	pay (deductible welved)
ý.	etes 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 weived)	<b>40</b> %
	thetic Davices		20.000
	Coverage for breast prestneses, prestnetic devices to restore a mainod of speaking; surgical implants; attiticial senses or eyes, the first pair of contact lenses or eyeglasses when required as a result of oye surgery; & therapeutic shoes & inserts	20%	40%
	abia Medical Equipment		· · · · · · · · · · · · · · · · · · ·
	Rental or perchase of DMC including , delysis equipment & supplies, frome modical equipment, proethelic/orthodes (heading aids benefit available for one heading ard ser ear every three years; heading and ser ear every three years; heading and supplies are covered under preventive care at no charge for in-net-	20% work)	20%
Rei	ated Outpatient Medical Services & Supplies	an ar i e	
è	Ground or air ambulance transportation, services & disposable supplies	20%3	
ختر	Blood transfusions, blood processing & the cost of unreplaced blood & blood products	20%/	
<i>y</i> -	Autologous blood (self-donated blood collection, testing, processing & storage for planned surgery)	20%3	

Covered Services	PPO: Per Marabar Copsy	Non-PPO: Per Member Copay <sup>r</sup>
Emargancy Care	······································	eren and an artist and a second a
Emergency room survices & supplies (\$100 deductible waited if admirisor)	20%	20%
Impatient hospitel services & supplies	\$250/admission + 20%	\$250/admission + 20%
> Physician services	20%	20%
Mental or Nervous Disorders and Substance Abusa		\$\$\$\$\$\$\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\
Impatient Care		
Facility-based care (subject to utilization review; wakred for emergancy admissions)	\$256/admission + 20%	40% (benetit kmited to \$600/dey)
> Inpatient physician visits	20%	40%
Ontpatient Care		
Facility-based case (autject to utilization review; waired for emergency admissions)	20%	40% (benefit kmited to \$600/day)
<ul> <li>Chipatiant physician visits</li> <li>(Behavioral Haalth treatment for Autism &amp; Persushie</li> </ul>	\$35/visit <sup>a</sup> (dedu <b>atible welvad)</b>	40%
Disorder will be subject to yea-service review)		

<sup>&</sup>lt;sup>1</sup> The percentage capay for non-emergency services from non-Ambern Blue Cross PFO providers is based on the scheduled amount.

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.

<sup>3</sup> The dollar capay applies only in the visit level. An additional 20% copay applies for any services performed in office (i.e., X-ray, lab, surgery), offer any applicable deductions.

### Classic PPO Plan Exclusions and Limitations

Not Stadically Macasomy. Survices or supplied that are not medically recessory, as defined Experimental or travestigative. Any experimentor or humsignific procedure or medication. But, if member is design breaks because it is determined that for sequented traditions are experimental or investigative, the member tray request so independent medical review, as described in the Endergraph of Courtage (5 OC).

Outside the Cerred States, Services of supplies furnished and billed by a provider oriside the Hollad Spain, Johass such services or supplies are bronched in connection with organitive in an energy proxy.

Origine or Nuclear Beargy, Contridens that result from (1) the member's construction of or alternation control is secured to a superior or an act of demonstrative or all any release of profess renergy, whether or not the modified size, when government tunds are available for the heatman of demonstrative or light matter than the talence of the first enterior of some versions.

Stat Coverad. Services received before the resmonts elective area, Benotes sensited after the member's coverage ends, except as specified as overead to the EOC.

Excess Ampuists. Any amounts in excess of advenue depends or the Helina maximise.

Wars-fill-lated, Veols satisfied conditions if benefits are renovated or on the renovated, either by adjudication, satisfoream or attended, under any workers' compensation, employed's Bahilla lave on compensational decrease law whether or not large named of their base conditions. If there is a disposit of sessional absence is a whether benefits may be exceived for those conditions planered to weather's employed state, we will provide the benefits of this plan for such conditions, subject to a right of representation, we will provide the benefits of this plan for such conditions, subject to a right of representation and relief collections.

Covernment Treatment. Any certicos los member actually received that were mediant by n local, state or tederal government agency, excupt when neumant value this riscus segmently required by federal or state law. We will not cover payment on these services it the member is not required to pay for item or they are given to the member for kets.

Semines of Petatives: Evolusional services randomis from a person living in the member to have provide a related to the marriag by blood or radings, secure on specified as arrested to the ECC.

Vehicutary Payasant Borvinus for telich the member has no toget ordination to pay, or for efficience change sound for medical to the absence of issurance reverses or other hands real coverage, except converses sensitived at a non-preventional chardsole research troubled form a troubled must med the following gradulines:

- If must be internationally known as being devoted mainly to medical research?
- a) report 10% of its yearly hadget must be agont on research not directly related to redison core.
- at least one table of its grees income must come from devalons or grants other than gifts or pattness for patient com;
- 4. It must accept pullants who are mobile to pay; and
- 5. Two thirds of its patients must have providions directly related in the hespital consequent.

Net Specifically Listed, Services not specifically listed in the plan or covered services.

Private Centroots, Sentroes or supplies provided paravant to a private control balance the mander and a provider, for which reinforcement under Madician program is problemal, as specified in Section 1909 (47 U.S.C. 1095a) of Title XVIII of the Social Control Au.

japoners Dagnestic Tesis, lapatent mem and brand charges in connection with a hot pital stay primarily for dispurped tests which could have been performed safety on an outputioni basis

Stantat en Marceure Olssartiers. Academie er Educational tasting, counseting, dat controllation. Microtal er decreus discreters as substance alasse, including returbilitative com in microtal in Preseconditions, except as specified as opvisant in the ECC.

Orthodostra, Graces, other enhadostic application or tethodostic services

Dental Services or Supplies. Dental places, pridiges, arrains, care or what dental provinces, dental suppride, dental equipos, ordinación of leath, tradement to the teath or game, or havincest to at parties parties of the temporomentifosiar ((see) joids, except as specifical as servared in the ECC Cosneste dental corpor or other dental convers to be additionation.

### Healing Aids or Tests

Optomardo Sarvices or Supplies. Colometria cervices, eyo exercises indiadeg critiaplics. Rauline eyo except and rauline eye refeations, as upocliced as covered in the EOC Ecoposass or contest leases, errept as specified as covered in the EOC.

Outpeffeet Occupational Therapy, Outpefeet compatinal therapy, outpet by a formativable against, incaping, or huma infession therapy provides, as specified as covered in the EOC.

Outpeffeet Speech Tearapy, Outpetient speech therapy, except an openified as covered in the EOC.

Coparette Surgery. Cosmetic stopery or other sorvers performed sorby for beautification of to other or restrope normal (recisions grad) structures or factors of the body to improve appearance. This enclarace does not apply to reconstructive surgery (that is, surgery performed to correct deformities observed by congester or determination). Since no highly for the performance management as a linear or highly for the performance improving body for the performance of improving body body or surgery surgery does not highly surgery generated in rection assumetry following tradections. Cosmeto surgery does not be over reconstructive surgery surgery does not be over-reconstructive surgery because of psychological or psychiatric resource.

Cogning relative Weight Loss Programs, Weight loss programs, whether to not they are pursued under made of a physician separation, unless constativy losed as covered in his plan.

This proposition limitation, but a multimated to communitation scalable long programs (Walgille Walgillens, Jamey Craig, the Weight Last) and lastical programs

This exchance during his apply to markeally recentively confirmed the months assembly at declary subjuggers and counteding, and highestical modification programs for the Besteront of somethin neurons or believes removed. Surgical treatment for modified obesity is covered as described to the Covering (COC).

Stariboudion Reservat.

inforflitty Treatment. Any sevenes or pupping transfert in connection with the dispersion and bendment of opension, and and income of the pupping the dispersion and income of the dispersion and a process of the dispersion of the

durringate Madriet Services. For any acrylices of septilies provided to a partite not beyend under the prop in connection with a europain programmy (including, but not limited to. the breaking of a child by greather without for an infertile counte)

Orthogodic stones and abuse insents. This protudion fone not apply to orthopodic indexes used as an integral part of a brace, stone manns first are pessent mobiled to the potent, or therepositio shows and insents designed to treat that complications due to distribute, as specifically stated in the E.O.C.

Air Conditioners. Air puritors, eix conditioners to hamidiliers,

Costandad Censia: Read Cures, impolised room and board charges in nonhection with a hostnist step primarily so encorpromotist change or physical ibarropy. Services provided by a rest botter, a home for the sped, a running home or any sindler lamily. Services provided by a sidded moting facility or costatist care or rest cures, coordinates provided as provided by the IEEE.

Health Club Memberskipe, Health sich membershipe, exempe endigment, dierges from a physica (larese instructor or personal trainer, or any other dierges for solvalies, equipation or facilities used for developing or maintaining physical faceur, over it ordered by a physiologic flore side registed to health speci.

Parabasi kema. Any supplies for comfort, hygione or brandfrollon.

Education or Counceding, Educational versions or natificate connecting accept as scraffed as covered in the ECC. This exclusion trees not apply to counceling for the hardworld of acceptable garvess or helicide councils.

Fond or Olatery Depotements. Nuntional antibor dialogy superments, named he provided in the plan or as regular by taw. This association industria, but is not limited to, those oblitional foreigns and dialogy supplements that can be purchased over the counter, which by taw to not resolvented without a written prescription or dispensing by a leasesed pharmacist.

Telephone and Facebulle Machine Consultations, Connections provided by telephone to localistic machine.

Plainting Essaye or Seefs. Recine physical examp or both which on oul disodly treat or active Boses, legans or condition, including those required by employment or presentment authority, accord as apacitized as nowered in the ECCO.

Appropriation, Appropriate treatment, except as appoided as previous in the EOC Approximator or resource to endful year, beat fibres or promote beath by applying pressure to end a more specific array of the hody based on democrates or explosions points.

Eye Busgary for Remarkine Defects. Any ago surgery solery or principly for the purpose of correcting reflective defects of the eye such as near-lightedness (regarde) and/or entermisms. Contact lenses and avaginates required as a result of his suspery.

Physical Therapy or Physical Medicina, Cardocs of a physician for physical flavour or physical medicina, succept when provided during a severed medicini confinement or as specified as lowered as the SOCO.

