

AGENDA

BOARD OF DIRECTORS

STEVE BRANDAU
KUYLER CROCKER
NATHAN MAGSIG
BUDDY MENDES
BRIAN PACHECO
AMY SHUKLIAN
PETE VANDER POEL

**Meeting Location:
County of Fresno
Board of Supervisors Chambers
2281 Tulare Street, #301
Fresno, CA 93721
November 8, 2019 9:00 AM**

In compliance with the Americans with Disabilities Act, if you need special assistance to participate in this meeting, please contact the SJVIA Manager at 559-636-4900 or the Assistant SJVIA Manager at 559-600-1810. Notification 48 hours prior to the meeting will help enable staff to make reasonable arrangements to ensure meaningful access.

1. Call to Order
2. Pledge of Allegiance
3. Roll Call
4. Approval of Agenda (A)
5. Closed Session CONFERENCE WITH LEGAL COUNSEL – EXISTING LITIGATION (Gov. Code, § 54956.9, subd. (d)(1)) — San Joaquin Valley Insurance Authority v. Gallagher Benefit Services, Inc., Fresno County Superior Court Case No. 17CECG01632, United States District Court for the Eastern District of California Case No. 1:17-cv-00861-LJO-EPG

The public may comment on Closed Session items prior to the Board's recess to Closed Session.

The remainder of the agenda will be heard following the Closed Session item.

6. Public Comment: At this time, members of the public may comment on any item, within the jurisdiction of the SJVIA, not appearing on the agenda. In order for everyone to be heard, please limit your comments to 3 minutes or less. Anyone wishing to be placed on the agenda for a specific topic should contact the SJVIA Manager's Office and submit correspondence at least 14 days before the desired date of appearance.
7. Approval of Minutes – Board Meeting of August 23, 2019 (A)

In compliance with the Americans with Disabilities Act, if you need special assistance to participate in this meeting, please contact the SJVIA Manager at 559-636-4900 or the Assistant SJVIA Manager at 559-600-1810. Notification 48 hours prior to the meeting will enable staff to make reasonable arrangements to ensure accessibility. Documents related to the items on this Agenda submitted to the Board after distribution of the Agenda packet are available for public inspection at the County of Fresno plaza Building, 2220 Tulare St, 14th Floor, Fresno, CA during normal business hours. All documents are also posted online to www.sjvia.org.

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8. SJVIA Director Questions, Announcements, and Activity Reports (Gov. Code, § 54954.2, subd. (a)(2)) (I)
9. Receive Update from Auditor-Treasurer on Cash Flow Projections (I)
10. Receive Update from Auditor-Treasurer on SJVIA Financials as of September 30, 2019 (I)
11. Receive the 2018 Audited Financial Statements (I)
12. Approve Amendment to Extend Contract with Price Paige & Company (A)
13. Approve Revised 2019 Board Meeting Calendar and Proposed 2020 Board Meeting Calendar (A)
14. Receive Notification from the City of Marysville of Its Intent to Terminate Participation in the SJVIA Effective December 31, 2019 (I)
15. Approve and Authorize President to Execute SJVIA Participation Agreements for the County of Fresno, Effective December 16, 2019, and the County of Tulare, Effective January 1, 2020 (A)
16. Receive Consultant's Medical, Dental, and Vision Experience Reports through September 2019 with Update on Reserve Accumulation and Projections (I)
17. Receive Consultant's Report on Plan Year 2020 Stop Loss/Reinsurance Renewal and Marketing Results and Authorize President to Execute Agreement Subject to Approval of SJVIA Counsel and Staff (A)
18. Approve Kaiser HMO Plan Design Changes for the County of Fresno to Create Parity with the Anthem EPO Plan (A)
19. Receive and Approve County of Tulare's New Anthem \$750 Deductible Plan Design Enhancements (A)

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20. Receive Update and Approve Change to County of Fresno's Anthem \$1,500 HDHP, Effective with the 2020 Plan Year, to be in Compliance with ACA Guidelines (A)
21. Receive Update and Approve Change to County of Tulare's Anthem \$2,500 HDHP, Effective January 1, 2020, to be in Compliance with ACA Guidelines (A)
22. Receive Update on the Delta Dental DHMO Employee Only Rate for Plan Year 2020 (I)
23. Receive Update on the Anthem Future Moms Program Cost for Plan Year 2020 (I)
24. Approve SJVIA Wellness Funds Allocation Procedure Recommendation for Plan Year Roll-Overs (A)
25. Receive Consultant's Update on Upcoming Annual SJVIA Strategy Meeting (I)
26. Adjournment

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MINUTES

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**Meeting Location:
County of Tulare
Board of Supervisors Chambers
2800 W. Burrel Avenue
Visalia, CA 93291
August 23, 2019 9:00 AM**

1. Call to Order
2. Pledge of Allegiance
3. Roll Call

All Directors Present with the exception of Director Brandau

4. Approval of Agenda (A)

Motion to approve by Director Crocker; Seconded by Director Shuklian;
Motion approved unanimously

5. Closed Session CONFERENCE WITH LEGAL COUNSEL – EXISTING LITIGATION (Gov. Code, § 54956.9, subd. (d)(1)) — San Joaquin Valley Insurance Authority v. Gallagher Benefit Services, Inc., Fresno County Superior Court Case No. 17CECG01632, United States District Court for the Eastern District of California Case No. 1:17-cv-00861-LJO-EPG

The public may comment on Closed Session items prior to the Board's recess to Closed Session.

The remainder of the agenda will be heard following the Closed Session item.

No public comments

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Public comments were made by Laura Hernandez, Sabina Ramos, and Riley Talford

7. Approval of Minutes – Board Meeting of July 19, 2019 (A)

Motion to approve by Director Shuklian; Seconded by Director Magsig;
Motion approved unanimously

8. SJVIA Director Questions, Announcements, and Activity Reports (Gov. Code, § 54954.2, subd. (a)(2)) (I)

No comments

9. Receive Update from Auditor-Treasurer on Cash Flow Projections (I)

Presented by Justin Pratt, County of Fresno

10. Receive Update from Auditor-Treasurer on SJVIA Financials as of June 30, 2019 (I)

Presented by Justin Pratt, County of Fresno

11. Receive the 2017 Audited Financial Statements (I)

Presented by Osvaldo Gutierrez and Larisa Murren, Price Page & Company

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12. Receive Consultant's Medical, Dental, and Vision Experience Reports through June 2019 with Update on Reserve Accumulation and Projections (I)

Presented by Bordan Darm, Keenan & Associates

13. Receive Consultant's SJVIA Actuarially Certified Incurred But Not Reported Reserve Report as of June 30, 2019 and Approve Funding Additional \$272,314 to Maintain the Fully Funded Status of the IBNR Reserve (A)

Presented by Christine Hough and Bordan Darm, Keenan & Associates

Motion to approve by Director Magsig; Seconded by Director Mendes; Motion approved unanimously

14. Approve Termination of Agreement with Rael & Letson (A)

Presented by Megan Marks, County of Fresno

Motion to approve by Director Vander Poel; Seconded by Director Pacheco; Motion approved unanimously

15. Receive Consultant's Plan Year 2020 Underwriting Renewal Report, Finalize and Approve 2020 Rates and Fees, Authorize Consultant and SJVIA Staff to Negotiate Agreements, and President to Execute Agreements Subject to Approval of SJVIA Counsel and Staff (A)

Presented by Bordan Darm, Keenan & Associates

Motion to approve SJVIA Staff recommendation to finalize and approve 2020 rates and fees as follows:

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County of Fresno

- **Self-Funded Medical (Anthem)**
 - Renew self-funded medical PPO and HDHP plans at 0% increase to rates;
 - For the self-funded medical EPO plan, apply a 3.25% increase to rates and create rate parity with the Kaiser HMO plan to reduce or eliminate anti-selection due to rate or plan design differentials
 - Overall self-funded medical plan (EPO, PPO, HDHP) renewal at 2.71%
- **Fully-Insured Medical (Kaiser)**
 - Renew fully-insured medical HMO plan at 7.78% to create rate parity with the self-funded EPO plan
- **Self-Insured Dental PPO (Delta Dental)**
 - Renew self-funded dental PPO plan at 0% increase to rates
- **Fully-Insured Dental DHMO (Delta Dental)**
 - Renew fully-insured dental DHMO plan at 4.33% increase to rates
- **Fully-Insured Vision (VSP)**
 - Renew fully-insured vision plan at 2% increase to rates

County of Tulare

- **Self-Funded Medical (Anthem)**
 - Common renewal of 4.72% increase for all medical self-funded plans;
 - Apply requested plan design changes by decreasing the Anthem \$1,000 Deductible Plan to a \$750 Deductible Plan

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- **Fully-Insured Medical (Kaiser)**
 - Renew fully-insured medical HMO at 0% increase to rates
- **Self-Insured Dental PPO (Delta Dental)**
 - Renew self-funded dental PPO plan at 0% increase to rates
- **Fully-Insured Dental DHMO (Delta Dental)**
 - Renew fully-insured dental DHMO plan at 4.07% increase to rates
- **Fully-Insured Vision (VSP)**
 - Renew fully-insured vision plan at 2% increase to rates

City of Marysville

- **Self-Funded Medical (Anthem)**
 - Renew self-funded medical PPO and HDHP plans at 0% increase to rates;
- **Fully-Insured Medical (Kaiser)**
 - Renew fully-insured medical HMO at 0% increase to rates

Motion made by Director Magsig; Seconded by Director Crocker; Motion approved unanimously

16. Approve Agreement with Life Saving Images and Authorize President to Execute Agreement (A)

Presented by Rhonda Sjostrom, County of Tulare

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Motion to approve by Director Shuklian; Seconded by Director Vander Poel;
Motion approved unanimously

17. Adjournment

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2281 Tulare Street, #301
Fresno, CA 93721

AGENDA DATE: November 8, 2019

ITEM NUMBER: Item 9

SUBJECT: Receive Update from Auditor-Treasurer on Cash Flow Projections (I)

REQUEST(S): That the Board Receives This Update on Cash Flow Projections

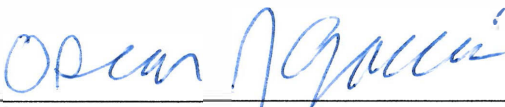
DESCRIPTION:

Informational item. Please see attached report.

FISCAL IMPACT/FINANCING:

None.

ADMINISTRATIVE SIGN-OFF:



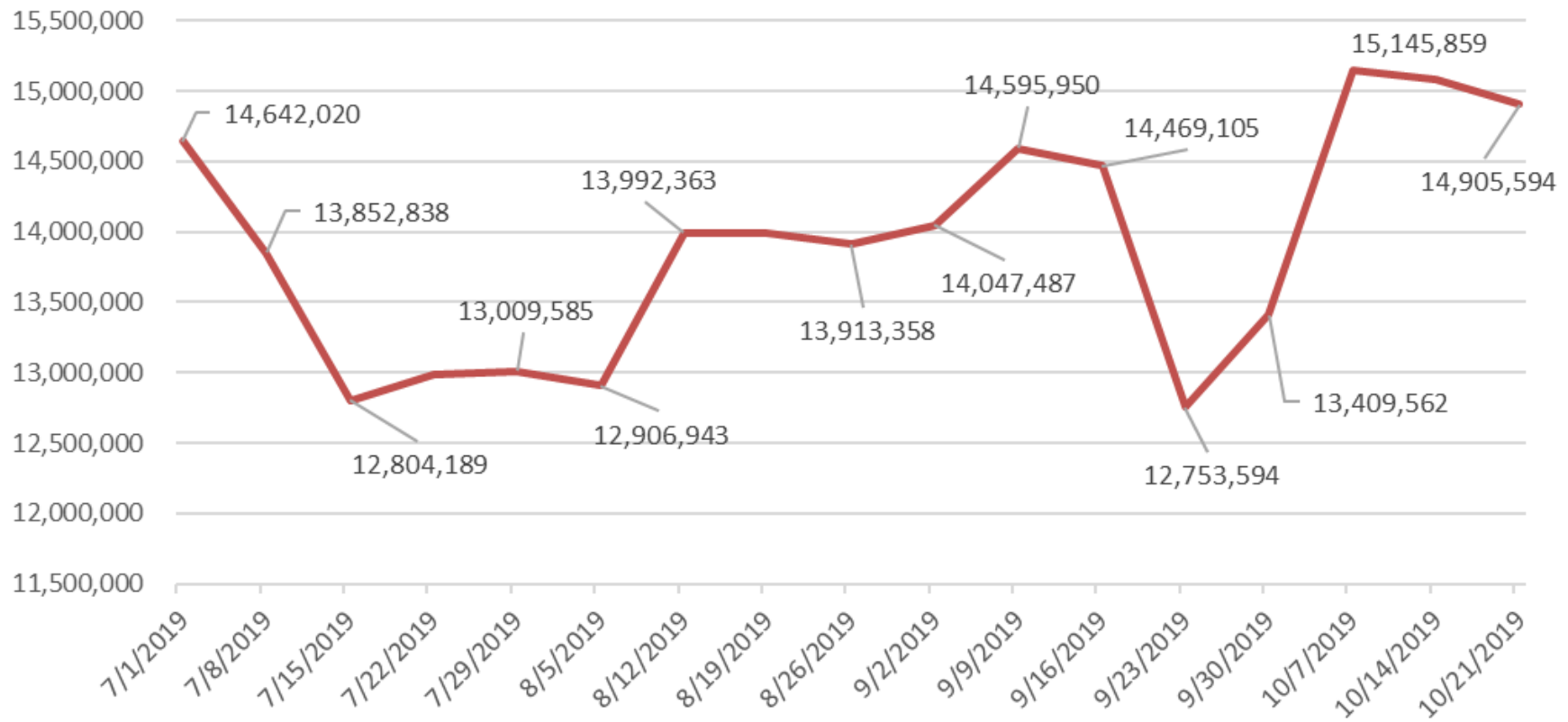
Oscar J. Garcia, CPA
SJVIA Auditor-Treasurer