Compatient Prescription Drugs and Bestications, Colpodent procription drups or mediantions and lessely, except as opacitied as covered in the 9000 Any one prescription, over the counted potential by proceeding drug or mediates. Committee, health or feeding sits

Specially Pharmacy Orage, Specially pharmacy drugs that studies obtained from the specially pharmacy grayron, but, which are obtained from a reliad pharmacy, see and covered by the plant. Specially phormacy are and covered by the plant. Specially phormacy drugs obtained from a reliable pharmacy that should have been obtained from the executivy pharmacy program.

Contraceptive Devices, Contraceptive devices prescribed for high control recept as epoched as covered in the ECC.

Otabadia diaggatea. Peacopipion and non-prescription diabado supplies amost es specified as consered in the ECCC

Philuste Duty Marking, impolem or adipolant territors of a private duty match

Orleanyle Programs. Programs to otter one's literate which may include but use and brilliad to disc. arencies, knogany or natrition. The exercision will act snally to cardiac rehabilitation programs approved by its.

Wes.

Third Party Lladifity — Anthem Blue Grass is artifed in remiscrosinent of benefits yard if the member recurren usmapus kom a lapully dable litted purly

Coordination of Senetice — The benefits of the plan may be reduced if the member him two other group health or remaind coverage on that the seneces received from all group coverages to not exceed 107% of the coverages appropriate.

Anthers Situs Cross is the hade neate of Situs Cross of California, independent Linensia, of the Situs Cross Association is ANTHIBM is a registered transment of Anthers Instruments Companies, Inc. You Situs Cross name and symbol are registered marks of the Situs Cross Association.

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# 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.

Guestions 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 1~806-444-3272 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 nonfoderal governmental plans, you may also contact the U.S. Department of Health and Human Services at www.healthreform.cov.

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 those 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/	\$1,000/member; \$2,000/family		
Deductible for non-Anthem Blue Cross PPO hospital or residential treatment center	None	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 (walved if admi	ltted 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-covere member remains responsible for non-PPO providers & other health		.20,000/family/year s the out-of-pocket maximum, the		
ifetime Maximum	Unlimited			
Sovered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay <sup>1</sup>		
Hospital Medical Services (subject to utilization review for inpatient services; waived for emergency artmissions)  Semi-private room, meals & special diets, & anciliary services  Outpatient medical care, surgical services & supplies (hospital care other than emergency room care)	\$1,000/year2 + 20% 20%	50% (benefit limited to \$600/day) 50% (benefit limited to \$600/day)		
Ambulatory Surgical Centers - Outpatient surgery, services & supplies	\$250/surgary + 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%		

Bereavement services

Hespice Care (subject to utilization review)

inpatient or outpatient services; for members

with up to one year life expectancy, family

anihem gomica — Anihem Bille Cross (PHR) — Ellicdivis 91/2017 - Punikid 13/4018

No copay

The percentage capey for non-entergency pervices from non-Artisem Blue Class PPG providers is based on the scheduled amount

<sup>&</sup>lt;sup>2</sup> Applicable to the Annuel Critici-Freeker maximums

Covered Services	PPO: Per Member Copay	Ron-PPO: Per Member Copsy <sup>1</sup>
Home Health Cere (subject to utilization review)		
Services & supplies from a home health agency (limited to 100 prior authorized visito/celendar year, one violt by a home health side 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, and liary 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" (deductible waized)	50% -
Hospital & skilled nursing facility visits	20%	90%
<ul> <li>Surgeon &amp; surgical assistant; ansatrealologist or anasthetist</li> </ul>	20%	86%
Caugs administered by a medical provider (certain drugs are subject to utilization review)	<u> </u>	5 <b>0%</b> 
Gragnostic X-ray & Lab		
MRI, CT scan, PET scan & nuclear cardiac scan (subject to utilization review)	20%	50%
🚧 – Other diagnostic x-ray å lab	Не сераў	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, insalth education, intervention services, HIV testing), and additional preventive care for women provided for in the guidalines 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 walved)	80%
Physical Therspy, Physical Medicine & Occupational	\$25/vialt	50%
Thérapy	(daductible waised)	
Chiropraetic Servicas (up to 1); visitisicalender year; additional visits may be approved, if medionity necessary)	\$25(visit (dedaclible walved)	50%
Speech Therapy		··
<ul> <li>Outpatient speech therapy following injury or organic disease</li> </ul>	\$45/visit (deductible waived)	50%
Acupuncture		
Sarvices for the treatment of disease, litness or injury (limited to 20 visits/calendar year)	20%2	56%3
Femperomandibular Joint Disorders		
<ul> <li>Splint liverapy &amp; surgical treatment</li> </ul>	20%	50%
Pregnancy & Meternity Care		
≽ Physician office visits	\$46/visii <sup>o</sup> (deduciible walved)	\$9% -
<ul> <li>Prescription drug for elective abortion (milepristone)</li> <li>Normal delivery, cesarean section, complications of pregnancy</li> <li>abortion</li> </ul>	20%	Not covered
<ul> <li>impatient physician services</li> </ul>	26%	60%
> Hospital & abolitary services	\$1,0000/year* + 20%	50% (henefit limited to \$600/day)
<ul> <li>Female Stadilization (including tubal ligation and councelling/consultation</li> </ul>	) No coinsi	féot covered
Male Starilization	20%	Not Covered
<ul> <li>Family planning counseling</li> </ul>	\$45/visit (deductible walved)	Not covered

The percensings capity for non-entimently activities from non-Artholm Blan Circle FFO proviews is based on the scheduled smolent.

The only energing only to the shallest. An additional light congruption for any survival performed in office (i.e., Array, too, surgers), often they production destructions.

Paramanare remands can be performed by a pertilled supported if (C.A.) is dissist in redictive (A.D.), a doctor or esteography (O.O.), a codistriat (D.P.M.) is a decision (O.O.S.).

 $<sup>^3</sup>$  Applicable to the Armosi Con-940 action reprimtions

Cov	ered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay <sup>1</sup>
S08	gan & Tissue Transplants (subject to utilization review; offied organ transplants covered only when performed ( Center of Expertise (COE))		
\$	Inpollent services provided in connection with non-investigative organ or its sue transplants	\$1,000	Vyear <sup>2</sup> + 20%
×	Transplant travel expense for an authorized, specified transplant at a COE (recipient & companion transportation limited to fi trips/episode & \$250/person/trip for round-trip coech airfare, hotel limited to 1 mom deuble occupancy & \$100/day for 21 days/trip, other expenses limited to \$25/lay/person for 21 days/trip, donor transportation limited to \$1 hipsyloode & \$250 for round-trip coach sirfare, hotel limited to \$100/day for 7 days, ether expenses limited to \$25/day for 7 days, ether expenses limited to \$25/day for 7 days.	Νο σος	cay (deductible waived)
nece	atric Surgary (subject to utilization raview, medically assery surgery for weight loss, only for morbid obesity, ared only when performed at a Center of Expertise Eff		
×	Impalient services provided in connection with medically necessary surgery for weight loss, only for morbid obesity	\$1,000	Nyear³ + 20%
<b>&gt;</b>	Barlatric travel expense when member's home is 50 miles or more from the nestiest Barlatric 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 nor member's initial surgery stay for 4 days; other reasonable expenses imited to \$25/day/person for 4 days/trip)	No co	pay (deductible waived)
Diat	setes Education Programs (requires physician supervision)		
ጅ	Teach members & their families about the disease process, the daily management of diabetic therapy & self-management training	\$45/visit (deductible weived)	50%
pros	sthetic 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%
Dur	able 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-net	50% work)	50%
Rei	ated Outpatient Medical Services & Supplies		
×	Ground or air ambulance transportation, services & disposable supplies	20%²	
jie .	Blood transfusions, blood processing & the cost of unreplaced blood & blood products	20%2	
خخ	Autologous blood (self-donated blood vollection, testing, processing & storage for planned surgery)	20%²	

resing, processing 6 aronage for partners surgerly.

The percentage copay for non-emergency services from non-Anthem Size Cross PPD providers is heard on the scheduled amount.

<sup>&</sup>lt;sup>9</sup> There providers are not represented in the Anthem Blue Cross PFO network.

<sup>&</sup>lt;sup>3</sup> Applicable to the Annual Cut-of-Pocket maximum

Co	vered Services	PPO: Per Member Copsy	Ros-FPO: Per Member Copay <sup>t</sup>
ã:	ergency Care		···
Ż.	Émergency mom services & supplies (\$100 deductible weived if edmitted)	20%	20%
ç s	Inpatient hospital services & supplies	\$1,000/year? + 20%	20%
<b>)</b>	Physician services	20%	20%
	ntal or Nervous Disorders and Substance Abuse atient Care		
Ø.	Facility-based care (autient to utilization review) waived for emergency admissions)	\$1,000/year* + 20%	50% (benafit limited to \$800/day)
<b>%</b>	Inpatient (hysician visits	26%	50%
્ર	toatient Care		
>	Facility-hased care (autiest to utilization review; waived for emergency admissions)	20%	50% (benefit limited to \$600/day)
<b>)</b>	Cutpatient physicien visits  Denoviver Hould treatment for Autism & Pervasive Disorder will be subject to pre-service ravism)	\$45/visit? (dadustitie malved)	50%

<sup>1</sup> The percentage copay for non-emergency services from non-Anthem Stue Cross PPC providers is based on the scheduled amount.

This Summary of Sanefits 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.

<sup>&</sup>lt;sup>2</sup> The dollar copy spokes only to the visit itself, An additional 20% copy applies for any services performed in office (i.e., X-ray, lab, surgery), after any applicable derivation.

<sup>3</sup> Applicable to the Annual Out-of Fucket maximums

### Classic PPO Plan Exclusions and Limitations

But Bedinally Recussory, Services in supplies that amount medically rectainally, in defined, for personal and medically rectainable, in defined, for personal and bedind something to the services of the defined something to the services of the defined something services and the defined services of the definition of the defi

Ordeine the builted States, Conduct or supplies formated and billed by a provider builded the California such services or supplies are hardshed in barnealism with bigoth case or an employer.