SJVIA Cash Flow Projections

Justin Pratt
November 8, 2019

Current Fiscal Year Cash Flows

For the Period July 1, 2019 to October 27, 2019



Lowest (Actual)

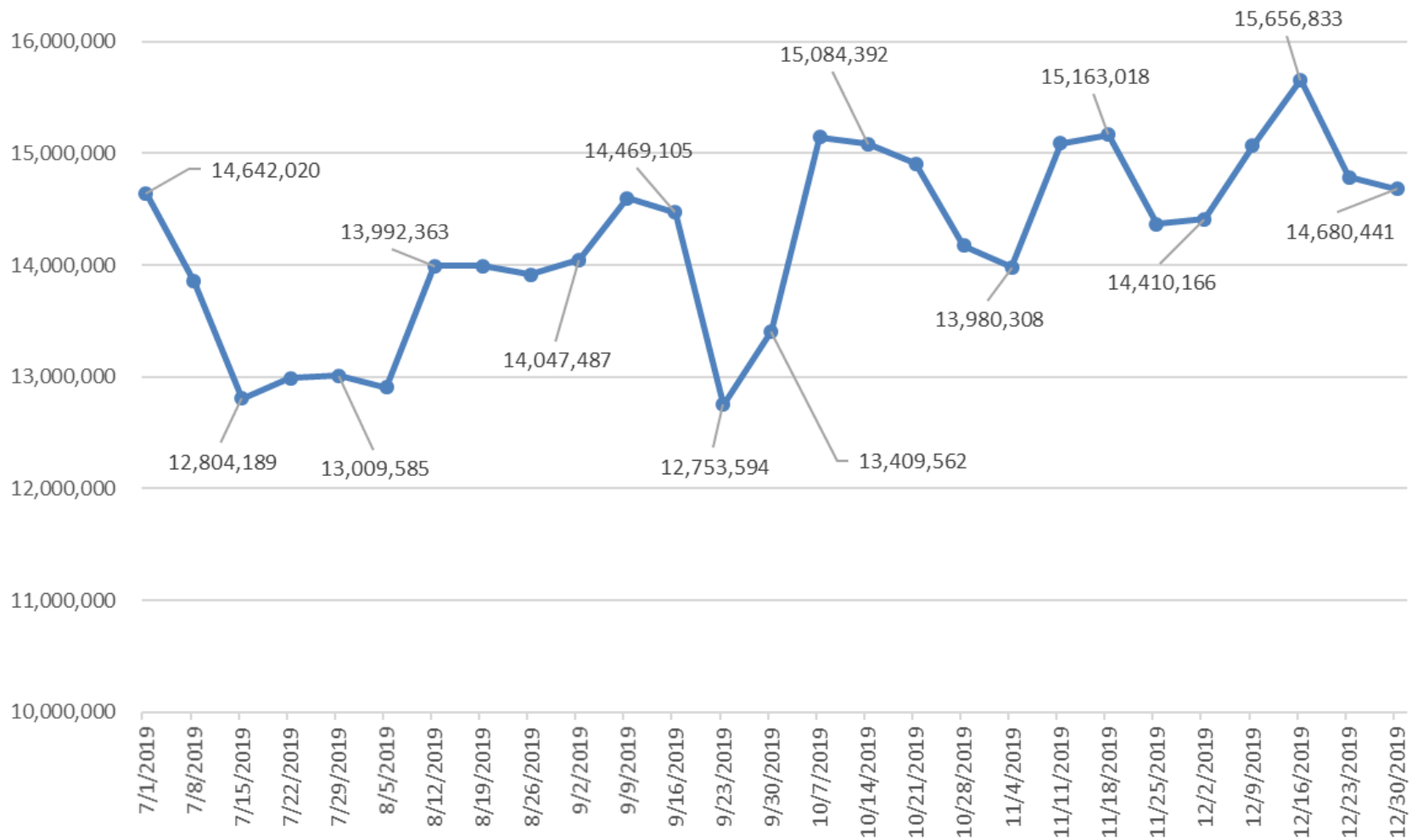
- 7/20 - \$11,792,894

Highest (Actual)

- 10/23 - \$16,348,440

Projected Cash Flows

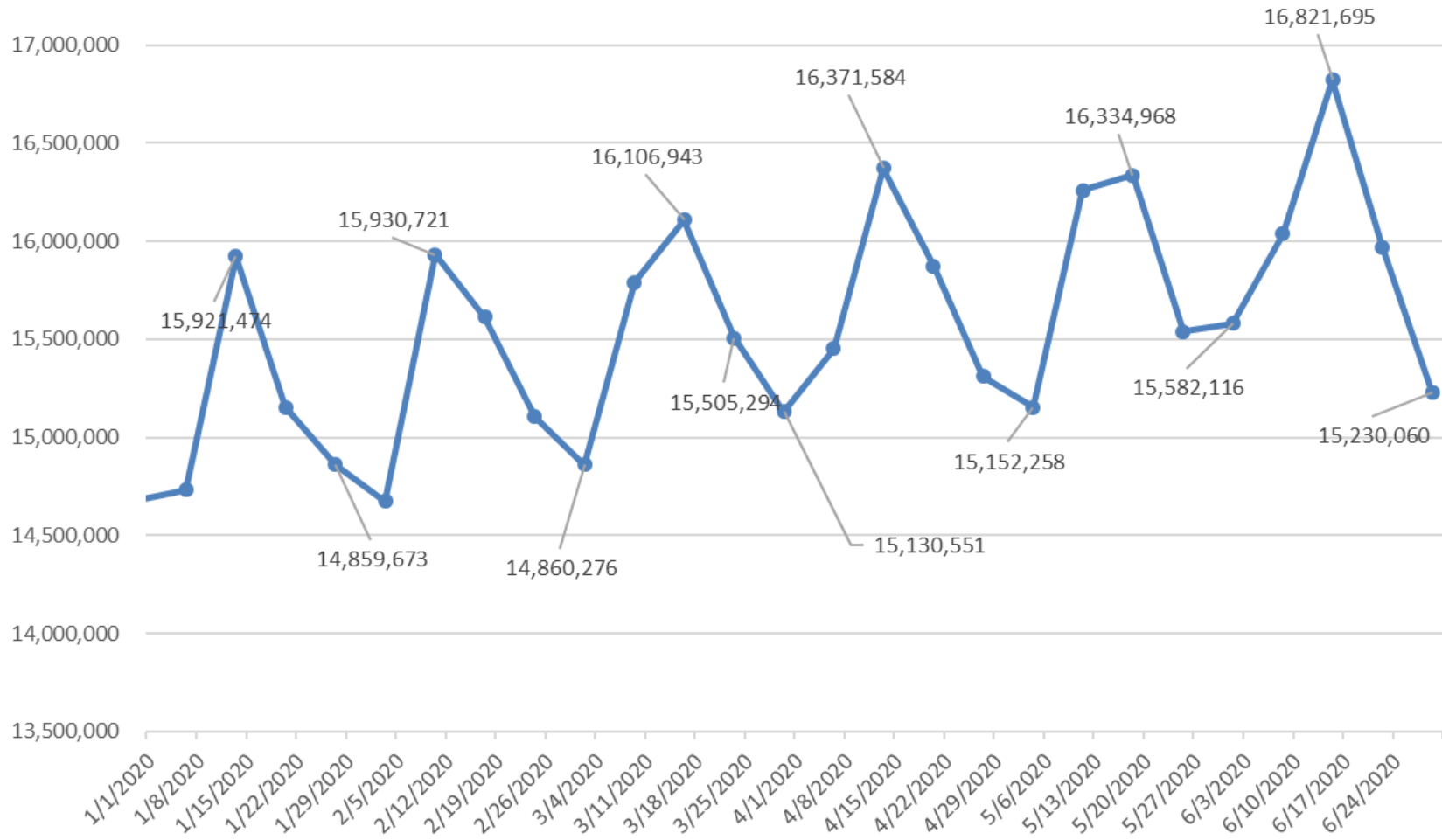
For Period 7/1/2019 to 12/31/2019



- Weekly PPO/EPO estimated at \$978K

Projected Cash Flows

For Period 1/1/2020 to 6/30/2020





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Meeting Location:
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AGENDA DATE: November 8, 2019

ITEM NUMBER: Item 10

SUBJECT: Receive Update from Auditor-Treasurer on
SJVIA Financials as of September 30, 2019 (I)

REQUEST(S): That the Board Receives the Financial Update
Through September 30, 2019

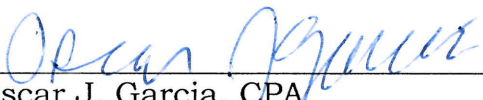
DESCRIPTION:

Informational item. Please see attached report.

FISCAL IMPACT/FINANCING:

None.

ADMINISTRATIVE SIGN-OFF:



Oscar J. Garcia, CPA
SJVIA Auditor-Treasurer

San Joaquin Valley Insurance Authority
Estimated Statement of Net Position
As of September 30, 2019
(UNAUDITED)

ASSETS

Current assets:

Cash and cash equivalents	11,097,861
Due from other governmental units	191,638
Total current assets	<u>11,289,499</u>

Noncurrent assets:

Other receivables	977,819
Total noncurrent assets	<u>977,819</u>

Total assets	<u><u>\$ 12,267,318</u></u>
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LIABILITIES

Current liabilities:

Accounts payable	4,069,000
Unearned member contributions	962,293
Unpaid claims and claims adjustment expenses	1,199,154
Total current liabilities	<u>6,230,447</u>

Noncurrent liabilities:

Due to other governmental units	9,887,669
Interest payable	441,044
Total noncurrent liabilities	<u>10,328,713</u>

Total liabilities	<u><u>\$ 16,559,160</u></u>
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NET POSITION

Unrestricted	(4,291,842)
Total net deficit	<u><u>\$ (4,291,842)</u></u>

Note:

This statement of net position is presented on an accrual basis. Certain related adjustments presented in this report are estimates. Additionally, this statement of net position does not include an IBNR accrual. Of the nine million currently loaned to SJVIA, five million is payable to the County of Fresno and four million is payable to the County of Tulare, both due by December 30, 2021.

SAN JOAQUIN VALLEY INSURANCE AUTHORITY
ACTUALS VS. BUDGETED RECEIPTS & DISBURSEMENTS
AS OF SEPTEMBER 30, 2019
(UNAUDITED)

	Current Quarter				Year-To-Date			
	BUDGET*	ACTUALS	FAVORABLE/ (UNFAVORABLE)	% VARIANCE	BUDGET*	ACTUALS	FAVORABLE/ (UNFAVORABLE)	% VARIANCE
RECEIPTS								
TOTAL RECEIPTS	\$27,664,965	\$ 33,807,863	\$ 6,142,898	22%	\$112,277,056	\$33,807,863	(\$78,469,193)	(70%)
DISBURSEMENTS: Fixed								
1 Specific Stop Loss Insurance (EPO/PPO)	489,462	609,574	(120,112)	(25%)	2,062,175	609,574	1,452,601	70%
2 Anthem Claims Administration & Network Fees (EPO/PPO)	884,158	1,111,807	(227,649)	(26%)	3,578,002	1,111,807	2,466,195	69%
3 Hourglass & ASI Administration (Anthem & Kaiser)	115,480	155,354	(39,874)	(35%)	461,920	155,354	306,566	66%
4 Keenan Consulting	89,857	128,384	(38,527)	(43%)	359,426	128,384	231,042	64%
5 SJVIA Administration	58,254	668,415	(610,161)	(1047%)	233,016	668,415	(435,399)	(187%)
6 Wellness	72,465	-	72,465	100%	289,860	-	289,860	100%
7 Communications	14,493	-	14,493	100%	57,972	-	57,972	100%
8 Delta Dental Claims Administration	111,630	-	111,630	100%	453,443	-	453,443	100%
9 ACA Reinsurance/PCORI (EPO/PPO)	-	27,854	(27,854)	0%	-	27,854	(27,854)	0%
TOTAL FIXED DISBURSEMENTS	1,835,798	2,701,388	(865,589)	(47%)	7,495,814	2,701,388	4,794,426	64%
DISBURSEMENTS: Claims								
10 Projected Paid Claims: EPO/PPO & RX	17,036,587	20,989,807	(3,953,220)	(23%)	69,544,622	20,989,807	48,554,815	70%
11 Projected Paid Claims Dental	951,115	-	951,115	100%	3,856,323	-	3,856,323	100%
TOTAL CLAIMS DISBURSEMENTS	17,987,701	20,989,807	(3,002,105)	(17%)	73,400,945	20,989,807	52,411,138	71%
DISBURSEMENTS: Premiums								
12 Delta Dental	258,928	772,349	(513,421)	(198%)	1,061,293	772,349	288,944	27%
13 Vision Service Plan	174,311	238,379	(64,068)	(37%)	707,700	238,379	469,321	66%
14 Kaiser Permanente	6,776,241	9,404,092	(2,627,851)	(39%)	26,592,095	9,404,092	17,188,003	65%
TOTAL PREMIUM DISBURSEMENTS	7,209,479	10,414,820	(3,205,340)	(44%)	28,361,088	10,414,820	17,946,268	63%
TOTAL DISBURSEMENTS	27,032,978	34,106,015	(7,073,037)	(26%)	109,257,847	34,106,015	75,151,832	69%
16 Change in Reserve	631,987	(298,152)	(930,139)	(147%)	3,019,209	(298,152)	(3,317,361)	(110%)
COMBINED DISBURSEMENTS & CHANGES IN RESERVES	\$27,664,965	\$33,807,863	\$6,142,898	22%	\$112,277,056	\$33,807,863	(\$78,469,193)	(70%)

*The approved budget contains assumptions that may differ throughout the fiscal year. The budget amounts presented in this report were revised and approved on the 2/22/2019 Board Meeting.

Note: These schedules are on the cash basis.

SAN JOAQUIN VALLEY INSURANCE AUTHORITY
ANALYSIS OF ADMINISTRATION, WELLNESS & COMMUNICATIONS (FEES) - RECEIPTS & DISBURSEMENTS
AS OF SEPTEMBER 30, 2019
(UNAUDITED)

	Current Quarter			Year-To-Date		
	SJVIA FEES			SJVIA FEES		
	Administration (*Line 5)	Wellness (*Line 6)	Communications (*Line 7)	Administration (Line 5)	Wellness (Line 6)	Communications (Line 7)
FY 19-20						
Receipts*	53,685		13,637	53,685		13,637
Disbursements:						
Auditor-Treasurer Services	32,134			\$ 32,134		
Legal Services (CoF & CoT)	16,542			16,542		
Litigation	474,811			474,811		
Human Resource Services	43,362			43,362		
Insurance (Liability, Bond, Etc)	71,624			71,624		
Audit Fees	19,695			19,695		
Actuary Fees				-		
Bank Service Fees	10,247			10,247		
Wellness						
Communications						
Total Disbursements**	\$ 668,415	\$ -	\$ -	\$ 668,415	\$ -	\$ -
Change in Administration, Wellness & Communications Reserve	\$ (614,730)		\$13,637	\$ (614,730)		\$13,637

*Receipts consist of fees collected from relevant enrollees at the following rates per employee per month: Various rates for administration(\$2.00 for SJVIA administration fees & various rates for non-founding member fees depending upon a participant's enrollment), \$2.50 for wellness & \$.50 for communications fees.

**Total disbursements for each column correspond to the line number shown on the "ACTUALS VS. BUDGETED RECEIPTS & DISBURSEMENTS" report.

Note: These schedules are on the cash basis.

San Joaquin Valley Insurance Authority
Schedule of Cash Flows by Month
As of September 30, 2019
(UNAUDITED)

	JULY	AUGUST	SEPTEMBER	TOTAL
BEGINNING CASH BALANCES:				
Claims Funding Account (294)	\$ 530,373	\$ 382,713	\$ 710,859	\$ 530,373
Claims Main Account (819)	3,144,247	2,682,789	980,093	3,144,247
Investment Pool	9,710,504	9,345,969	12,533,705	9,710,504
Total Beginning Balances	13,385,124	12,411,471	14,224,657	13,385,124
RECEIPTS:				
Claims Funding Account (294)	5,721,609	4,903,671	4,833,449	15,458,729
Claims Main Account (819)	9,687,192	8,732,786	8,648,210	27,068,188
Investment Pool	6,635,465	9,187,736	3,306,333	19,129,533
	22,044,266	22,824,193	16,787,992	61,656,450
DISBURSEMENTS:				
Claims Funding Account (294)	5,869,269	4,575,525	4,888,215	15,333,009
Claims Main Account (819)	10,148,650	10,435,482	8,032,425	28,616,557
Investment Pool	7,000,000	6,000,000	6,000,000	19,000,000
TOTAL DISBURSEMENTS	23,017,919	21,011,007	18,920,640	62,949,566
ENDING CASH BALANCES:				
Claims Funding Account (294)	382,713	710,859	656,093	656,093
Claims Main Account (819)	2,682,789	980,093	1,595,878	1,595,878
Investment Pool	9,345,969	12,533,705	9,840,038	9,840,037
Total Ending Balances	\$ 12,411,471	\$ 14,224,657	\$ 12,092,009	\$ 12,092,008
Less Outstanding Checks				(994,147)
Cash per Estimated Statement of Net Position				\$ 11,097,861

Glossary of Terms:

Actuals vs. Budgeted Receipts & Disbursements

1 Specific & Aggregate Stop Loss Insurance (PPO)

Specific: Insurance coverage for eligible individual specific claims in excess of the \$450,000 plan year deductible up to the lifetime maximum of \$6 million.

Aggregate: Insurance coverage for eligible claims under the specific deductible on the aggregated amount for all member claims.

2 Administration & Network Fees (Anthem & Blue Shield PPO)

ASO is "Administrative Services Only". These are administrative services for the PPO plans. This definition includes Anthem Blue Cross & Health Now Administrative Services administration fees and includes access fees to use the Anthem Blue Cross & Blue Shield networks of providers. These services do not include the Anthem HMO plan.

3 Administrative Solutions Inc. (ASi)/Hourglass Systems Administration (Anthem & Kaiser)

ASi and Hourglass are independent vendors providing COBRA billing, eligibility, automated enrollment and Section 125 administrative services. This line is for health plans excluding HealthNow/Blue Shield.

4 Benefit Consulting

These are payments to the benefit consultant who provides professional guidance to SJVIA and respective members concerning health plan matters including but not limited to compliance, underwriting, renewal bidding, employee communication, cost analysis, actuarial, etc.

5 SJVIA Administration

These fees will be used by SJVIA for administrative, management, legal, accounting and other services needed to effectively establish and maintain proper functioning of the Joint Powers Authority. It includes the association fee and the non-founding member fee which is assessed to non-founding member entities.

6 Wellness

This rate category is earmarked for special claims management services and may include some wellness applications that are outside and additional to the claims management services provided by the insurance company.

7 Communications

This rate category is earmarked for special employee communication materials and prospective new City/County member promotional materials. It may include fees for maintaining a presence at such trade associations as CALPELRA, etc.

8 Anthem HMO Pooling

This is for the specific stop loss pooling insurance for claims in excess of \$400k within the HMO (not PPO).

9 Anthem HMO Administration/Retention

These are Anthem Blue Cross administration fees and include access fees to use the Blue Cross network of providers for the HMO plan.

10 ACA Reinsurance/PCORI (PPO & HMO)

The Affordable Care Act (ACA) includes the following fees on insurance plans: 1) Patient Centered Outcomes Research Institute (PCORI) fee. 2) Transitional Reinsurance Fee.

11 Projected Paid Medical & Rx Claims-PPO and Non-Cap HMO

Projected self-insured PPO claims for medical and Rx and non-capitated HMO claims (hospital).

12 Anthem MPP HMO Capitation

Amount paid in advance of services on a fixed per member per month basis for professional services (physician) as part of the HMO.

13 Delta Dental

Premium for entities covered under the SJVIA Delta Dental program.

Glossary of Terms:

Actuals vs. Budgeted Receipts & Disbursements

14 Vision Service Plan

Premium for entities covered under the SJVIA VSP Vision program.

15 Kaiser Permanente

Premium for entities covered under the SJVIA Kaiser HMO program.

16 Change in Reserve

Excess receipts over claims, premiums and fixed costs.

Estimated Statement of Net Position

17 Due from other governmental units

These represent premiums due to SJVIA from various participants.

18 Other receivables

This is primarily a deposit that SJVIA is required to keep with Anthem Blue Cross as part of the capitated HMO claims activity. For a discussion of capitated HMO claims, see item 12 above.

19 Accounts payable

This represents non-claims payments owed to vendors which have not yet been remitted.

20 Unearned member contributions

This represents premiums paid early to SJVIA before the premiums are due.

21 Unpaid claims and claims adjustment expenses

This represents claims payments owed to vendors which have not yet been remitted.

22 Due to other governmental units

This represents various loans made to SJVIA by the County of Fresno & the County of Tulare as well as start up payments made by the County of Fresno at SJVIA's inception.

23 Unrestricted Net Position

This represents the assets less any liabilities.



BOARD OF DIRECTORS

STEVE BRANDAU
KUYLER CROCKER
NATHAN MAGSIG
BUDDY MENDES
BRIAN PACHECO
AMY SHUKLIAN
PETE VANDER POEL

Meeting Location:
County of Fresno
Board of Supervisors Chambers
2281 Tulare Street, #301
Fresno, CA 93721

AGENDA DATE: November 8, 2019

ITEM NUMBER: Item 11

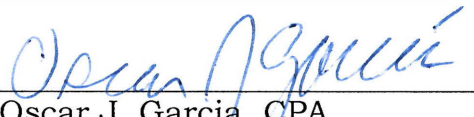
SUBJECT: Receive the 2018 Audited Financial Statements (I)

REQUEST(S): That the Board Receives the 2017-2018 Audited Financial Statements

DESCRIPTION:
Informational item. Please see attached report.

FISCAL IMPACT/FINANCING:
None.

ADMINISTRATIVE SIGN-OFF:



Oscar J. Garcia, CPA
SJVIA Auditor-Treasurer



San Joaquin Valley
Insurance Authority

BOARD OF DIRECTORS

STEVE BRANDAU
KUYLER CROCKER
NATHAN MAGSIG
BUDDY MENDES
BRIAN PACHECO
AMY SHUKLIAN
PETE VANDER POEL

Meeting Location:
County of Fresno
Board of Supervisors Chambers
2281 Tulare Street, #301
Fresno, CA 93721

AGENDA DATE: November 8, 2019

ITEM NUMBER: Item 12

SUBJECT: Approve Amendment to Extend Contract with
Price Paige & Company (A)

REQUEST(S): That the Board Approves the Amendment to
Extend the Contract With Price Paige & Company
to Cover the Audits of Fiscal Years 2019 & 2020

DESCRIPTION:

The SJVIA wishes to exercise the term extension options in Section 4.1 of the agreement with Price Paige & Company (PPC) for no more than two additional one-year terms. This extension will allow for the audits of the SJVIA's financial statements for fiscal years ending 2019 & 2020.