Crims or Newton Energy. Conditions had result from (1) the member's commission of or alternative countries in the product of the product of the second of the product of th

Mod Covered. Ecology received before the manifests effective data. Sortium technical who the member's coverege ends, sweet as specified as sovered in the CCC

Excluse Augustia. Any omainte in access of covered expense as any finalists Benefit Mainthin.
Waste-Related, White-related conditions if benefits are recovered or can be recovered, either by expediation, neighborides, and to be under any weather of compensation, employer's bability last or compensation denotes law, whether in not the member of these boxeds, if there is a distribute of entelligible energiately as to whether benefits may be reserved for those conditions for small to weather properties on a red includes the benefits of this plan for such conditions, while it is a regist of increasing and relative sention and Collegia bases Code Section 4001, as a recovered on the time to the ECC.

Concernment, if restricted, they beneath the mornist onlinely received that were provided by a recel, state or tederal generalism is parcy, sweep when payment under this plan is expressly semplied by faderal or state law. We sail not cover payment for thuse concern if the member is not required for thuse otherwise if the member is not required for thuse.

Services of Referinge, Proteodinal service received from a person height in the member of trace previor is related to the member by blood or memage, except as sportled as povered to the EOC.

Veteratory Peymeer, Services for which the member has an legal obligation to pay, or for which no charge would be made in the absence of insurance coverage or other finish, plats coverage, except services secrived at a non-governmental chartlable research busplint. Such a tetapital must meet the following goldsofrees:

- If must be interredicably known as being devoted mainly to medical research;
- si resp: 10% of it, yearly hydger must be spent on renearch act brently related to patient care;
- a) report one dailed of its grass income must come from densitions or gradit other than gifts or payments for patient date.
- 4. It must except policitis who are unable to pury and
- 3. I avoid thinks of the pastorale must have considered describy retained to the hospital's retains in

Wat Specifically Listed. Services not specifically listed in the pion as covered cervices.

Private Contracts. Services of supplies provided pursuant to a privace contract between the regiment and a provider, to which reinforcement ander Madiciare program is probletion as operation to decide in Section 1962 (42.0 S.C. 1986s) of Tide XVIII of the Social Section Ad.

Segethers they are the Toete. Republication on a board attend to connection with a heapite stay paintedly to diagnostic tests where could have been performed asiety on an authorise tests where could have been performed asiety on an authorise those.

Stempt or Manyous Disenders, Appdymic or advicational tedang, populasting, and remadulitationally experience disorders or substance observ, including rehabilities care in relation to these containers, according as specified as covered in the EOC.

Oktubilistika Braces, other orbitolopide applicaces or officialistic services

Beasist Services or Supplies. Dealst plate: Pastyrs, cream, caption other densit prostheses, dealst imprants, contail services, extraction of both, resistant to the resist or grants, or breakness to or sor any disentance has been promonocious (law) jobs, except as specified se novered in the SOC. Cosmella period surgery or other center services on the authorising.

### Bearing Ards or Feets.

Optionatair, Sensions en Eugatina. Optionation somices, ave associates including urbimplica. Routine sun source and recitine eye referations, on appetitied as covered in the EDC. Eyeglassics of context leases, covere as specified as covered in the EDC.

Competion: Occupational Therapy. Compotent occupational therapy, extent by a bond finalliting and, baseline, or home introduction discrete provides, as spended as concernd in the ECC. Despation Spends Therapy, Cospation, spends therapy, except as spended as covered in the ECC.

Cosmistic Surgery. Cosmicia surgery or other services performed subtly for besulfication at to after a resource normal final ding ages) should not insure, of the body to improve appointment. This profused does not again to reconstruction surgery that is, surgery performed to turned, determinists caused by congestial or developmental abnormalities, niness, or injury for the proposal distance to build fundancy or symptomissions or is amain a normal appointment, including surgery performed to extrem through obtaining medications. Cosmistic turnery does not become expressional surgery because of profundacion or nayothing medication.

Commercial Weight unas Programs. Weight lost programs, whether is not they are positived under medical or physician oppowished, under medical or physician oppowished, under specifically listed as covered in this plan.

Take exclusion includes that is not landed to, communicial weight feat, programs (Weight Weighten), Jenny Greig, LA Weight Laust and testing programs

This washesion does not apply to marketaly accessory beatments for metale about or decorp systemicus and counseling, and behavioral anotification programs for the beatment of atmost nervose or building nemocal Burgiosi Iraniment to market observy is concern as described in the Evidence of Construct (COC) Steritication forversal

subgrettiny freedigment. Any socialises or oxygenos ourn steed in nonner tion light this disign, this and Seeggesen or industrially, including, but not brokked on discreption resist, medication, sergetse, artificial Instantination, in wine londination, cientination reviewed and permits introduction in another

Eurroguse Sorters Bervices. For any services or supplies provided to a parson not converted Uniter the preson not converted Uniter the preson to connection with a correspois preparancy (including, test for Soviet to, the bearing of a collection or supplied by cooling woman for an interface country.

Orthographic attends and above inserts. This secriticism does not aduly at orthographic footbeard medias on trianguely part of a brace, orthographic final precipitation and footbeard or the political or the political or the properties of the secretary and timeds designed to the designed to the trianguely or the designed to the designed to the trianguely or the designed to the des

Mr Conditioners: Air publiers, oir norddioners or humbilliers.

Created at a Care or Rest Curren, inquited room and board changes in contention with a hospital stay primarity in any consolid change or physical than process consisted by a rest from a a house for the agent, a not stag home or very similar tentile. Denotine provided by a skilled harding facility or costation one or met notes, except as an added as covered in the ECC.

Health Club Mambersines, Health ulph residensines, contribu equipment, charges from a physicist fileson (entropic or personal toles), or one other charges for activities, equipment or localides must for developing or materiary physics fileses, even if referred by a physicish. This explaints also applies to health space.

Paravaux tems. Any supplies for conduct by dens or beautification.

Education or Dougseting, Educations services or mailtand consecting, extract as specified or covered in the EOC. This exclusion that soft apply to covereding for the having of the covered normal or builties nervose.

Shaud or Elektury Suppliements, his richand within dialony outpikenomis, exiteff as provided in first year or as required by tase. This explosion hammas, had in not limited to, those achilland formalist and dialony supplements that own be northwest over the parameter, which by law do not requirement either a written prescription or dispensing by a licensed phoromolisi.

Talophysia and Farsimila Section Consultations, Consultations provided by totalises or facilities provided by totalises

Bauting Swerns or Yests. Routing physical expens or book which do but fittedly itself on activit tiopses, layary or condition, including those majored by employment or povernment authority. except as openited to obvered in tim 5 OC.

Acceptantitore, Acceptantive treatment, escapi as specified as overted in the EOC. Acceptassing or massage to operationally lead timess or protecte hadden by applying products to one of mass appetite apape of the body based on democratics or posturoleus politic.

Eye Surgary for Behactive Defects, Any eye surgery tolely of primarily for the portrose of correcting rehactive defects of the eye such as neareightedeass (myopia) andm collapsellers. Content tempers and cycyfectors required on a result of this surgery.

Physical Therapy or Physical Residence. Boolets of a physical for physical thingey draftips of a physical foreign or physical thingey draftips of a covered in patient confinement or an expensive account of the ECC.

Compaginal Prosperiation Drugs and Idealizations, Colordent prescription drugs of medications and incube, except be specified as covered in the EOC, Any memprescription, one deviation patent or proprieting drug or medicins. Correctors, health or Beauty titles.

Shortally Pharmany Drugs, Specially pharmany drugs that must be obtained from the openaty pharmany program, but, which are colabled from a raisil pharmany, are not created by this plan deprivate will have by pay the full cost of the appositify pharmany drugs obtained from a main pharmany that should have been extremed from the specially pharmany program.

Commanageriae Desireus. Commenspére devices prescribed in Print control exempl às statified as covared in Pre ECC.

Obstacle Byggelee, Prescription and one prescription diabelic surgides extent at specified or covered in the EOC.

Private Daily Burning, Ingolical or outpotent services of a frevalle duty races.

Cificatyle Progresses. Pergesses to alter medis blasiple which may include bulliare not broken to diel, accernise, incagary or addition. This exclusion will not apply to continu rehitoblished progresse approved by us

Wigs.

Thing Parly Mahility — Antierm Store Crose is entitled to reinformement of benefit) part if the memory representationages from a tegraly bable than party.

Consideration of Densities — The band is of this plan may be recluded if the married has any other group speakings deaded commany to also the cereboas received from all group coverages do not exceed 100% of the covered expense.

Authory Blue Cross Is the trade name of Blue Cross of Colfornia, Independent Lisensee of the Blue Cross Association, & ARTHEM is a registered trademark of Authori Insurance Companies, Inc., the Blue Cross name and symbol are registered trades of the Blue Cross Association.

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# 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 stready in effect when that lisw 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.rtol.goviebsa/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.hgalthreform.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 Italias. Benefits are subject to all terms, conditions, limitations, and exclusions of the Policy.

### Explanation of Maximum Allowed Amount

Maximum Allowed Amount is the total relimbursement 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 consurance. 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)-Relmbursement 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, relimbursement may be based on 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
- 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)

\$2,500/individual insured person \$5,000/indured family

yo,oocaaaaa aaaaa

### Deductible for hospital if utilization review not obtained

Annual Out-of-Rocket Maximums (in-networknot-of-lietwork out-of-packet maximums are exclusive of each other, includes calendar year dedictible & prescription drug covered expense) \$250 admission (waived for emergency admission)

\$5,000/individual insured person; \$10,000/insured

 For all Providers & Other Health Care Providers & all Participating Pharmacies

familylywai

The following to 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 finduces insured employee & one or more members of the employee & family) reaches the out-of-pocket insulation for all insufacilities and prescription drug covered expense the individual insured person or insured family will no temper be inquired to pay a compy for the remainder of that year. The individual insured person or insured family remains required for costs in excess of the covered expense when provided by non-perticipating providers and other health care providers; non-covered expense.