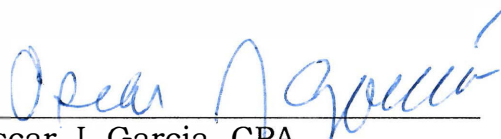
Upon approval of this amendment, the SJVIA Auditor-Treasurer staff along with the auditors at PPC will immediately begin conducting audit work for the fiscal year ending June 30, 2019 financial statements.

Because this signed amendment is dated October 18, 2019 – the original date of Board presentation – this agenda item will be considered retroactive.

FISCAL IMPACT/FINANCING:

None.

ADMINISTRATIVE SIGN-OFF:



Oscar J. Garcia, CPA
SJVIA Auditor-Treasurer

AMENDMENT NO. 1 TO AGREEMENT

This Amendment No. 1 to Agreement ("Amendment 1") is dated October 18, 2019, and is between PRICE, PAIGE & COMPANY ACCOUNTANCY CORPORATION, a California corporation doing business at 677 Scott Avenue, Clovis, California 93612 ("**Contractor**"), and the SAN JOAQUIN VALLEY INSURANCE AUTHORITY, a joint powers agency ("**SJVIA**").

On August 25, 2017, the parties entered into an agreement to provide for annual audits of the SJVIA's financial statements for the Fiscal Years ending June 30, 2016, June 30, 2017, and June 30, 2018 ("Agreement"). Section 4.1 of the Agreement provided that the term of the Agreement may be extended for no more than two additional one-year terms by modification as provided in section 10.1 of the Agreement.

The parties now desire to enter into this Amendment 1 extend the Agreement for two additional one-year terms, to provide for annual audits of the SJVIA's financial statements for the Fiscal Years ending June 30, 2019, and June 30, 2020.

The Contractor represents and warrants to the SJVIA that it is ready, willing, and able to provide the services desired by the SJVIA subject to the terms and conditions of this Amendment 1, and in cooperation with and under the direction of the SJVIA Board of Directors and SJVIA management.

The parties therefore agree as follows:

1. Section 1.3 of the Agreement is amended to provide in its entirety as follows:

"1.3 **Key Persons.** The Contractor shall provide all services under this agreement through the following key persons:

Fausto Hinojosa, CPA CFE – Principal

Usman Ilyas, CPA – Manager

Osvaldo Gutierrez, CPA – QC Manager

Larisa Murren, CPA – Senior"

2. Section 1.7 of the Agreement is amended to replace the listed Designated Representative with Fausto Hinojosa, CPA CFE, Principal.

3. Section 4.1 of the Agreement is amended to provide in its entirety as follows:

"4.1 **Term.** This agreement is effective on August 25, 2017, until the Contractor has performed all of its obligations under this agreement, or until February 28, 2021, whichever is later."

4. Section 4, "Audit Schedules," of Exhibit A to the Agreement, "Contractor Scope of Services," is amended to add the following:

"d. The audit of the Fiscal Year Ending June 30, 2019, shall commence no later than October 1, 2019, with the final report for Fiscal Year Ending June 30, 2019, to be submitted on or before February 28, 2020.

e. The audit of the Fiscal Year ending June 30, 2020, shall commence no later than October 1, 2020, with the final report for Fiscal Year Ending June 30, 2020, to be submitted on or before February 28, 2021."

5. Exhibit B to the Agreement, "Contractor Compensation," is amended to add the following hourly compensation amounts above the middle paragraph (beginning "The compensation payable..." and ending "...the following total amounts:"):

"For the Fiscal Years ending June 30, 2019 and June 30, 2020, the SJVIA shall pay and the Contractor shall receive compensation for services under this agreement at the following hourly rates:

Partner: \$280 per hour

Manager: \$175 per hour

Senior: \$150 per hour

Staff: \$120 per hour"

6. Exhibit B to the Agreement, "Contractor Compensation," is further amended to delete the last paragraph (beginning "If this agreement..." and ending "...and the Contractor") and to add the following maximum compensation amounts:

"Fiscal Year Ending June 30, 2019: \$20,100

Fiscal Year Ending June 30, 2020: \$20,700"

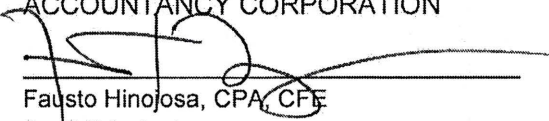
7. When both parties have signed this Amendment 1, the Agreement and this Amendment 1 together constitute the Agreement.

8. The Agreement as amended by this Amendment 1 is ratified and continued. All terms of the Agreement not amended by this Amendment 1 remain in full force and effect.


[SIGNATURE PAGE FOLLOWS]

The parties are signing this agreement on the date stated in the introductory clause.

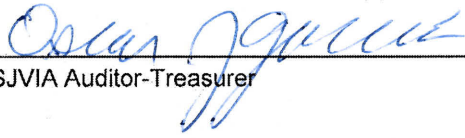
PRICE, PAIGE & COMPANY
ACCOUNTANCY CORPORATION


Fausto Hinojosa, CPA, CFE
Audit Principal

SAN JOAQUIN VALLEY INSURANCE
AUTHORITY


Buddy Mendes
President, Board of Directors

Reviewed and recommended for approval.


SJVIA Auditor-Treasurer

**BOARD OF DIRECTORS**

STEVE BRANDAU
KUYLER CROCKER
NATHAN MAGSIG
BUDDY MENDES
BRIAN PACHECO
AMY SHUKLIAN
PETE VANDER POEL

Meeting Location:
County of Fresno
Board of Supervisors Chambers
2281 Tulare Street, #301
Fresno, CA 93721

AGENDA DATE: November 8, 2019

ITEM NUMBER: Item 13

SUBJECT: Approve Revised 2019 Board Meeting Calendar and Proposed 2020 Board Meeting Calendar (A)

REQUEST(S): That the Board approve the revised 2019 Board Meeting Calendar and the proposed 2020 Board Meeting Calendar.

DESCRIPTION:**Revised 2019 Board Meeting Calendar**

The Board approved the revised 2019 SJVIA Board Meeting Calendar at the July 19, 2019 Board meeting. Due to another scheduling conflict, the October 18, 2019 Board meeting was rescheduled to November 8, 2019.

Proposed 2020 Board Meeting Calendar

The proposed schedule recommends six meetings of the Board in 2020 and maintains the tradition of alternating meeting locations between the County of Fresno and the County of Tulare with meeting times scheduled from 9:00am to 12:00pm. The Board may elect to adopt other dates and times or add meetings based on SJVIA business and Board availability. Adopting dates today will allow staff to reserve locations and publish the final 2020 SJVIA Board Calendar.

FISCAL IMPACT/FINANCING:

None.

ADMINISTRATIVE SIGN-OFF:

A handwritten signature in black ink that reads "Rhonda Sjostrom".

Rhonda Sjostrom
SJVIA Manager

A handwritten signature in black ink that reads "Paul Nerland".

Paul Nerland
SJVIA Assistant Manager

Board of Directors Meetings—2019

SCHEDULE

<u>Date</u>	<u>Time</u>	<u>City</u>	<u>Location</u>
February 22, 2019 (Friday)	9:00am - 12:00pm	Fresno	Fresno County BOS Chambers
May 3, 2019 (Friday)	9:00am - 12:00pm	Visalia	Tulare County BOS Chambers
July 19, 2019 (Friday)	9:00am - 12:00pm	Fresno	Fresno County BOS Chambers
August 23, 2019 (Friday)	9:00am - 12:00pm	Visalia	Tulare County BOS Chambers
November 8, 2019 (Friday)	9:00am - 12:00pm	Fresno	Fresno County BOS Chambers
December 6, 2019 (Friday)	9:00am - 12:00pm	Visalia	Tulare County BOS Chambers

LOCATIONS:

Fresno County Board of Supervisors Chambers

2281 Tulare Street, #301
Fresno, CA 93721

FCERA - Fresno County Employees' Retirement Association*

7772 N. Palm Avenue
Fresno, CA 93711

Tulare County Board of Supervisors Chambers

2800 W. Burrell Avenue
Visalia, CA 93291

TCERA - Tulare County Employee Retirement Association*

136 N. Akers Street
Visalia, CA 93291

*Alternate location should County Board of Supervisors Chambers not be available

Board of Directors Meetings—2020 SCHEDULE

<u>Date</u>	<u>Time</u>	<u>City</u>	<u>Location</u>
February 21, 2020 (Friday)	9:00am - 12:00pm	Fresno	Fresno County BOS Chambers
May 8, 2020 (Friday)	9:00am - 12:00pm	Visalia	Tulare County BOS Chambers
July 17, 2020 (Friday)	9:00am - 12:00pm	Fresno	Fresno County BOS Chambers
August 21, 2020 (Friday)	9:00am - 12:00pm	Visalia	Tulare County BOS Chambers
October 16, 2020 (Friday)	9:00am - 12:00pm	Fresno	Fresno County BOS Chambers
December 11, 2020 (Friday)	9:00am - 12:00pm	Visalia	Tulare County BOS Chambers

LOCATIONS:

Fresno County Board of Supervisors Chambers

2281 Tulare Street, #301
Fresno, CA 93721

FCERA - Fresno County Employees' Retirement Association*

7772 N. Palm Avenue
Fresno, CA 93711

Tulare County Board of Supervisors Chambers

2800 W. Burrell Avenue
Visalia, CA 93291

TCERA - Tulare County Employee Retirement Association*

136 N. Akers Street
Visalia, CA 93291

*Alternate location should County Board of Supervisors Chambers not be available

**BOARD OF DIRECTORS**

STEVE BRANDAU

KUYLER CROCKER

NATHAN MAGSIG

BUDDY MENDES

BRIAN PACHECO

AMY SHUKLIAN

PETE VANDER POEL

Meeting Location:
County of Fresno
Board of Supervisors Chambers
2281 Tulare Street, #301
Fresno, CA 93721

AGENDA DATE: November 8, 2019

ITEM NUMBER: Item 14

SUBJECT: Receive Notification from the City of Marysville of Its Intent to Terminate Participation in the SJVIA Effective December 31, 2019 (I)

REQUEST(S): That the Board receive the notification of the City of Marysville's intent to terminate participation in the SJVIA effective December 31, 2019.

DESCRIPTION:

At the July 19, 2019 meeting, the Board approved a motion requesting a reduction of notification of intent to terminate participation in the SJVIA from 120 days to 90 days by the City of Marysville.

On September 25, 2019, the SJVIA received official notification from the City of Marysville that they will be terminating participation in the SJVIA effective December 31, 2019.

FISCAL IMPACT/FINANCING:

The impact of run-out claims for the City of Marysville is estimated at \$130,000. This includes a 15% margin. These monies are currently reserved and funded in the IBNR reserve. If projections equal realized run-out claims, the IBNR reserve will decrease by \$130,000.

ADMINISTRATIVE SIGN-OFF:

A handwritten signature in black ink, reading "Rhonda Sjostrom".

Rhonda Sjostrom
SJVIA Manager

A handwritten signature in black ink, reading "Paul Nerland".

Paul Nerland
SJVIA Assistant Manager



CITY OF MARYSVILLE

FINANCE DEPARTMENT
526 C STREET
MARYSVILLE, CALIFORNIA
95901

TELEPHONE
(530) 749-3903
FACSIMILE
(530) 749-3992

September 25, 2019

Rhonda Sjostrom
SJVIA Manager
2500 West Burrel Avenue
Visalia, CA 93291

Paul Nerland
SJVIA Assistant Manager
2220 Tulare Street, 14th Floor
Fresno, CA 93721

Sent via email:

sjvia-admin@co.fresno.ca.us

Subject: Notification of Termination

Dear Ms. Sjostrom and Mr. Nerland,

Please accept this notification that the City of Marysville will be terminating participation in the SJVIA effective December 31, 2019.