Lifetime Maximum

Untimited

.04	rered Services	Traditional Health Coverage		
		Insured Person In-Network	Copay Cut-of-Network (Insured is also responsible for charges in excess of covered expense.)	
10 ( 07 )	spital Medical Services (subject is univertan essara impullent services; wered for emergeracy admirpions)			
æ	Sami-private room, meals & special diets, & annillary services	10%	50% up to \$580 plan payment per day	
خز	Outpatient medical care, surgical services & supplies (hospital care other than emergency room care)	10%	50% (benefit limited to \$350/day)	
33	bulatory Surgical Centers			
lio.	Outpatient surgery, services & supplies	10%	50% (beneilt limited to \$350/day)	
×:	ited Nursing Facility (cubject to utilization review)			
È.	Semi-private room, services & supplies (Imited to 100 days/calender year)	10%	10%	
10: 37	spice Care (cubject to utilization review) 0,000 combined maximum per member per lifetime)			
<u>}-</u>	inpatient or outpatient services for insured persons with up to one year life expectancy; family bereevement services	10%	10%	
10:	me Health Care (subject to utilization review)			
À	Services & supplies from a home health eigenry (limited to 100 visits/calendar year, one visit by a frome health side aquate four hours or less; not povered while insured person receives hospice cere)	10%	10%	
{Q	me Infusion Therapy			
٠٠٠	Includes medication, ancillary services & supplies, caregiver training & visits by provider to monitor therapy; durable medical equipment, lab services	10%	10%	
3	ysician Medical Services		NONENHANDARIA (NECENTRALIA (NECENTRALIA (NECENTRALIA (NECENTRALIA (NECENTRALIA (NECENTRALIA (NECENTRALIA (NECE	
خ	Office & borne visits	10%	50%	
ù.	Hospital & skilled nursing facility visits	10%	#0%	
	Surgeon & surgical assistant; anesthesiologist or anesthetist	10%	80%	
è	Drugs administered by a medical provider	10%	50%	
	(vertain drugs are subject to utilization review)			
Жa	ignostic X-ray & Lab			
-	MRI, CT scan. PET scan & nuclear cardiac scan (subject to utilization review)	10%	50%	
	Other diagnostic x-ray & lab	10%	50%	
e,	eventive Care Services eventive Care Services including*, physical exams, preventive eerings (including acreenings for cancer, HPV, diabetes, cholesterol.			
blo Hill Re Me	od pressure, hearing and vision immunizations, health editication, prvention services, FIV testing), and additional preventive care women provided for in the guidelines supported by the Health sources and Services Administration as list is not exheustive. This benefit includes all Preventive Care rvices required by federal and state law.	No copay (deductible waived)	50%	
At The	ysical Therapy, Physical Medicine & Occupational erapy, including Chiropractic Services ated to 12 estionateado: year, additional visits y ha approved: If medically recessivity)	10%	50%	
Sρ	eech Therapy			
	Outpetient speech therapy following injury or organic disease	10%	50%	

Covered Services		Traditional Health Coverage insured Ferson Copay		
		inst In-Network	Ou (In for	y t-of-Network sured is also responsible charges in excess of vered expense.)
۱c:	donucinie			
خخ 	Services for the treatment of disease, ithness or injury (limited to 20 visits/calendar yeer)	10%1	50	%1
81	nporomandibular Joint Disorders			
¥۶	Splint therapy & surgical treatment	10%	50'	%
348	gnancy & Maternity Care			
<b>&gt;</b>	Physician office visits	10%	50'	%
ķîr	Prescription drug for elective abortion (milepristane)	10%	50	%
	rmal delivery, desarean section, compilications of pregnancy bortion			
io	Inpatient physician services	10%	501	Ve
<b>≫</b>	Hospital & ancillary services	10%	60' (be	% enefit limited to \$580/day)
313	gan & Tissue Transplants (subject to utilization review; wified organ transplants covered only when performed a Center of Expertise (COE))			
ji.	Inpatient services provided in connection with non-investigative organ or tissue transplants		10%	
<i>ي</i> ند	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 einfere hotel limited to 1 round double occupency & \$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 sinfere, hotel limited to \$100/day for 7 days, other expenses limited to \$25/day for 7 days)		No сорау	
JÐ.	riatric Surgery (subject to utilization review; medically sessery surgery for weight loss, only for morbid obesity, sered only when performed at a Center of Expertise (COE)			
خنز	Inpatient services provided in connection with medically necessary surgery for weight loss, only for morbid obesity		10%	
<i>&gt;</i>	Baristric travel expense when insured person's home is 50 miles or more from the nearest baristric COE (insured person's trensportation to & from COE limited to \$130/person/trip for S 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 finitial surgery & one follow-up visit); hotel for insured person & one companion limited to one room double occupancy & \$100/day for 2 days/frip, 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	
Dla	ebetes Education Programs (requires physicien supervision)			
`}~	Teach insured persons & their families about the disease process, the daily management of diabelic therapy & self-management training	10%	50	%

<sup>\*</sup>Acopurations services can be performed by a certified anoparchimit (C.A.), a doctor of medicine (M.D.), a doctor of detempariny (D.O.), in podiatrist (D.P.M.), or a dentiar (D.D.S.)

Cov	vered Services	Traditional Hoal Insured Fe- in-Network	In Coverage mon Copay Out-of-Midwork (Insured is also responsible for charges in excess of ouveraid expense.)
F 50	sthetic Devices		
<b>&gt;&gt;</b>	Coverage for breast prosilieses; prosthetic devices to restore a method of speaking; surgical implants; artificial limbs or eyes; the first pair of contact tenses or eyeglasses when required as a result of eye surgery; wigs for slopeda resulting from champine rapy or radiation therapy; & lineappeutic shoes & inserts for insured persons with diabetes.	16%	10%
Due	rable Medical Equipment		
ana bro pro	ital or purchase of DME including ysis equipment & supplies, home medical equipment, stretice/orinolics (hearing aids benefit dable for one hearing aid per ear every three years; breast pump t supplies are covered under preventive care et no change for in-richwolk) ated Outpetient Medical Services & Supplies	10%	10%
)»	Ground or all ambelance transportation, services & disposable supplies	10%	Ş)
خيز	Block transfusions, blood processing & the cost of unreplaced blood & blood products	10%	5:
<i>}</i> ~	Autologous blood (self-donsted blood collection, feeting, processing & storage for planned surgery)	10%	5 <sup>4</sup>
	ergency Care	ز به ده د	cox:
70	Emergency room services & supplies	10%	10%
<u>\$</u> -	inpetient hospital services & supplies	10%	10%
خار	Physician services	10%	10%
Me	ntal or Nervous Disorders and Substance Abuse		
,	atient Care		cost
<u>}</u> \	Facility-based care (subject to offication review; walved for emergency admissions)	10%,	50% (benefit limited to \$580/day)
>	inpatient physician visits	10%	58%
	tpatient Care		<b></b>
ఘ	Facility-based care (subject to utilization review; walved for emergency admissions)	10%	50% (beneilt lenited to \$350/day)
ji.	Campatient physician vialts (Biolegizzal Health treatment for Autism & Pervesive Discular will be subject to pre-service review)	10%	50%

Covered Services	Traditional Health Coverage			
(For Outpatient Prescription Drugs)	Per insured Person Copay for Each Prescription or Refill			
Outpatient Prescription Drug Benefits				

(Lintil the calendar year deductible is satisfied, the insured person pays the proceeding drug maximum already amount and not the consus listed below.

	the prescription drug , maximum allowed amount and not the copays listed below.)				
3	Retail Pharmacy				
2	Preventive immunizations administered by a retail pharmacy -	No copay (deductible waived)			
3	Female oral contraceptives generic and single source brand	No copay (deductible walved)			
٦	Generic drugs	\$7			
X	Brend name formulary drugs1.2	\$25			
≫	Self-administered injectable drugs, except insulin	\$25			
ΝÌ	me Delivery				
ž.	Female oral contraceptives generic and single source brand	No copay			
هزز	Generic drugs	\$14			
خنز	Brand name formulary drugs1.2	\$\$G			
Þ	Self-administered injectable drugs, except insulin	\$25			
	scialty pharmacy drugs sy only be obtained through the specialty pharmacy program)				
*	Generic drugs	<b>\$</b> 7			
شر	Brand name formulary drugs <sup>t</sup>	\$25			
X.	Self-administered injectable drugs, except insulin	\$25			
Nen-participating Pharmacies (compound drugs & specially pharmacy drugs not covered at retail participaling pharmacies)		Instrict person pays the above retail plantiacy copiny plus: 30% of the remaining prescription drug maximum allowed amount & casts in excess of the maximum amount allowed			
Su	pply Limits <sup>3</sup>				
<u>پ</u>	Retail Pharmacy (participating and non-participating)	30-day supply, 60-day supply for federally classified Schedule II attantion deficil disorder drugs that require a triplicate proscription form, but require a double copay, 6 habats or units/30-day period for impotence and/or secural dystunction drugs (available ordy at minit phormacles)			
<i>&gt;</i> -	Home Delivery	90-day supply			
- XV	Specialty Pharmacy	30-day supply			

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 regulated rate for the generic drug and the brand name drug, but not more than 60% 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.

### 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 phenyiketonuria.
- > insulii
- 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-administrated by the suscutaneous route (under the skin) by the patient or insured person. Drugs that have Food and Drug Administration (FDA) tabisling 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.

When the member's physician has specified "dispense as written" (DAW) for fermulary brand drugs, the copey 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 copsy plus the difference in not between the drug negotiated rate for the generic drug and the brand name fermulary 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 Stue Cross Life and Health Insurance Company.

Supply limits for carrain deeps may be different. Prease refer to the Certificate of Insurance for complete Information

### Lumenos HSA Plan — Exclusions and Limitations

Sumplify are not sponded for expenses the area for as in connection with the following items.

Hat Washbady Maxassary. Services at supplies that we are rangingly amortally in probability.

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signet liktly from the any Druge. Specially taken dry brook the choice be obtained from the apaciently pleasenably program, but, when the classical from a recall pleasenably, and collections by this planinger risk persons will have to pay the first past of the apaciently pharmany druge a broken flease a reput plane proof that which these these obtained from the apaciently pharmany program.

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-Operation Supporters. Proceedings from new personal point distribution supporter executed an operational terromomorphic terrological section.

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Effective Programs Peopress to other one is this type which may include but one but finded to disk exercise imaging a militaric except we operated in powered in the Conflictal Class backdoorwell are pulgly to conflict rebathdrotics; programs approved by us

Charlest Mater. Services and supplies in connection value of facilities, expensive staudiest or connection the Controller

### 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:

trempelzing agenis, biological sera, blood, blood products or blood plasma

Hygnaternet, syringas lister netebos, eastept when disparated for use with inside it liters self-injectable forgy or medicalities

Eugs & medicalions used la induce spontaneaux & non-sportaneous aboritors

Drugs & medications dispensed or administrated in an adjustmen setting, including authorism? hospital (subbos and physicians) offices

Professional charges in connection with administrating, tripology or dispensing drags

Chaps & medicalities that may be obtained without a physician's written prescription, Prompt Insuliaor reading for choosestered leavening and excision over the ununer drops expensional by the Phaemacy and Therepoulies Committee in builholded in the precoription drug familiarly.