Sincerely,

Jennifer Styczynski
Finance Director
jennifers@marysville.ca.us

**BOARD OF DIRECTORS**

STEVE BRANDAU

KUYLER CROCKER

NATHAN MAGSIG

BUDDY MENDES

BRIAN PACHECO

AMY SHUKLIAN

PETE VANDER POEL

Meeting Location:
County of Fresno
Board of Supervisors Chambers
2281 Tulare Street, #301
Fresno, CA 93721

AGENDA DATE: November 8, 2019

ITEM NUMBER: Item 15

SUBJECT: Approve and Authorize President to Execute SJVIA Participation Agreements for the County of Fresno, Effective December 16, 2019, and the County of Tulare, Effective January 1, 2020 (A)

REQUEST(S): That the Board approve and authorize President to execute SJVIA Participation Agreements for the County of Fresno and the County of Tulare for the 2020 Plan Year.

DESCRIPTION:

Each entity that participates in the SJVIA's program offerings executes a participation agreement with the SJVIA. Each participation agreement includes exhibits that cover the programs the entity has chosen and the benefits and rates that apply to those programs.

FISCAL IMPACT/FINANCING:

None.

ADMINISTRATIVE SIGN-OFF:

A handwritten signature in black ink that reads "Rhonda Sjostrom".

Rhonda Sjostrom
SJVIA Manager

A handwritten signature in black ink that reads "Paul Nerland".

Paul Nerland
SJVIA Assistant Manager

SJVIA PARTICIPATION AGREEMENT

THIS AGREEMENT ("Agreement") is made and entered into this 16th day of December 2019, by and between **COUNTY OF FRESNO**, a political subdivision of the State of California, hereinafter referred to as "**COUNTY OF FRESNO**," 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 FRESNO 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 FRESNO elects to participate in the selected SJVIA health insurance programs as referenced in Exhibit "A" (collectively, "SELECTED PROGRAMS"); and

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 FRESNO'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 FRESNO and the SJVIA now desire to enter into this Agreement to secure the COUNTY OF FRESNO's commitment to remit premium payments to the SJVIA for the Various Benefits to be provided under the Insurance Contract, and the COUNTY OF FRESNO'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. COUNTY OF FRESNO's OBLIGATIONS: The COUNTY OF FRESNO acknowledges that this agreement requires a commitment to participate in SJVIA Various Benefits effective December 16, 2019 through December 31, 2020. 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 FRESNO 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 FRESNO 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 December 16, 2019. The attached rates in Exhibit "B" reference only the SELECTED PROGRAMS the COUNTY OF FRESNO is electing. Exhibit "B" also references the effective term such rates apply to the COUNTY OF FRESNO which are effective December 16, 2019 through December 31, 2020. The COUNTY OF FRESNO 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 uses actuarially based underwriting standards.

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

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

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

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

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

COUNTY OF FRESNO

Paul Nerland
Director of Human Resources
2220 Tulare St, 16th Floor
Fresno, CA 93721
PNerland@fresnocountyca.gov

SJVIA

Rhonda Sjostrom
SJVIA Manager
2500 West Burrel
Visalia, CA 93291
rsjostro@co.tulare.ca.us

Any and all notices between the COUNTY OF FRESNO and the SJVIA provided for or permitted under this Agreement shall be in writing and delivered either by person service, by first-class United States mail, by an overnight commercial courier service, or by telephonic facsimile transmission. A notice delivered by personal service is effective upon service to the recipient. A notice delivered by first-class United States mail is effective three business days after deposit in the United States mail, postage prepaid, addressed to the recipient. A notice delivered by an overnight commercial courier service is effective one business day after deposit with the overnight commercial

courier service, delivery fees prepaid, with delivery instructions given for next day delivery, addressed to the recipient. A notice delivered by telephonic facsimile is effective when transmission to the recipient is completed (but, if such transmission is completed outside of COUNTY OF FRESNO business hours, then such delivery shall be deemed to be effective at the next beginning of a COUNTY OF FRESNO business day), provided that the sender maintains a machine record of the completed transmission. For all claims arising out of or related to this Agreement, nothing in this section establishes, waives, or modifies any claims presentation requirements or procedures provided by law, including but not limited to the Government Claims Act (Division 3.6 of Title 1 of the Government Code, beginning with section 810).

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 December 16, 2019 and shall terminate on December 31, 2020.

9. **TERMINATION:**

- a. The terms of this Agreement, and the health insurance programs, administrative services, and/or SJVIA staff costs to be provided hereunder, are contingent on the approval of funds by the COUNTY OF FRESNO. 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 FRESNO 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 FRESNO 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 FRESNO with respect to the subject matter hereof and supersedes all previous agreement negotiations, proposals, commitments, writings, advertisements, publications, and understandings of any nature whatsoever unless expressly included in this Agreement.

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

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///

(Go to next page for signatures)

**AGREEMENT BETWEEN COUNTY OF FRESNO AND THE
SAN JOAQUIN VALLEY INSURANCE AUTHORITY**

**SAN JOAQUIN VALLEY INSURANCE
AUTHORITY:**

By: _____
Ernest Buddy Mendes
SJVIA Board President

Date: _____

**REVIEWED & RECOMMENDED
FOR APPROVAL**

By: _____
Rhonda Sjostrom
SJVIA Manager

COUNTY OF FRESNO:

By: _____
Nathan Magsig
Chairman of the Board of Supervisors of
the County of Fresno

Date: _____

ATTEST:

Bernice E. Seidel
Clerk of the Board of Supervisors
County of Fresno, State of California

By: _____



BOARD OF DIRECTORS

STEVE BRANDAU

KUYLER CROCKER

NATHAN MAGSIG

BUDDY MENDES

BRIAN PACHECO

AMY SHUKLIAN

PETE VANDER POEL

Exhibit A

County of Fresno

**Plan Year 2020
Benefit Summaries**

- Anthem Blue Cross EPO 0/15/0
- Anthem Blue Cross PPO 250/20/100/50
- Anthem Blue Cross PPO 1000/45/80/50
- Anthem Blue Cross HDHD PPO 1500/2700/80/60
- Anthem Blue Cross HDHP PPO 3000/100/50
- EmpiRx Health Prescription Benefit
- Kaiser Permanente HMO
- Delta Dental PPO
- Delta Dental DHMO
- VSP Vision Benefits

Your summary of benefits

Anthem Blue Cross

Your Plan: SJVIA Custom EPO 0/15/0

Your Network: EPO

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Certificate of Insurance or Evidence of Coverage (EOC). If there is a difference between this summary and the Certificate of Insurance or Evidence of Coverage (EOC), the Certificate of Insurance or Evidence of Coverage (EOC), will prevail.

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible <i>See notes section to understand how your deductible works.</i>	\$0 single / \$0 family	Not covered
Out-of-Pocket Limit (Medical only) <i>When you meet your out-of-pocket limit, you will no longer have to pay cost-shares during the remainder of your benefit period. See notes section for additional information regarding your out of pocket maximum.</i>	\$1,000 single / \$2,000 family	Not covered
Preventive care/screening/immunization	No charge	Not covered
Doctor Home and Office Services		
Primary care visit to treat an injury or illness	\$15 copay per visit	Not covered
Specialist care visit	\$15 copay per visit	Not covered
Prenatal and Post-natal Care	No charge	Not covered
Other practitioner visits: Retail health clinic On-line Visit with LiveHealth Online <i>Includes Mental/ Behavioral Health and Substance Abuse</i> Chiropractor services <i>Coverage for In-Network Provider is limited to 40 visit limit per benefit period. Chiropractic appliances are limited to \$50 per benefit period.</i> Acupuncture	\$15 copay per visit \$15 copay per visit \$10 copay per visit \$15 copay per visit	Not covered Not covered Not covered Not covered

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Other services in an office: Allergy testing Chemo/radiation therapy Hemodialysis Prescription drugs <i>For the drugs itself dispensed in the office thru infusion/injection</i>	No charge No charge No charge No charge	Not covered Not covered Not covered Not covered
Diagnostic Services Lab: Office Freestanding Lab Outpatient Hospital	No charge No charge No charge	Not covered Not covered Not covered
X-ray: Office Freestanding Radiology Center Outpatient Hospital	No charge No charge No charge	Not covered Not covered Not covered
Advanced diagnostic imaging (for example, MRI/PET/CAT scans): Office Freestanding Radiology Center Outpatient Hospital	No charge No charge No charge	Not covered Not covered Not covered
Emergency and Urgent Care Emergency room facility services <i>This is for the hospital/facility charge only. The ER physician charge may be separate. Copay waived if admitted.</i> Emergency room doctor and other services	\$100 copay per visit No charge	Covered as In-Network Covered as In-Network

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Ambulance (air and ground)	No charge	Covered as In-Network
Urgent Care (office setting/freestanding facility)	\$15 copay per visit	Not covered
Outpatient Mental/Behavioral Health and Substance Abuse		
Doctor office visit or LiveHealth Online visit	\$15 copay per visit	Not covered
Facility visit:		
Facility fees	No charge.	Not covered
Outpatient Surgery		
Facility fees:		
Hospital	No charge	Not covered
Freestanding Surgical Center	No charge	Not covered
Doctor and other services	No charge	Not covered
Hospital Stay (all inpatient stays including maternity, mental / behavioral health, and substance abuse)		
Facility fees (for example, room & board)	No charge	Not covered
Doctor and other services	No charge	Not covered
Recovery & Rehabilitation		
Home health care <i>Coverage for In-Network Provider is limited to 100 visits per calendar year.</i>	\$15 copay per visit	Not covered

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Rehabilitation services (for example, physical/speech/occupational therapy): Office <i>Costs may vary by site of service. Limited to a 60-day period of care.</i> Outpatient hospital <i>Limited to a 60-day period of care.</i> Habilitation services Office Outpatient hospital	\$15 copay per visit No charge \$15 copay per visit No charge	Not covered Not covered Not covered Not covered
Cardiac rehabilitation Office Outpatient hospital	\$15 copay per visit No charge	Not covered Not covered
Skilled nursing care (in a facility) <i>Coverage for In-Network Provider is limited to 100 days per calendar year.</i>	No charge	Not covered
Hospice	No charge	Not covered
Durable Medical Equipment <i>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.</i>	No charge	Not covered
Prosthetic Devices	No charge	Not covered
Home Infusion Therapy <i>Subject to utilization review.</i>	\$15 copay per visit	Not covered
Family Planning and Infertility Services <ul style="list-style-type: none"> Infertility studies and tests Female sterilization (<i>including tubal ligation and counseling/consultation</i>) Male sterilization Counseling and consultation California fetal genetic testing 	\$15 copay per visit No charge \$15 copay \$15 copay per visit No charge	Not covered

Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Smoking Cessation Program	No charge	Not covered

Your summary of benefits

Notes:

- This Summary of Benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this Summary of Benefits. This Summary of Benefits, as updated, is subject to the approval of the California Department of Insurance and the California Department of Managed Health Care (as applicable).
- In addition to the benefits described in this summary, coverage may include additional benefits, depending upon the member's home state. The benefits provided in this summary are subject to federal and California laws. There are some states that require more generous benefits be provided to their residents, even if the master policy was not issued in their state. If the member's state has such requirements, we will adjust the benefits to meet the requirements.
- The family deductible and out-of-pocket maximum are embedded meaning the cost shares of one family member will be applied to the individual deductible and individual out-of-pocket maximum; in addition, amounts for all family members apply to the family deductible and family out-of-pocket maximum. No one member will pay more than the individual deductible and individual out-of-pocket maximum.
- All medical services subject to a coinsurance are also subject to the annual medical deductible.
- Annual Out-of-Pocket Maximums includes deductible, copays, coinsurance and prescription drug.
- Preventive Care Services includes physical exam, preventive screenings (including screenings for cancer, HPV, diabetes, cholesterol, blood pressure, hearing and vision, immunization, health education, intervention services, HIV testing) and additional preventive care for women provided for in the guidance supported by Health Resources and Service Administration.
- For plans with an office visit copay, the copay applies to the actual office visit and additional cost shares may apply for any other service performed in the office (i.e., X-ray, lab, surgery), after any applicable deductible.
- If your plan includes an emergency room facility copay and you are directly admitted to a hospital, your emergency room facility copay is waived.
- Certain services are subject to the utilization review program. Before scheduling services, the member must make sure utilization review is obtained. If utilization review is not obtained, benefits may be reduced or not paid, according to the plan.
- Additional visits may be authorized if medically necessary. Pre-service review must be obtained prior to receiving the additional services.
- Transplants covered only when performed at Centers of Medical Excellence or Blue Distinction Centers.
- Bariatric Surgery covered only when performed at Blue Distinction Center for Specialty Care for Bariatric Surgery.
- Skilled Nursing Facility day limit does not apply to mental health and substance abuse.
- Respite Care limited to 5 days per admission.
- Freestanding Lab and Radiology Center is defined as services received in a non-hospital based facility.
- 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 coverage do not exceed 100% of the covered expense

Your summary of benefits

- For additional information on limitations and exclusions and other disclosure items that apply to this plan, go to https://le.anthem.com/pdf?x=CA_LG_EPO
- For additional information on this plan, please visit sbc.anthem.com to obtain a Summary of Benefit Coverage.

SJVA Modified Chiropractic Care EPO Rider Plan 10/40

The benefits described in this Rider are provided through an agreement between Anthem Blue Cross and American Specialty Health Plans of California (ASH Plans). The services listed below are covered only if provided by an ASH Plans Chiropractor. These benefits are provided in addition to the benefits described in the Anthem Blue Cross EPO Evidence of Coverage (EOC) document. However, when expenses are incurred for treatment received from an ASH Plans Chiropractor, no other benefits other than the benefits described in this Rider will be paid.

Covered Services	Member's Copayment
Office Visit to a Chiropractor	\$10/visit
Maximum Benefits	
Office visits to a Chiropractor	40 visits per calendar year
Chiropractic appliances	\$50 per calendar year
Covered Services	

Chiropractor Services: Member has up to 40 visits in a calendar year for chiropractor care services that are determined by ASH PLANS to be medically/clinically necessary. All visits to an ASH Plans chiropractor will be applied towards the maximum number of visits in a calendar year. The ASH Plans chiropractor is responsible for submitting a treatment plan to ASH Plans for prior approval.

Covered services include:

- An initial new patient exam by an ASH Plans chiropractor to determine the appropriateness of chiropractic services.
- Follow-up office visits as set forth in a treatment plan approved by ASH Plans and provided by an ASH Plans chiropractor
- An established patient exam performed by an ASH Plans chiropractor to assess the need to continue, extend or change a treatment plan approved by ASH Plans.
- Adjunctive physiotherapy modalities and procedures as set forth in a treatment plan approved by ASH Plans and provided by ASH Plans chiropractor.
- Radiological x-rays and laboratory tests when prescribed by an ASH Plans chiropractor and approved by ASH Plans. Covered services include radiological consultations when determined by ASH Plans to be medically/clinically necessary and provided by a licensed chiropractic radiologist, medical radiologist, radiology group or hospital which has contracted with ASH Plans to provide those services.
- **Chiropractic Appliances:** Up to \$50 per calendar year when prescribed by an ASH Plans chiropractor and approved by ASH Plans. Covered chiropractic appliances are limited to:
 - elbow supports, back supports (thoracic), lumbar braces and supports, rib supports, or wrist supports;
 - cervical collars or cervical pillows;
 - ankle braces, knee braces, or wrist braces;
 - heel lifts;
 - hot or cold packs;
 - lumbar cushions;
 - rib belts or orthotics; and
 - home traction units for treatment of the cervical or lumbar regions.

Chiropractic Care Rider Exclusions & Limitations

Care Not Approved: Any services provided by an ASH Plans chiropractor that are not approved by ASH Plans except as specified as covered in the Evidence of Coverage (EOC). An ASH Plans chiropractor is responsible for submitting a treatment plan to ASH Plans for prior approval.

Care Not Covered: In addition to any service or supply specifically excluded in the EOC, no benefits will be provided for chiropractic services or supplies in connection with:

- Diagnostic scanning, such as magnetic resonance imaging (MRI) or computerized axial tomography (CAT) scans.
- Thermography.
- Hypnotherapy.
- Behavior training.
- Sleep therapy.
- Weight programs.
- Any non-medical program or service.
- Pre-employment examinations, any chiropractic services required by an employer that are not medically/clinically necessary, or vocational rehabilitation.
- Services and/or treatments which are not documented as medically/clinically necessary.
- Massage therapy.
- Any service or supply for the exam and/or treatment by an ASH chiropractor for conditions other than those related to neuromusculoskeletal disorders.
- Transportation costs including local ambulance charges.
- Education programs, non-medical self-care or self-help, or any self-help physical exercise training or any related diagnostic testing.
- Hospitalization, surgical procedures, anesthesia, manipulation under anesthesia, proctology, colonic irrigation, injections and injection services, or other related services;

- All auxiliary aids and services, including, but not limited to, interpreters, transcription services, written materials, telecommunications devices, telephone handset amplifiers, television decoders and telephone compatible with hearing aids;
- Adjunctive therapy not associated with spinal, muscle or joint manipulation.
- Laboratory and diagnostic x-ray studies, except as specified as covered in the EOC.

Non-ASH Plans Chiropractors: Services and supplies provided by a chiropractor who does not have an agreement with ASH Plans to provide covered services under this plan.

Work Related: Care for health problems that are work-related if such health problems are covered by workers' compensation, an employer's liability law or similar law. We will provide care for a work-related health problem, but we have the right to be paid back for that care as described in the EOC.

Government Treatment: Any services actually given to the member by a local, state or federal government agency, except when this plan's benefits, must be provided by 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.

Drugs: Prescription drugs or medicines, including a non-legend or proprietary medicine or medication not requiring a prescription.

Supplement. Vitamins, minerals, dietary and nutritional supplements or other similar products and any herbal supplements.

Air Conditioners: Air purifiers, air conditioners, humidifiers, supplies or any other similar devices or appliances. All appliances or durable medical equipment, except as specified as covered in the EOC..

Personal Items: Any supplies for comfort, hygiene or beauty purposes, including therapeutic mattresses.

Out-Of-Area and Emergency Care: Out-of-area care is not covered under this Chiropractic benefit, except for emergency services. The member should follow the procedures specified by their Anthem Blue Cross EPO plan to obtain emergency or out-of-area care.

Third Party Liability

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

Anthem Blue Cross is the trade name of Blue Cross of California. Independent Licensee of the Blue Cross Association. ® ANTHEM is a registered trademark. ® The Blue Cross name and symbol are registered marks of the Blue Cross Association.

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.

Subject to Utilization Review

Certain services are subject to the utilization review program. Before scheduling services, the member must make sure utilization review is obtained. If utilization review is not obtained, benefits may be reduced or not paid, according to the plan.

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.

Benefit year deductible for all providers	\$250/member \$500/family (combined/aggregate)	
Deductible for non-Anthem Blue Cross PPO hospital or residential treatment center	\$500/admission <i>(waived for emergency admission)</i>	
Deductible for non-Anthem Blue Cross PPO hospital or residential treatment center if utilization review not obtained	\$500/admission <i>(waived for emergency admission)</i>	
Deductible for emergency room services	\$100/visit <i>(waived if admitted directly from ER)</i>	
Annual Out-of-Pocket Maximums <i>(no cross application)</i>		
PPO Providers & Other Health Care Providers	\$3,000/member/year; \$5,000/family/year	
Non-PPO Providers	\$10,000/member/year; \$15,000/family/year	
The following do not apply to the medical out-of-pocket maximums: non-covered expenses and prescription drugs. After an annual out-of-pocket maximum is met for medical during a calendar year, the individual member or family will no longer be required to pay a copay or coinsurance for medical. The member remains responsible for non-covered expenses and prescription drugs		
Lifetime Maximum	Unlimited	
Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay
Hospital Medical Services <i>(subject to utilization review for inpatient services; waived for emergency admissions)</i>		
➤ Semi-private room, meals & special diets, & ancillary services	No copay	50% ¹
➤ Outpatient medical care, surgical services & supplies <i>(hospital care other than emergency room care)</i>	No copay	50% ¹
Ambulatory Surgical Centers		
➤ Outpatient surgery, services & supplies	No copay	50% <i>(benefit limited to \$350/day)</i>
Skilled Nursing Facility <i>(subject to utilization review)</i>		
➤ Semi-private room, services & supplies <i>(limited to 100 days/benefit year)</i>	No copay	50%
Hospice Care		
➤ Inpatient or outpatient services ; family bereavement services	No copay ²	
Home Health Care <i>(subject to utilization review)</i>		
➤ Services & supplies from a home health agency <i>(limited to 100 visits/benefit year, one visit by a home health aide equals four hours or less; not covered while member receives hospice care)</i>	No copay	50%

¹ For California facilities, a discount will be applied if the facility has a contract with Anthem Blue Cross for fee-for-service business. For California facilities without a contract, covered expense for non-emergency hospital services and supplies is reduced by 25%, resulting in higher costs for members.

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

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay
Home Infusion Therapy <i>(subject to utilization review)</i>		
➤ Includes medication, ancillary services & supplies; caregiver training & visits by provider to monitor therapy; durable medical equipment; lab services	No copay	50% <i>(benefit limited to \$600/day)</i>
Physician Medical Services		
➤ Office & home visits	\$20/visit ¹ <i>(deductible waived)</i>	50%
➤ Preferred On-line Visit <i>(Includes Mental/Behavioral Health and Substance Abuse)</i>	\$20/visit ² <i>(deductible waived)</i>	50%
➤ Hospital & skilled nursing facility visits	No copay	50%
➤ Surgeon & surgical assistant; anesthesiologist or anesthesiologist	No copay	50%
➤ Drugs administered by a medical provider <i>(certain drugs are subject to utilization review)</i>	No copay	50%
Diagnostic X-ray & Lab		
➤ MRI, CT scan, PET scan & nuclear cardiac scan <i>(subject to utilization review)</i>	No copay	50%
➤ Other diagnostic x-ray & lab	No copay	50%
Preventive Care services		
Preventive Care Services including*, physical exams, preventive screenings (including screenings for cancer, HPV, diabetes, cholesterol blood pressure, hearing and vision, immunizations, health education, intervention services, HIV testing), and additional preventive care for women provided for in the guidelines supported by the Health Resources and Services Administration. *This list is not exhaustive. This benefit includes all Preventive Care Services required by federal and state law.	No copay <i>(deductible waived)</i>	50%
Physical Therapy, Physical Medicine & Occupational Therapy, including Chiropractic Services <i>(limited to 24 visits/benefit year; additional visits may be authorized)</i>	No copay	50%
Speech Therapy		
➤ Outpatient speech therapy following injury or organic disease	No copay	50%
Acupuncture		
➤ Services for the treatment of disease, illness or injury <i>(limited to 12 visits/benefit year)</i>	No copay ²	50% ²
Temporomandibular Joint Disorders		
➤ Splint therapy & surgical treatment	No copay	50%
Pregnancy & Maternity Care		
➤ Physician office visits	No copay	50%
➤ Prescription drug for elective abortion <i>(mifepristone)</i>	No copay	50%
Normal delivery, cesarean section, complications of pregnancy & abortion		
➤ Inpatient physician services	No copay	50%
➤ Hospital & ancillary services	No copay	50% ³

¹ The dollar copay applies only to the visit itself. An additional No copay applies for any services performed in office (i.e., X-ray, lab, surgery), after any applicable deductible.

² 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.). ³ For California facilities, a discount will be applied if the facility has a contract with Anthem Blue Cross for fee-for-service business. For California facilities without a contract, covered expense for non-emergency hospital services and supplies is reduced by 25%, resulting in higher costs for members.

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay
Organ & Tissue Transplants <i>(subject to utilization review; specified organ transplants covered only when performed at Center of Expertise [COE])</i>		
➤ Inpatient services provided in connection with non-investigative organ or tissue transplants		No copay
➤ Transplant travel expense for an authorized, specified transplant at a COE <i>(recipient & companion transportation limited to 6trips/episode & \$250/person/trip for round-trip coach airfare, 21 days/trip, other expenses 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)</i>		No copay <i>(deductible waived)</i>
Bariatric Surgery <i>(subject to utilization review; medically necessary surgery for weight loss, only for morbid obesity, covered only when performed at a Center of Expertise [COE])</i>		
➤ Inpatient services provided in connection with medically necessary surgery for weight loss, only for morbid obesity		No copay
➤ Bariatric travel expense when member's home is 50 miles or more from the nearest bariatric COE <i>(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)</i>		No copay <i>(deductible waived)</i>
Diabetes Education Programs <i>(requires physician supervision)</i>		
➤ Teach members & their families about the disease process, the daily management of diabetic therapy & self-management training	\$20/visit <i>(deductible waived)</i>	50%
Prosthetic Devices		
➤ Coverage for breast prostheses; prosthetic devices to restore a method of speaking; surgical implants; artificial limbs or eyes; the first pair of contact lenses or eyeglasses when required as a result of eye surgery; & therapeutic shoes & inserts for members with diabetes	No copay	50%
Durable Medical Equipment		
➤ Rental or purchase of DME including hearing aids, dialysis equipment & supplies <i>(hearing aids benefit is 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)</i>	No copay	50%
Related Outpatient Medical Services & Supplies		
➤ Ground or air ambulance transportation, services & disposable supplies		No copay ¹
➤ Blood transfusions, blood processing & the cost of unreplaced blood & blood products		No copay ¹
➤ Autologous blood <i>(self-donated blood collection, testing, processing & storage for planned surgery)</i>		No copay ¹

¹ These providers are not represented in the Anthem Blue Cross PPO network.