Emigs 5 medications dispensed by or white confess in a hospital, skilled natring fieldly. sest name, eshalorium, charefescant haspital of similar labbly

Conside medical agreement, devices, appliances à corples, even il presorbet by a physicien. except contraceptive diaphragms, as specified as devered in the Carlifloxia

Services or supplies for which the insured perconte not charged

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Cosmelice & health or besselv aids.

Orags Edealad "Coutron, Circles by Pederos East in Investigations's Geolf or Mos FOA sportived investigational drags. Any drops or medicodoes prescribed for experimental indications

Any expense for a using or medication incurred in excess of the prescription drug treatment allowed

Exuge values have not been approved for general use by the State of California Department of Plantin Europea, or the Ford and Orang extreme below. This does not apply to though that are medically accessory for a covered condition.

Drugs to strainals or radices dependency on, or edificient to, tobacco and tobacco products. This does not apply to medically recessary drops that the incread necessariant only get with a prescription under state and federal tea-

Drugs used primarily for cosmolic purposes (a.g., Klatin A for wandles). However, this will that apply to the one of the type of drug for medically necessary treatment of a medical associate attack then una tast ta constatio.

Grage used primarily to resoliate dish (auturing, but as) thated to, Clarid, Pergonal and Notrodish, unless medically necessary for another covered condition.

Appropriately and charge used for weight loss, except when used to heat morbid cheefly (e.g., diet pille & appetite suppressunts)

Drugs obtained outside the U.S. unless they are furnished in connection with ingent half or an emercency

Altergy desensitization proposts or altergy corum

introlon drugs, except drugs that are self-administered subsidered with

Hermal supplements, mimilional and distary supplements except to torreduction for the treatment of obenythetonese.

Prescription daugs with a non-prescription (over-the-counter) chamical and data equivalent except insulin. This does not apply if an over-the-counter againstant was trice and was in affective.

Composed medications unless:

- a. There is all least one component in it that is a prescription drug; and
- b. It is oblighted from other then a participating pharmony, to sured person with have to pay the full soci of the sprapound medications if insured person obtains drug at a egn-particlosting pharmacy.

Specially pharmacy drugs that reject be obtained from the specially pharmacy program, but, which are obtained from a retail pharmacy are not covered by this claim from our person will have to pay the full cost of the specialty pharmacy drugs obtained from a retail pharmacy that incured params should have obtained from the specially pharmony program.

Third Party Liability - Aginem Skip Cross life and Health Incorance Company is entitled to relimbursement of benefits paid if the insured person renovers demages from a legally fiable

Coordination of Benefits - the benefits of this gast new be reduced if the insured person has any other group health or denial coverage on that the services renained from all group converges we not exceed 100% of the covered expense.

Learning plans provided by Anthon Clina Cines Life and Haziffs Inducated Company. Antonoughout Reserves of the Blan Cross Association of ARYMOR and LUMENOS are registrated transmitted of Anthom Insurance Congruence, Inc. The thire Cross name with symbol are registered merks of the filts Gross Association.

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### Frequently Asked Questions

## Now do! find a participating network pharmacy?

including all pharmacy chains. You can find a network pharmacy by logging onto You can use your Empility Health II) card at over 68,005 pharmacies nationwide www.emparthealth.com or calling 877-262-7455.

## What is a prior authorization and why is it nevessary?

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 Certain medications require prior authorization (PA) because of their potential side safety if a PA is needed, Empilix Hostith 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 benegits?

Call 877.262-7435 to speak to a representative who can assist you with drug coverage questions or log onto www.empirmeaith.com for detalls.

# How can I find out if generic or lower cost afternatives may be available to ma?

log into the member partal at wava ampirahalith.com and select "Oneg Pricing." Both the brand as well as the generic. You can also call 877-262-7435 to speak to a Search when medication and if there is a generic available, you will see the cost for representative who can assist year, or consult your physician or pharmacist to determine if generic equivalents are available for your presoripiton

## Why does my copay change from month to month?

pharmacy. Hyber copay is based on a percentage rather than a fixed dollar ambum The cost of medications shanges regularly and prices are not all the seme at each then depending on the pharmacy you use and the cost of the medication at the time your prescription is filled, you may see a varietion in your copey amount

connected, and applicable law. All prescons health information is wast singly confidential, as rewind ltes bresinus is ergis genand description el you pass ription banditi program and it is not a contract. As benetics described benefit are subject to the terms, conditions and languages of the group mester by the schools rutes of the Health makenose Portaintly and Associated Risky Ast

Lagas am service marks of Emptifix Health. Searced Scatters, LDS17

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877-262-7435; TDD: 1-888-907-0020 EmpiRx Health Member Services 24 hours a day, 7 days a week

### Your Prescription Benefit Program

### Annual Maximum Gut of Pocket Amount

hour plan includes a \$2,000 individual / \$4,000 remay annual meathrum dut of probat annual

### Retail Phanmacy Copayment

hou are responsible to pay the retail phormacus, the copayment per prescriptum which is leasted below.

	38	Sab do lor a Preferred	Scand Adecident	\$60.00 for a Non-Preferred	Arand Massications
3 X X 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3	\$10.00 for a Generic Medication	\$20.00 for a Preferred	Brand Medication	535,00 for a Non-Preferred	Stroot Medication

This is a Dispense As Varitee Plan (CAVO), meaning your phasmodist must dispense the generic energiest and week and several properties to broad be dispensed. If you request the broad name medication from your phasmasks, you are dispensed. If you request the broad name medication from your phasmasks, you are respansible for the difference in cost becover the brand and the generic plus the capasyment.

Betail quantities will be drippensed actoromy to your physician's instructions willien on the prescionion up to a masment it a 20-revisupply. Presse Rocer II the cost of your needlandon is lers then your calculated argument, you will only pay the cost of the medication.

### Mail Order Pharmacy Copaymont

Manuentara conditations can be submitted to Benetrard Central Fill, the finish's Health mail ander uptifity. Your plan allows for by to a Shiday supply with three (2) refills, according to your physical's instructions. Your copay amount will be.

540.00 to a Preferred Brand Medication 550.00 for a New Preferred Brand Medication
---

### Specially Madication Copagniam.

Sysplatry medications are high-cost brokedmology drugs requiring special distribution, bandled, and administration. These medications are typically designed to treat thronto and administration of the contractions are suppossible designed to treat thronto an expectation of the contractions are contracted as the contraction of the contr

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36		377
- 1	3.0	133
3	130	200
	100	253
2.0	. 99	1.3
24.4	2.5	100
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	70	: 💥 }
	. 60	93
1	1	1.6
0.0	307	1773
	****	183
		200
1.7		(44)
30% (\$106 max) for a Seneric Specialty Medication	30% (5100 max) for a Preferred Brand Specially Medicarich	30% (\$188 m.s.) for a Non-Preferred Brand Specially Medication
33	100	993
	1	2
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12		: ;;;;
5.0	100	\$3 L
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	100	2.5
400	X.,	( C. )
200	100	
100	3.1	2.
	3%	200
* 1.7		1 77 1

Systemity madications can be filled one (1) there as a recent pharmacy. All famors prescriptions must be obtained as Benecard Central Full's specially Pharmacy. Phase note that specially medicatern are inneed to a 30-day supply.

### Online Member Tooks

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 afternatives
- 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.

Regimention is easy! Along with your Empiks Health ID card, you will need basic member information, a phone number and an emali address. Refer to our website periodically for the most repert pharmacy network finder and preferred medication list.





### 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 phirmochitic judgment with regard to a patient's pharmaceutical care. Refer to www.empirxhealth.com for the most recent version of the Preferred Medication list.

### Exciusions

Your prescription program covers most Medically Necessary, Federal legend, State Restricted and Cormpounded Medicaliths 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.

### Retall Pharmacy Metwork

Your Empilix 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 30-day supply of maintenance medications. Your ID card provides all the information your pharmacie: will need to process your prascription through capitality Health. To locate a participating network pharmacy, log onto www.empirchialth.com or call Empilix Health Member Services toil-free at 677-262-7435 (TDD: 1-858-907-0020).

### Mail Order Pharmacy

The Empikx Health mail service pharmacy, Senecard Central Fill, is an option for you to obtain mailntenance medications. Typically, prescriptions filled through mail service include medications used to treat chronic conditions and are written for up to a 95-day supply, plus rafilis, 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 Misil Service Order Form and mail it aliang with your original prescription using the pre-eddressed envelope provided to Benecard Central Fill. You can also have your physician submit your prescription elemnonically to Senecard Central Fill or fax your prescription to 1-888-307-4X340. Be sure that your physician includes the cardioiden name. ID number, shipping address, and patient's date of birth. Only prescriptions faxed from a doctor's office will be accepted via litx.

### fo order refills you have three options:

- Internet: Visit www.empirkhealth.com. If you have not yet registered, alick 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

## Empikx Realth does NOT outomotically refill your prescriptions.

To avoid delays, stways include the appropriate copayment (if applicable) when your order is placed. What MesterCard, Discover, or American Express and debit cards are accepted. You may also pay by check or money order made payable to Benevard 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 Pharmany

isoeclativ phermaceuticals are typically produced through biotechnology, administered by rejection, and/or respire special handing and patient moritoring.

Through the Specialty Pharmacy, you receive personalized attention to help you manage your mentical condition including one consciling with our team of pharmacians and trained medical professionals.

Our clinical team partners with you and your prescribing doctor to ensure you extension?

- How to marringe your condition
- What medications you have been prescribed
- How to take your medication
- What lower cost options may be available
- How to chordinate delivery of your medication
- How to safety handle and store your predication

Shipments will arrive in lincure, temperature controlled packagery (if necessary) and will include everything you will need to take your medication. Five to the sensitive inture of medications, some packages may require a dignature.