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay
Emergency Care		
➤ Emergency room services & supplies (<i>\$100 deductible waived if admitted</i>)	No copay	No copay
➤ Inpatient hospital services	No copay	No copay
➤ Physician services	No copay	No copay
Mental or Nervous Disorders and Substance Abuse		
➤ Inpatient facility care (<i>subject to utilization review; waived for emergency admissions</i>)	100%	50% ¹
➤ Inpatient physician visits	100%	50%
➤ Outpatient facility care	100%	50% ¹
➤ Physician office visits (<i>Behavioral Health Treatment for Autism & Pervasive Development disorders requires pre-service review</i>)	\$20/visit ² (<i>deductible waived</i>)	50%

¹ For California facilities, a discount applies if the facility has a contract with Anthem Blue Cross for fee-for-service business. For California facilities without a contract, covered expense for non-emergency hospital services and supplies is reduced by 25%, resulting in higher out-of-pocket costs for members.

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.

This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits. This proposed benefit summary is subject to the approval of the California Department of Insurance and the California Department of Managed Health Care.

Premier 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 insured person for free.

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

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

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

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

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

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

Mental or Nervous Disorders. Academic or educational testing, counseling, and remediation. Mental or nervous disorders and alcohol or drug dependence, 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. Hearing aids and routine hearing tests, except as specified as covered in the EOC.

Optometric Services or Supplies. Optometric services, eye exercises including orthoptics. Routine eye exams and routine eye refractions, 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 infusion therapy provider, except as specified as covered in the EOC.

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

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

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

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

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

Sterilization Reversal.

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

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

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

Air Conditioners. Air purifiers, air conditioners or humidifiers.

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

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

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

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

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

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

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

Acupuncture. Acupuncture treatment, 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.

Residential accommodations. Residential accommodations to treat medical or behavioral health conditions, except when provided in a hospital, hospice, skilled nursing facility or residential treatment center. This exclusion includes procedures, equipment, services, supplies or charges for the following:

- Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
- Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
- Services or care provided or billed by a school, custodial care center for the developmentally disabled, or outward bound programs, even if psychotherapy is included.

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.

This plan includes custom benefits that may supersede some of the information included in the Limitations and Exclusions provided here. Please see your EOC for full details on your covered benefits.

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.

Subject to Utilization Review

Certain services are subject to the utilization review program. Before scheduling services, the member must make sure utilization review is obtained. If utilization review is not obtained, benefits may be reduced or not paid, according to the plan.

Explanation of Maximum Allowed Amount

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

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

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

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

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

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

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

²The 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.

³Acupuncture 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.).

⁴Applicable to the Annual Out-of-Pocket maximums

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay ¹
Organ & Tissue Transplants <i>(subject to utilization review; specified organ transplants covered only when performed at a Center of Expertise [COE])</i>		
➤ Inpatient services provided in connection with non-investigative organ or tissue transplants		\$1,000/year ³ + 20%
➤ Transplant travel expense for an authorized, specified transplant at a COE <i>(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)</i>		No copay <i>(deductible waived)</i>
Bariatric Surgery <i>(subject to utilization review; medically necessary surgery for weight loss, only for morbid obesity, covered only when performed at a Center of Expertise [COE])</i>		
➤ Inpatient services provided in connection with medically necessary surgery for weight loss, only for morbid obesity		\$1,000/year ³ + 20%
➤ Bariatric travel expense when member's home is 50 miles or more from the nearest Bariatric COE <i>(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)</i>		No copay <i>(deductible waived)</i>
Diabetes Education Programs <i>(requires physician supervision)</i>		
➤ Teach members & their families about the disease process, the daily management of diabetic therapy & self-management training	\$45/visit <i>(deductible waived)</i>	50%
Prosthetic Devices		
➤ Coverage for breast prostheses; prosthetic devices to restore a method of speaking; surgical implants; artificial limbs or eyes; the first pair of contact lenses or eyeglasses when required as a result of eye surgery; & therapeutic shoes & inserts	50%	50%
Durable Medical Equipment		
➤ Rental or purchase of DME including dialysis equipment & supplies, home medical equipment, prosthetic/orthotics <i>(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)</i>	50%	50%
Related Outpatient Medical Services & Supplies		
➤ Ground or air ambulance transportation, services & disposable supplies		20% ²
➤ Blood transfusions, blood processing & the cost of unreplaced blood & blood products		20% ²
➤ Autologous blood <i>(self-donated blood collection, testing, processing & storage for planned surgery)</i>		20% ²

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

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

³ Applicable to the Annual Out-of-Pocket maximums

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

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

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

³ Applicable to the Annual Out-of-Pocket maximums

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

Classic PPO Plan Exclusions and Limitations

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Orthodontia. Braces, other orthodontic appliances or orthodontic services.

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

Hearing Aids or Tests.

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

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

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

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

Commercial Weight Loss Programs. Weight loss programs, whether or not they are pursued under medical or *physician* supervision, unless specifically listed as covered in this plan. This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

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

Sterilization Reversal.

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

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

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

Air Conditioners. Air purifiers, air conditioners or humidifiers.

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

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

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

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

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

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

Routine Exams or Tests. Routine physical exams or tests which do not directly treat an 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.

Residential accommodations. Residential accommodations to treat medical or behavioral health conditions, except when provided in a hospital, hospice, skilled nursing facility or residential treatment center. This exclusion includes procedures, equipment, services, supplies or charges for the following:

- Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
- Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
- Services or care provided or billed by a school, custodial care center for the developmentally disabled, or outward bound programs, even if psychotherapy is included.

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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SJVA County of Fresno Modified Health Savings Account (HSA) Anthem PPO HSA-H (1500/2800/80/60)

PPO Benefits

This 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.

Subject to Utilization Review

Certain services are subject to the utilization review program. Before scheduling services, the member must make sure utilization review is obtained. If utilization review is not obtained, benefits may be reduced or not paid, according to the plan.

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 & Home Delivery 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

(applicable to medical care & prescription drug benefits; the single deductible is applicable to a member that is enrolled as the only covered person on the plan (no dependents). Two or more people can accumulate towards the family deductible. No one member will pay more than the per member deductible of \$2,800. The deductibles accumulate (embedded) individuals on a family plan)

- For all Providers \$1,500 single/\$2,800per member/\$3,000 family
- Individual can receive benefits once individual deductible has been met

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)*

- Participating Providers, Participating Pharmacy & Other Health Care Providers \$3,000 single/\$3,000 per member/; \$5,000 family
- Non-Participating Providers & Non-Participating Pharmacy \$10,000 single/\$10,000 per member/ \$15,000 family

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

Lifetime Maximum

Unlimited

Covered Services	Traditional Health Coverage	
	In-Network	Out-of-Network (Insured is also responsible for charges in excess of covered expense.)
Hospital Medical Services <i>(subject to utilization review for inpatient services; waived for emergency admissions)</i>		
➤ Semi-private room, meals & special diets, & ancillary services	20%	40%
➤ Outpatient medical care, surgical services & supplies <i>(hospital care other than emergency room care)</i>	20%	40%
Ambulatory Surgical Centers		
➤ Outpatient surgery, services & supplies	20%	40% <i>(benefit limited to \$350/day)</i>
Skilled Nursing Facility <i>(subject to utilization review)</i>		
➤ Semi-private room, services & supplies <i>(limited to 100 days/calendar year; limit does not apply to mental health and substance abuse)</i>	20%	40%
Hospice Care		
➤ Inpatient or outpatient services for insured persons with up to one year life expectancy; family bereavement services	20%	40%
Home Health Care		
➤ Services & supplies from a home health agency <i>(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)</i>	20%	40%
Home Infusion Therapy		
➤ Includes medication, ancillary services & supplies; caregiver training & visits by provider to monitor therapy; durable medical equipment; lab services	20%	40% <i>(benefit limited to \$600/day)</i>
Physician Medical Services		
➤ Office & home visits	20%	40%
➤ Preferred On-line Visit <i>(Includes Mental/Behavioral Health and Substance Abuse)</i>	20%	40%
➤ Hospital & skilled nursing facility visits	20%	40%
➤ Surgeon & surgical assistant; anesthesiologist or anesthetist	20%	40%
➤ Drugs administered by a medical provider <i>(certain drugs are subject to utilization review)</i>	20%	40%
Diagnostic X-ray & Lab		
➤ MRI, CT scan, PET scan & nuclear cardiac scan <i>(subject to utilization review)</i>	20%	40%
➤ Other diagnostic x-ray & lab	20%	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.	No copay <i>(deductible waived)</i>	40%
*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) <i>(limited to 24 visits/calendar year)</i>	20%	40%
Speech Therapy		
➤ Outpatient speech therapy following injury or organic disease	20%	40%
Acupuncture		
➤ Services for the treatment of disease, illness or injury <i>(limited to 12 visits/calendar year)</i>	20% ¹	40% ¹
Temporomandibular Joint Disorders		
➤ Splint therapy & surgical treatment	20%	40%

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

Covered Services	Traditional Health Coverage	
	In-Network	Out-of-Network (Insured is also responsible for charges in excess of covered expense.)
Pregnancy & Maternity Care		
➤ Physician office visits	20%	40%
➤ Prescription drug for elective abortion (<i>mifepristone</i>)	20%	40%
Normal delivery, cesarean section, complications of pregnancy & abortion		
➤ Inpatient physician services	20%	40%
➤ Hospital & ancillary services	20%	40%
Organ & Tissue Transplants (<i>subject to utilization review; specified organ transplants covered only when performed at Centers of Medical Excellence [CME]</i>)		
➤ Inpatient services provided in connection with non-investigative organ or tissue transplants		20%
➤ Transplant travel expense for an authorized, specified transplant at a CME (<i>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</i>)		20%
Bariatric Surgery (<i>subject to utilization review; medically necessary surgery for weight loss, only for morbid obesity, covered only when performed at Centers of Medical Excellence [CME]</i>)		
➤ Inpatient services provided in connection with medically necessary surgery for weight loss, only for morbid obesity		20%
➤ Bariatric travel expense when insured person's home is 50 miles or more from the nearest bariatric CME (<i>insured person'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 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</i>)		20%
Diabetes Education Programs (<i>requires physician supervision</i>)		
➤ Teach insured persons & their families about the disease process, the daily management of diabetic therapy & self-management training	20%	40%
Prosthetic Devices		
➤ Coverage for breast prostheses; prosthetic devices to restore a method of speaking; surgical implants; artificial limbs or eyes; the first pair of contact lenses or eyeglasses when required as a result of eye surgery; wigs for alopecia resulting from chemotherapy or radiation therapy; & therapeutic shoes & inserts for insured persons with diabetes	20%	40%

Covered Services	Traditional Health Coverage	
	In-Network	Out-of-Network (Insured is also responsible for charges in excess of covered expense.)
Durable Medical Equipment		
Rental or purchase of DME including hearing aids, dialysis equipment & supplies (<i>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</i>)	20%	40%
Related Outpatient Medical Services & Supplies		
➤ Ground or air ambulance transportation, services & disposable supplies	20% ¹	
➤ Blood transfusions, blood processing & the cost of unreplaced blood & blood products	20% ¹	
➤ Autologous blood (<i>self-donated blood collection, testing, processing & storage for planned surgery</i>)	20% ¹	
Emergency Care		
➤ Emergency room services & supplies	20%	20%
➤ Inpatient hospital services & supplies	20%	20%
➤ Physician services	20%	20%
Mental or Nervous Disorders and Substance Abuse		
➤ Inpatient facility care (<i>subject to utilization review; waived for emergency admissions</i>)	20%	40%
➤ Inpatient physician visits	20%	40%
➤ Outpatient facility care	20%	40%
➤ Physician office visits (<i>Behavioral Health treatment for Autism & Pervasive Development Disorders require pre-service review</i>)	20%	40%

¹ These providers are not represented in the PPO network.