### Where Can I Ship kby Medications?

Was offer the convenience you need. Your enableation can be shipped directly for

- Your facing
- \* Your work
- े १००४ केट्स्टार ऑस्ट
- 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 valety as brand name drugs. They also must have the same active hypredients and identical absorption rate within the body as the brand name version. If you wish to take advantage of this savings opportunity, spenif with your physician about the use of generics. You may also consult with your plinystrian about the use of generics. You may also consult with your plinystrian about the use of generics. You may also consult with your plinystrian are drug oppoint that may be evalible to you

### ID Cards

If your ID card is foot, you may print a temporary card unline at www.empirahealth.com. If there is a emergency and you need a prescription Illiad, call Empire Health Member Services toll-free at \$772.243, 7435, (1902-1-888-907-8020), and we will provide your pharmadist with the required information to facilitate propessing the claim.

### Direct Member Reimbursement

If you must pay but of pocker for your medication which is diverted by your plan, submit a filteest. Member Reiniburement Porm, which is available online at wavening characteristic medication, which is available online at wavening characteristic medication dispensed, manufacturer, dosage form, surength, quantity, and date dispensed. Your pharmacks can assist you do not have a detailed recept. Direct reimbursement is based upon your plan benefits and the amount reimfuried may be significantly lower than the vetail place you pind therefore, always by the use a participating network pharmacy and present your ID card to reduce any unnecessary but-of-postent expenses.

### 229275 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-Picket Maximum, you will not pay any more Cost Share for the rest of the Accumulation Period once you have reached the amounts listed below.

	Self-Only Coverage	Family Coverage	Family Coverage	
Amounts Per Accumulation Period	(a Family of one Member)	Each Member in a family of two	Entire Family of two or more Members	
L. 18. 1. 1. 18. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.	\$1.500	ar more Members \$1,500	\$3,000	
iso Dut-of-Pocket Maximum Covins Dawn	i 91,500 i None	Nane	None	
an Deductible rug Deductible	None	None	None	
rofessional Services (Plan Provider office vi	<u> </u>	Yec Pay	***************************************	
lost Primary Care Visits and most Non-Physi	dan Specialist Visits			
lost Physician Specialist Visits				
outine physical maintenance exams, including				
fell-child preventive exams (through age 23)	•	_		
amily planning counseling and consultations cheduled prepatal care exams		•		
outine eye exams with a Pian Optometrist				
irgest care consultations, evaluations, and to				
Nest physical, occupational, and speech then				
tuspatient Services		You Fay		
utpatient surgery and certain other outpath	ent procedures	525 per procedure		
ligray injections (including allergy serum)				
fost germanizations findbuding the vaccine)		The state of the s		
fost X roys and isboratory tests.				
evered individual health education counsell				
lovered health education programs		No charge		
lospitalization Services		You Pay	***************************************	
toom and board, surgery, anesthesia, X-rays,	laboratory tests, and drugs	\$250 per admission		
margancy Haalth Coverage		Уоц Рау		
mergeacy Department visits				
tote: This Cost Share does not apply if you e	e admitted directly to the hospita	il as an impationt for covered Salvici	es (s <mark>ee "</mark> Hospituitation Services	
for legations Cost Share).				
unbulance Services			····	
imbilance Services		550 per trip		
rescription Drug Coverage		You fay		
levered outpatient items in accord with our				
Most generic items at a Plan Pharmacy or t		\$30 for up to a 100-da	ly supply	
Most brand-name items at a Plan Pharmac	y or through our mail-order sarvis	re	. \$20 for up to a 200-day supply	
Most specially items at a Plan Pharmacy	T 	\$20 for up to a 30-day	supply	
		You Pay		
hasble Medical Equipment (BME)	~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	20% Comsurance		
	guidelines	An additional and a section of the s		
IME Items in accord with our DME formular	guidelines			
DME Items in accord with our DME formular Memal Realth Services	, guidelines	You Pay \$250 per admission		
Purable Medical Equipment (DME)  DME items in accord with our DME formular,  Viental Health Services  noalient psychiatric hospitalization.  nuividual outpationt montal health evaluation.		You Pay 	·····	

### Dischasive Form - (continued)

1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -	
Substance Use Discrate: Tresiment	You Pay
Inpatient detadification	
Individual outpatient substance use disorder evaluation and treatment	-825 year what
Scoup autpassers substance use disorder beatment	SS per visit
Borne Meath Services	You key
Home health care (up to 100 visits per Accumulation Period)	
Oğres	You fay
Byagissess or contact lenses every 24 months	Amount in excess of \$150 Allowance
Skilled mussing facility care (up to 300 days per benefit pertod)	No charge
Prosthetic and ortholic devices	
Covered tertificy Services (2004) (2004) (2004) (2004) (2004)	S0% Coinsurance
Hospics care	Pka charge

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Share, out-of-packet meximums, exclusions, or limitations, not 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, disherer testing supplies).

### Disclosure Form

### 229275 SIVIA-COUNTY OF TULARE

### Principal Benefits for

### Kaiser Permanente Deductible HMO Plan (1/1/18-12/31/18)

### Accomulation 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)

Amounts Per Accumulation Period

4160872,34,25009400067 | DEMAN 6200 NOR

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.

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

(constitues)

		a more wiempers :	Menaces		
Plan Out-of-Pocket Maximum	\$3,000	\$3,000	\$6. <b>0</b> 00		
Plan Deductible	\$1,660	\$1,000	\$2,000		
Drug Ceductible	None	None	None		
Professional Services (Plan Provider office visit:	3}	You Pay			
West Primary Care Visits and most Non-Physicia			ctible doesn't apply)		
Most Physician Specialist Visits			\$20 per visit (Plan Deductible deesn't apply)		
Routine physical maintanance exams, including			No charge (Plan Deductible doesn't apply) Ro charge (Plan Deductible doesn't apply) No charge (Plan Deductible doesn't apply)		
Well-child preventive exams (through age 23 mo	*				
Family planning counseling and consultations		-			
Scheduled prenatal care exams			- 1		
Routine sye exams with a Plan Optometrist					
Urgent care consultations, evaluations, and trea					
Most physical, occupational, and speech therap	A	manyaranya 520 per visit after Plan (	Deductible		
Outpatient Services		Y60 P39			
Outpatient surgery and certain other subpatient	: srocedares	20% Coinsurance after i	Han Ceductible		
Allergy injections (including allergy serim)		No charge after Plan De	No charge after Plan Deductible		
Mest immunications (including the vaccine)			20		
Most X-rays and laboratory tests		\$10 per encounter after			
Preventive X-rays, screenings, and laboratory te		No charge (Flan Geductible dossn't apply)			
MRI, most CT, and PET scans		\$50 per procedure after Plan Deductible			
Covered individual health education counseling					
Covered health education programs		No charge (Plan Deduct	No charge (Plan Deductible doesn't apply)		
Haspitalization Services		You Pay			
Room and board, surgery, anesthesia, X-rays, la	bor <mark>atory t</mark> ests, and drugs	20% Colosurance after	Plan Deductible		
Emergency Health Coverage	000000000000000000000000000000000000000	You Pay			
Emergency Department visits			Pian Gaductible		
Note: This Cost Share does not apply if you are:	admitted directly to the bospital	as an inpatient for covered Services	i (see "Haspitalizadan Services" -		
for inpatient Cost Share).		· ·			
Ambulance Services		You Pay			
Antibulance Sarvices	Sittill ner frin after Plan	Control of the Contro			
		**************************************			
Prescription Drug Coverage					
Prescription Osug Coverage Covered gutastient items in accord with our dr					
Prescription Greg Coverage  Covered autpatient items in accord with our dr  Alast generic items at a Fibr Pharmacy	ug formulary guidelines:	You Pay	upply (Plan Deductible doesn't		
Covered autoation: Items in accord with our dri	ug fortendary guidelines:	You Pay  \$10 for up to a 30-day s apply)	supply (Plan Deductible doesn't supply (Plan Deductible doesn't		
Covered autoatient items in accord with our dr Most generic frems at a Flan Pharmacy	ug fortondary gundelines:	You Pay  \$10 for up to a 30-day a apply)  \$20 for up to a 100-day apply)			

Disclosure Form (continued)

Most specialty items at a Plan Pharmacy	\$30 for up to a 30-day suppry (Plan Deductible doesn't books)
Durable Medical Equipment (DME)	You Pay
DME Items in accord with our DME formulary guidelines	30% Collesurance (Fish Deductible descrift apply)
Mentel Health Services	You Рау
Inpatient psychiatric hasolialization	\$30 per visit (Plan Ordentible doesn't apply)
Substance Use Disorder Treatment Inpatient detoxification	You Pay  20% Coinsurance after Plan Deductible
individual outpatient substance use disorder evaluation and treatment	
Home Realth Care (up to 100 visits per Accumulation Period)	Yes Pay No charge (Plan Oeductible doesn't apply)
Other  Skilled nursing facility care (up to 100 days per benefit period).  Prosthetic and orthode devices.	No charge (Pius Deductible doesn't apply)
Covered fertility Services	- 50% Coinsurance (Pien Deductible do esn't apply) - No charge (Pian Deductible doesn't apply)

This is a summary of the most frequently asked about benefits. This chart does not explain benefits, Cost Share, but of pucket maximums, exclusions, or limitations, nor sees it list all benefits and Cost Share amounts. For a complete explanation, please refer to the 80C Please note that we provide all trenefits required by law (for example, dishetes seating supplies).

### 39189 SJVIA-COUNTY OF TULARE

4158274.43.1.5000493148 - Sr Adv Grp HMO NCR - Set 2

### Principal Benefits for

Elen On card araka Masumon

Kaiser Permanente Senior Advantage (HMO) with Part D (1/1/18—12/31/18)

For Services subject to the maximum, you will not pay any more C	ost Share for the rest of the calendar
year if the Copayments and Coinsurance you pay for those Service	ces add up to one of the following
amounts:	
For any one Member	\$1,500 per calendar year
Plantitedinalists	Reige
Professional Services (Plan Provider office visits)	You Pay
Most Primary Care Visits and most Non-Physician Specialist Visits	3
es escressors considerates es considerates escres escripto outlant plant plant to plant plant plant plant to the plant p	An arrangement of the second o
Most Physician Specialist Visits	
Annual Wellness visit and the "Welcome to Medicare" preventive	
visit;;	
Routine physical exams	
Routine eye exams with a Plan Optometrist	
Urgent care consultations, evaluations, and treatment	and the state of t
Physical, occupational, and speech therapy	
Officialisates crotices	
Outpatient surgery and certain other outpatient procedures	
Allergy injections (including allergy serum)	
Most immunizations (including the vaccine)	
Most X-rays and laboratory tests	
Manual manipulation of the spine	\$15 per visit
Gospanitzation Georges	Vott (Flav
Room and board, surgery, anesthesia, X-rays, laboratory tests,	
and drugs	\$200 per admission
Emergency stealing overage	Yolk Edit
Emergency Department visits	
Subulture: Stratete	Y618 2 1V
Ambulance Services ,	\$50 per trip
Presentation Brug Corerage	X618 3 s
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	
Durasie Medical Equipment (DME)	
Covered durable medical equipment for home use	. 20 percent Coinsurance
Inpatient psychiatric hospitalization	
Group outpatient mental health treatment	
weng vogenous steeles readt steeles a continuent and a co	. Ф. Р. А. В.

Disclosure Form (continued)

Inpatient detoxification \$200 per admission
Individual outpatient substance use disorder evaluation and
veatmant
Group outpatient substance use disorder treatment
forms feetings saviess out to
Home health care (part-time, intermittent)
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
Ostomy and urological supplies

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: 16128

Signatur	Primary enrollee, spouse and eligible dependent children to the end of the month dependent turns age 26			n to the end of
Deductibles	Delta Dental PPO dentists:			
	None			
	Non-Delta Dental	PPO dentists:		3
	\$25 per person / \$	\$75 per family each	calendar year	
Deductibles waived for Diagnostic & Preventive (D & P)?	Delta Dental PPO dentists: None P)? Non-Delta Dental PPO dentists: Yes			
Maximums	\$1,000 per person each calendar year			
Waiting Period(s)	Basic Benefits None	Major Benefits None	Prosihedontics None	Orthodontics None

	Delta Dental PPO dentiata"	Non-Delta Cental 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 Sasic 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	\$1,600 Lifetime
Dental Accident Benefits	100 % (separate \$1,000 maximum per person per calendar year)	100 % (separate \$1,000 maximum per person per calender 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.

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

**Customer Service** 806-765-8003

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.

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

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ENROLLEE

### 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 S for further clarification of Benefits. Enrolless should discuss all treatment options with their Contract Dentist prior to services being randered.

Text that appears in italics below is specifically intended to starify 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 Indexal legislation.

GOPE	DESCRIPTION	8	MY3
D0108-	D8999 I. DIAGNOSTIC		
D0120	Periodic oral evaluation - established patient	. No	Cost
00140	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
00150	Comprehensive oral evaluation - new or established patient		
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	ධරණ
00171	Re-evaluation - post-operative office visit	No	Cost
D0180	Comprehensive periodontal evaluation - new or established patient	No	Cost
D0190			
00191	Assessment of a patient		
00210	Intraoral - complete series of radiographic images - limited to 1 series every 24 months	, No	Cost
00220	Intragral - periapical first radiographic image		
00230	Intraoral - pariapioal each additional radiographic image		
D0240	Intracrat - occlusal radiographic image	Na	Cost
D0250	Extraoral - 2D projection radiographic image created using a stationary radiation source, and detector	. No	Cost
00261	Extraoral posterior dental radiographic image	. No	Cost
D0270	Bitewing - single rediographic 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
00277	Vertical bitewings - 7 to 8 radiographic images	, No	Cost
D0330		. Vis	Cost
00415	Collection of microorganisms for culture and sensitivity	No	Cost
00425	Carles susceptibility tests		
D0460	Pulp vitality tests (A.A.A.A.A.A.A.A.A.A.A.A.A.A.A.A.A.A.A.	No	Cost
00470	Diagnostic casts		
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 bloosy		
00474			
D0601			
D0602			
D0603			
00999	Unspecified diagnostic procedure, by report - includes office visit, per visit (in addition to other services)	., No	Cost
	-01999 II. PREVENTIVE		
D1110	Prophylaxis cleaning - adult - 1 per 6 month period	No	Cost
D1110	Additional prophylaxis cleaning - adult (within the 6 month period)	34	5.00

D3310	Roof canal - endodostic therapy, anterior tooth (excluding final restoration)	
D3320	Rocal canal - endodontic therapy, bicuspid tooth (excluding final restoration)	
03330	Book canel - endodomic therapy, molar (excluding final restoration)	
D3331	Treatment of root canal observation; non-surgical access	
D3333 D3333	incomplete endodontic therapy, inoperable, unrestorable or fractured tooth www.communications.communications internal root repair of perforation defects	
D9346	Refreatment of previous mot canal thereby - anterior - I all the second	
03347	Refreshment of previous root canal therapy - blouspid	
03348	Refreshment of previous root canal therapy - moler	
03351	Apexilication/recalcification - initial visit (apicel closure/calcific repair of perferations, root resorption, etc.)	
D3362		
	rescription, jetip apace distribution, etc.)	\$45.00
03383	Appsification/recalcification - final visit (includes completed root canel therapy - apposi closure/calcific repair of	646.60
03410	perforations, root recognition, etc.)	\$45.00 No Cont
03421	Apionectomy - bicuspid (lirst roat) - a consequence a consequence de consequence a consequence de consequence d	
D3425	Apicosciciny - moiar (first rest)	
D3426	Apitosciemy (each additional root)	
03427	Pariradiosiar surgery will wait apicoscionry	
D3430	Retrograde filling - per root	
03450	Rock amputation - per rock	
83330	Heraisection (Industing any root removal), not including root canal therapy	No Cost
D4808-	D4898 V. PERIODONTICS	
- Includ	ss preoperative and postoperative evaluations and treatment under a local anesthetic.	
D4210	Gingivectomy or gingivoplasty - four or more configuous teeth or tooth bounded spaces per quadrant	
04211	Gingivectomy or gingivoplasty - one to three contiguous teath or tooth bounded spaces per quadrant	
D4212	Gingl/rectomy or gingl/optasty to allow access for restorative procedure, per footh	No Cost
D4240	Gingivel flap procedure, including root planing - four or more contiguous teeth or toolin bounded spaces per quadrant	Ne Cost
D4241	Gingival flap procedure, including root planing - one to three configuous teeth or tooth bounded spaces per quadrant	
04246	Apically positioned flap	
04249	Clininal crown lengthening - hard tissue (Linux and District of Family Linux and Linux	\$45.00
04280	Osseous surgery (including slevetion of a full thickness flep and closure) - four or more contiguous teeth or tooth bounded spaces per guedrent	\$75.00
04281	Ossegus surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	<b>3</b> 60,88
D4263	Sone replacement graft - first site in quadrant	
04264	Bone replacement graft - each additional site in quadrant	
04268	Guided fissue regeneration - resemblis barrier, per site	
04287	Guided tissue regeneration - nonresorbable barrier, per site (includes membrane removel)	\$140,00
04270	Pedicle seft tissue graft procedure	\$125.00
04273	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tecth, implent, or edantulous tooth position in graft and approximate and approximately approximatel	\$75.00
04274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same scretomical area)	Ne Cost
04275	Non-autogenous connective tissue graft (including recipient site and donor material) first tocsh, implent, or edentulous tooth position in graft	\$115,08
04277	Free sall fissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft	
04273	Free soft tissue graft procedure (including recipient and donor surgical sites) each additional configurous tooth, implant, or edentulous tooth position in same graft site	
04283	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) - each additional configuous tooth, implant or adentulous tooth position in same graft site	
04288	Non-autogenous connective tissue graft procedure (including recipient surgicel sits and donor material) - each	
D4341		
	consecutive months	No Cost

12/01	n CALIFE DetaCare USA Description of Senefits and Copay	11111
D4342	Periodontal scaling and root planing - one to three teeth per quadrant - limited to 4 quadrants during any 12 consecutive months :	ia Cast
D4355		
04381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per	\$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	
04910		
D4910		
D4921	· · · · · · · · · · · · · · · · · · ·	
	DS899 VI. PROSTHODONTICS (removable)	.% Si i
six mon where to - Rebas	I listed dectures and partial dectures. Copsyment includes after delivery adjustments and tissue conditioning, if geoded, for oths after placement. The Engollae must continue to be eligible, and the service taust be provided at the Contract Dentist's to the denture was originally delivered. The testines and lissue conditioning are limited to 1 per denture during any 12 consecutive months. The coment of a denture or a partial denture requires the existing denture to be 5+ years old.	Use tirsi scility
D5110	Complete denture - maxillary	\$75.00
	Complete danture - mandibular consequences and a consequence and a	\$75.00
D5130	**************************************	\$85.00
D5140	linmediate dentura - mandibular	\$85.00
D5211	the state of the s	\$80.00
O5212		\$80.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, resis and teeth)	\$95.00
D5214		\$95.00
D5221	Immediate maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	\$80.00
D5222		\$80.00
D5223		\$95.00
D5224	immediate mandibular partial denture - cast metal framework with resin denture bases (including any	\$95.00
05225		195.00
05226	Mandibular partial denture - flexible base (including any clasps, rests and teath)	\$195.00
05281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth)	\$80,00
D5410		
D5411	Adjust complete denture - mandibular	vo Cost
D5421	Adjust partial denture - maxillary	
D5422	and the second of the second o	
D5510	Repair broken complete denture base .,	∜o Cost
06520	Replace missing or broken teeth - complete denture (each tooth)	Vo Cost
05610	Repair resin denture base	Vo Cost
D5620	Repair cast framework	Vo Cost
D5630	Repair or replace broken clasp - per tooth	√o Cost
D5640		
D5650		
D5660		
D5670		
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	
D5710		
05711	Rebase complete mandibular dentura	
05720		
05721		
D5790		
D5731		
D5748		
D5741	Ratine mandibutar partial denture (chairside)	

Files e 1920 Bella care USA Bella care from the Benjament Canada Company of the Company of Canada Ca
D5782 Retainer crown - ¼ cast noble metal \$60.00 D5783 Retainer crown - ¾ porcelain/ceramic* \$70.00
D6790 Retainer crown - full cast high noble metal
D6791 Retainer crown - full cast predominantly base metal
D6792 Retainer crown - full cast noble metal
D8794 Retainer crown - titanium
D6990 Re-cement or re-bond fixed partial denture
D6940 Stress breaker D6980 Fixed partial denture repair necessitated by restorative material failure
noson. Livos bariai neutrie tebait uscassiistas på tastolana ulatelia jalinté "eretimenti processiones des Post
D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY
- Includes preoperative and postoperative evaluations and treatment under a local enasthatic.  D7111 Extraction, coronal remnants - deciduous tooth
D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
D7210 Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of
mucoperiosteal flap if Indicated
D7230 Removal of impacted tooth - partially bony
D7240 Removal of impacted tooth - completely bony
D7241 Removal of impacted tooth - completely bony, with unusual surgical complications
D7250 Surgical removal of residual tooth roots (cutting procedure)
D7251 Coronectomy - Intentional partial tooth removal
D7270 Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth
D7280 Surgical access of an unerupted tooth
D7282 Mobilization of erupted or malpositioned tooth to aid eruption \$25.00
D7263 Placement of device to facilitate eruption of impacted tooth
D7286 Indisional biopsy of oral tissue - soft - does not include pathology laboratory procedures
D7310 Alveolopiasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant
D7311 Alvedioplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant
D7320 Alveolopiasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant No Cost
D7321 Alvedioplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant
D7450 Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm
D7451 Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm
D7471 Removal of lateral exostosis (maxille or mendible)
D7472 Removal of torus palatinus
D7473 Removal of torus mandibularis
D7960 Francisciomy - also known as francciomy or franctiomy - separate procedure not incidental to another procedure No Cost
D7970 Excision of hyperplastic tissue - per arch Additional Continuous and Cost
D7971 Excision of pericoronal gingiva
DB000-D8999 XI, ORTHODONTICS
<ul> <li>The listed Capayment for each phase of orthodonilo 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.</li> <li>The Retention Capayment includes adjustments and/or office visits up to 24 months.</li> </ul>
Pre and post orthodontic records include:
The benefit for pre-treatment records and diagnostic services includes:
D0210 Intracrat - complete series of radiographic images
D0322 Tomographic survey
D0330 Panoramic radiographic Image
D0340 2D cephalometric radiographic image - acquisition, measurement and analysis
D0350 2D cral/facial photographic images obtained intraorally or extraorally
D0351 3D photographic image
D0470 Diagnostic casts
The benefit for post-treatment records includes:
D0210 Intraoral - complete series of radiographic images
D0470 Diagnostic casts

	Limited orthodontic invetment of the primary dentition
	Limited orthodontic heatment of the transitional deptition - child or adolescent to age 19
06030	Limited orthodontic treatment of the adolescent dentition - adolescent to age 19
08040	Limited arthodontic treatment of the adult dentition - adults, including covered dependent adult children
D8050	Interceptive orthodontic treatment of the primary dentition
08080	
08070	Comprehensive arthodontic treatment of the transitional dentition - child or adolescent to age 19
08060	·
08080	
086943	
08876	Periodic orthodortic trestment visit - included in comprehensive case fee
	Orthodontic retention (removal of appliances, construction and placement of removable reteiners)
	Removable orthodonic retainer adjustment
	Re-bond or re-cement fixed retainer - limited to 2 per 6 month period
D8594	
D8999	
09880	09999 XII. ADJUNCTIVE GENERAL SERVICES
D9110	Palitative (emergency) treatment of dental pain - minor procedure converses a converse and a converse and No Cost
09211	Regional block anesthesia No Cost
09212	
09216	Local sneathesia in conjunction with operative or surgical procedures
09219	Evaluation for deep sodation or general anesthesis
08323	Deep sedation/general anesthesis - each 15 minute increment
	Intravenous moderate (conscious) seciation/analgasia - each 15 minute increment
	Consultation - diagnostic service provided by dentist or physicien other than requesting dential or physicien No Cost
	Office visit for observation (during regularly scheduled hours) - no other services performed
09440	
09450	
D9932	, •
09933	
09934	Clashing and inspection of removable partial denture, maxillary
08835	· · · · · · · · · · · · · · · · · · ·
09840	
D\$943	
D4951	Occlusial adjustment, limited
09982	
98876	
	one bleading bay and get for two weeks of self-treatment
03988	· · · · · ·
	of \$45,00 consequences and accompanies of the second consequences and the second consequences and the second consequences are second consequences.
09987	
	34 \$40 pg

If sarvices for a listed procedure are performed by the assigned Contract Dentist, the Enrollee pays the specified Copayment, Eisland 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 Dential. Questions regarding these fees should be directed to the Customer Service department at 800-423-4234.

### SCHEDULE 8

### Limitations of Benefits

- The frequency of certain Benefits is limited. All frequency limitations are listed in Schedule A, Description of Benefits and Copayments.
- If the Enrolled accepts a treatment plan from the Contract Dentist that includes any combination of more than six crowns, bridge
  pontics and/or bridge retainers, the Enrolled may be charged an additional \$100,00 above the listed Copayment for each of these
  services after the sixth unit has been provided.
- 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 Dentet, 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. Orthodonfic treatment in progress is limited to new DaltaCare 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 Scheduls A, Description of Benefits and Copeyments.
- 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
  - is inconsistent with generally accepted standards for dantistry.
- 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 heraditary or developmental defects, such as delt palate, upper and tower jaw malformations,
  congenitally missing feeth and testh that are discolored or lacking enamel, except for the treatment of newborn children with
  congenital defects or birth abnormalities.
- 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.
- Lost or stolen appliances including, but not limited to, full or partial dentures, space maintainers, crowns and fixed partial dentures (bridges).
- Procedures, appliances or restoration if the purpose is to change vertical dimension, or to diagnose or treat abnormal conditions of the temporomandibular joint (TMJ).
- Precious metal for removable appliances, metallic or permanent soft bases for complete dentures, poroclain 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.
- 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.
- 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.

### The state of Exclusions of English

- 13. Dantal expenses incorred in connection with any deptat or orthodonillo procedure started belong the Enrollogic oligibility with the DattaCare USA Program. Examples include: teeth propered for crowns, rost councils in progress, full or partial dentures for which an impression has been taken and orthodonics unless qualified for the orthodonic treatment in progress provision.
- 14. Lost, stolen er broken orthodontio appliances,
- 15. Changes in orthodontic treatment necessitated by accident of any kind.
- 16. Myofunctional and paratimolional appliances antior therapies, with the exception of procedure D9946 (occlusal guard, per report).
- Composite or carenta brackets, lingual adeptation of prinodentic bends and other specialized or cosmetic alternatives to standard fixed and removable prinodentic appliances.
- 15. Treatment or appliances that are provided by a Dantist whose practice specializes in prosthodontic services.

### Your Vision Benefits Summary

Clef the bast in eye care and eyewear with COUNTY OF TULARE and VSP\* Vision Care.

### Using your VSP benefit is easy.

- Create an account at vep.com. Once your plan is effective, review your benefit information.
- Find an eye cere provider who's right for you. The decision is yours to make—choose a VSP dector, a participating retail chain, or any our-of-network provider. To find a VSP provider, visit vap.com or call 800.877,7198.
- 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 vep.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 mamber, 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 audden 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 brends like bebe?, Calvin Klein, Cole Haan, Flexon?, Lacoste, Nike, tvine West, and more', Visit vsp.com to find a Premier Program location that carries these brands. Prefer to shop online? Chack out all of the brands at Eyeconic.com, VSPs online eyewear store.

### Plan information

VSP Coverage Effective Date: 01/01/2018 VSP Provider Network: VSP Choice

SAN JOACEN VALLEY INSURANCE AUTHORITY and VSP provide you with an affordable eyecers plan.

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Oranias/Procedure subject to change.

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	four Coverage with a MSR the Willer	
Wallvision Exam	Focuses on your eyes and overall wellness     Every IC months	\$10
Prome	\$330 allowance for a wide selection of flames     \$150 allowance for flaming frame brands (see Extre Savings below)     20% savings on the amount over your allowance     \$70 Costoo* frame allowance     Every 24 months	Included in Prescription Glasses
**************************************	Single vision, lined bifocal, and fined tifocal lenses     Polycarbonate lenses for dependent children     Every 12 months	included in Prescription Glasses
Lene Cobancements	Standard progressive lenses     Premium progressive lenses     Custom progressive lenses     Average savings of 20-25% on other lens enhancements     Every I2 menths	855 865 - \$105 \$150 - \$175
Contacts Englesed of classes)	\$100 allowence for contacts and contact lens exam (fitting and evaluation)     169/ savings on a contact lens exam (fitting and avaluation)     Evacy (if months	80
Britancy Eyadara	<ul> <li>Treatment and diagnosis of eye conditions like plak eye, vision loss and monitoring of catalacts, glaucome and diabatic ratinopathy. Limitations and coordination with medical coverage may apply. Ask your VSP doctor for details.</li> <li>As needed</li> </ul>	<b>62</b> 0
	Glasses and Sunglasses  Extra \$20 to spend on featured frame vap.com/apaciatoffers for details.  20% savings on additional glasses are including lens enhancements, from as within 12 months of your fast WellVisio.	d sunglasses, y VSP provider
Extra Savinga	Retinal Screening • No more than a \$39 copey on routine as an enhancement to a WellVision Ex	
: :	Laser Vision Correction  • Average 16% off the regular price or 6 promotional price; discounts only avail contracted facilities	
Visió Vegacións territor	ing Court age of Brown Nation & Provid 1884, if you plan to see a provider offer their x V	
	up to \$26 Lined Tritocal Lense	

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	San Josephic Valley in: County of		Y	
	January 1, 2018 - De	cember 31, 2019		
	Emplayee	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
Kalser 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	\$103.33
Delta Dental DHMO	\$26.38	\$45.27	\$45.58	\$65,70
/SP Vision	\$4.86	\$8.20	\$8.68	\$12.93
Casier Senior Advantage				
Subscriber with Medicare				\$303.25
Subscriber with Medicare/Sp r	ion-Medicare			\$1,084.4
Subscriber non-Mediare/Sp Medicare				\$1,084.4
Subscriber with Medicare/Sp with Medicare				\$582.5
Subscriber with Medicare/Child(ren) non-Medicare				\$936.0
Subscriber with Medicare/Sp with Medicare/Child non-Medicare				\$1,363.75
ubscriber Medicare/Sp non-Medicare/Child non-Medicare				\$1,865.73
Subscriber non Medicare/Sp w	ith Medicare/Child non-	Medicare		\$1,865.74

Subscriber with Medicare/Sp with Medicare/Children non-Medicare Subscriber with Medicare/Sp non-Medicare/Children non-Medicare

Subscriber non Medicare/Sp with Medicare/Children non-Medicare

\$1,363.79

\$1,865.73

\$1,865.74