Covered Services	Traditional Health Coverage	
	In-Network	Out-of-Network (Insured is also responsible for charges in excess of the prescription drug maximum allowed amount)
Outpatient Prescription Drug Benefits		
➤ Preventive immunizations administered by a retail pharmacy	No copay (<i>deductible waived</i>)	
➤ Female oral contraceptives generic and single source brand	No copay (<i>deductible waived</i>)	
➤ Flu, Zostavax & Pneumococcal vaccines	No copay	
➤ Retail pharmacy prescription drug maximum allowed amount	20%	40% ¹
➤ Home Delivery prescription drug maximum allowed amount	20%	Not applicable
➤ Specialty pharmacy drugs (<i>obtained through specialty pharmacy program</i>)	20%	Not applicable
Supply Limits²		
➤ Retail Pharmacy (<i>participating and non-participating</i>)	30-day supply; 60-day supply for federally classified Schedule II attention deficit disorder drugs that require a triplicate prescription form, but require a double copay; 6 tablets or units/30-day period for impotence and/or sexual dysfunction drugs (available only at retail pharmacies)	
➤ Home Delivery	90-day supply	
➤ Specialty Pharmacy	30-day supply	

¹ Insured person remains responsible for the costs in excess of the prescription drug maximum amount allowed.

² Supply limits for certain drugs may be different. Please refer to the Certificate of Insurance for complete information.

The Outpatient Prescription Drug Benefit covers the following:

- All eligible immunizations administered by a participating retail pharmacy.
- 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
- All FDA-approved contraceptives for women, including oral contraceptives; contraceptive diaphragms and over-the-counter contraceptives prescribed by a doctor.
- 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.
- Flu, Zostavax & Pneumococcal vaccines obtained at a local network pharmacy must be administered by a pharmacist

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.

This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits. This proposed benefit summary is subject to the approval of the California Department of Insurance and the California Department of Managed Health Care.

Health Savings Account Plan — Exclusions and Limitations

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Orthodontia. Braces, other orthodontic appliances or orthodontic services.

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

Hearing Aids or Tests. Hearing aids, except as specified as covered in the Certificate. Routine hearing tests, except as specified as covered in the Certificate.

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

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

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

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

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

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

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

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

Sterilization Reversal.

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

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

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

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.

Residential accommodations. Residential accommodations to treat medical or behavioral health conditions, except when provided in a hospital, hospice, skilled nursing facility or residential treatment center. This exclusion includes procedures, equipment, services, supplies or charges for the following:

- Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
- Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
- Services or care provided or billed by a school, custodial care center for the developmentally disabled, or outward bound programs, even if psychotherapy is included.

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.

Health Savings Account 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 (a) the Drug Limited Fee Schedule for drugs dispensed by non-participating pharmacies; or (b) the outpatient prescription drug negotiated rate for drugs dispensed by participating pharmacies or through the mail service program

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.

Over-the-counter smoking cessation drugs. 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 obtained from other than a participating pharmacy. **Insured person will have to pay the full cost of the compound drugs 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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This plan includes custom benefits that may supersede some of the information included in the Limitations and Exclusions provided here. Please see your EOC for full details on your covered benefits.



SJVIA County of Fresno Modified Health Savings Account (HSA) Anthem PPO HSA (3000/100/50)

This 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.

Subject to Utilization Review

Certain services are subject to the utilization review program. Before scheduling services, the member must make sure utilization review is obtained. If utilization review is not obtained, benefits may be reduced or not paid, according to the plan.

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 & Home Delivery 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 \$3,000/individual insured person
- Insured family \$6,000/insured family

Individual can receive benefits once individual deductible has been met

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)*

- Participating Providers, Participating Pharmacy & Other Health Care Providers \$3,000/individual insured person; \$6,000/insured family/year
- Non-Participating Providers & Non-Participating Pharmacy \$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
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Covered Services	Traditional Health Coverage	
	In-Network	Out-of-Network (Insured is also responsible for charges in excess of covered expense.)
Hospital Medical Services <i>(subject to utilization review for inpatient services; waived for emergency admissions)</i>		
➤ Semi-private room, meals & special diets, & ancillary services	No copay	50%
➤ Outpatient medical care, surgical services & supplies <i>(hospital care other than emergency room care)</i>	No copay	50%
Ambulatory Surgical Centers		
➤ Outpatient surgery, services & supplies	No copay	50% <i>(benefit limited to \$350/day)</i>
Skilled Nursing Facility <i>(subject to utilization review)</i>		
➤ Semi-private room, services & supplies <i>(limited to 100 days/calendar year)</i>	No copay	50%
Hospice Care		
➤ Inpatient or outpatient services for insured persons with up to one year life expectancy; family bereavement services	No copay	50%
Home Health Care		
➤ Services & supplies from a home health agency <i>(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)</i>	No copay	50%
Home Infusion Therapy		
➤ Includes medication, ancillary services & supplies; caregiver training & visits by provider to monitor therapy; durable medical equipment; lab services	No copay	50% <i>(benefit limited to \$600/day)</i>
Physician Medical Services		
➤ Office & home visits	No copay	50%
➤ Preferred On-line Visit <i>(Includes Mental/Behavioral Health and Substance Abuse)</i>	No copay	50%
➤ Hospital & skilled nursing facility visits	No copay	50%
➤ Surgeon & surgical assistant; anesthesiologist or anesthesiologist	No copay	50%
➤ Drugs administered by a medical provider <i>(certain drugs are subject to utilization review)</i>	No copay	50%
Diagnostic X-ray & Lab		
➤ MRI, CT scan, PET scan & nuclear cardiac scan <i>(subject to utilization review)</i>	No copay	50%
➤ Other diagnostic x-ray & lab	No copay	50%
Preventive Care Services		
Preventive Care Services including*, physical exams, preventive screenings (including screenings for cancer, HPV, diabetes, cholesterol, blood pressure, hearing and vision, immunizations, health education, intervention services, HIV testing), and additional preventive care for women provided for in the guidelines supported by the Health Resources and Services Administration.	No copay	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 <i>(limited to 24 visits/calendar year)</i>	No copay	50%
Speech Therapy		
➤ Outpatient speech therapy following injury or organic disease	No copay	50%
Acupuncture		
➤ Services for the treatment of disease, illness or injury <i>(limited to 12 visits/calendar year)</i>	No copay ¹	50% ¹
Temporomandibular Joint Disorders		
➤ Splint therapy & surgical treatment	No copay	50%

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

Covered Services	Traditional Health Coverage	
	In-Network	Out-of-Network (Insured is also responsible for charges in excess of covered expense.)
Pregnancy & Maternity Care		
➤ Physician office visits	No copay	50%
➤ Prescription drug for elective abortion (<i>mifepristone</i>)	No copay	50%
Normal delivery, cesarean section, complications of pregnancy & abortion		
➤ Inpatient physician services	No copay	50%
➤ Hospital & ancillary services	No copay	50%
Organ & Tissue Transplants (subject to utilization review; specified organ transplants covered only when performed at Centers of Medical Excellence [CME])		
➤ Inpatient services provided in connection with non-investigative organ or tissue transplants		No copay
➤ Transplant travel expense for an authorized, specified transplant at a CME (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 Centers of Medical Excellence [CME])		
➤ Inpatient services provided in connection with medically necessary surgery for weight loss, only for morbid obesity		No copay
➤ Bariatric travel expense when insured person's home is 50 miles or more from the nearest bariatric CME (insured person'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 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	No copay	50%
Prosthetic Devices		
➤ Coverage for breast prostheses; prosthetic devices to restore a method of speaking; surgical implants; artificial limbs or eyes; the first pair of contact lenses or eyeglasses when required as a result of eye surgery; wigs for alopecia resulting from chemotherapy or radiation therapy; & therapeutic shoes & inserts for insured persons with diabetes	No copay	50%
Durable Medical Equipment		
Rental or purchase of DME including hearing aids, dialysis equipment & supplies (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)	No copay	50%

Covered Services	Traditional Health Coverage	
	In-Network	Out-of-Network (Insured is also responsible for charges in excess of covered expense.)
Related Outpatient Medical Services & Supplies		
➤ Ground or air ambulance transportation, services & disposable supplies		No copay ¹
➤ Blood transfusions, blood processing & the cost of unreplaced blood & blood products		No copay ¹
➤ Autologous blood (<i>self-donated blood collection, testing, processing & storage for planned surgery</i>)		No copay ¹
Emergency Care		
➤ Emergency room services & supplies	No copay	No copay
➤ Inpatient hospital services & supplies	No copay	No copay
➤ Physician services	No copay	No copay
Mental or Nervous Disorders and Substance Abuse		
➤ Inpatient facility care (<i>subject to utilization review; waived for emergency admissions</i>)	No copay	50%
➤ Inpatient physician visits	No copay	50%
➤ Outpatient facility care	No copay	50%
➤ Physician office visits (Behavioral Health treatment for Autism & Pervasive Development Disorders requires pre-service review)	No copay	50%

¹ These providers are not represented in the PPO network.

Covered Services	Traditional Health Coverage	
	In-Network	Out-of-Network (Insured is also responsible for charges in excess of the prescription drug maximum allowed amount)
Outpatient Prescription Drug Benefits		
➤ Preventive immunizations administered by a retail pharmacy	No copay (<i>deductible waived</i>)	
➤ Female oral contraceptives generic and single source brand	No copay (<i>deductible waived</i>)	
➤ Flu, Zostavax & Pneumococcal vaccines	No copay	
➤ Retail pharmacy prescription drug maximum allowed amount	No copay	50% ¹
➤ Home Delivery prescription drug maximum allowed amount	No copay	Not applicable
➤ Specialty pharmacy drugs (<i>obtained through specialty pharmacy program</i>)	No copay	Not applicable
Supply Limits²		
➤ Retail Pharmacy (<i>participating and non-participating</i>)	30-day supply; 60-day supply for federally classified Schedule II attention deficit disorder drugs that require a triplicate prescription form, but require a double copay; 6 tablets or units/30-day period for impotence and/or sexual dysfunction drugs (available only at retail pharmacies)	
➤ Home Delivery	90-day supply	
➤ Specialty Pharmacy	30-day supply	

¹ Insured person remains responsible for the costs in excess of the prescription drug maximum amount allowed.

² Supply limits for certain drugs may be different. Please refer to the Certificate of Insurance for complete information.

The Outpatient Prescription Drug Benefit covers the following:

- All eligible immunizations vaccines administered by a participating retail pharmacy.
- 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
- All FDA-approved contraceptives for women, including oral contraceptives; contraceptive diaphragms and over-the-counter contraceptives prescribed by a doctor.
- 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.
- Flu, Zostavax & Pneumococcal vaccines obtained at a local network pharmacy must be administered by a pharmacist

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.

This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits. This proposed benefit summary is subject to the approval of the California Department of Insurance and the California Department of Managed Health Care.

Health Savings Account Plan — Exclusions and Limitations

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

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

Experimental or Investigative. Any experimental or investigative procedure or medication.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Orthodontia. Braces, other orthodontic appliances or orthodontic services.

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

Hearing Aids or Tests. Hearing aids, except as specified as covered in the Certificate. Routine hearing tests, except as specified as covered in the Certificate.

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

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

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

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

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

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

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

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

Sterilization Reversal.

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

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

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

Air Conditioners. Air purifiers, air conditioners or humidifiers.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Residential accommodations. Residential accommodations to treat medical or behavioral health conditions, except when provided in a hospital, hospice, skilled nursing facility or residential treatment center. This exclusion includes procedures, equipment, services, supplies or charges for the following:

- Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
- Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
- Services or care provided or billed by a school, custodial care center for the developmentally disabled, or outward bound programs, even if psychotherapy is included.

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

Health Savings Account 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 (a) the Drug Limited Fee Schedule for drugs dispensed by non-participating pharmacies; or (b) the outpatient prescription drug negotiated rate for drugs dispensed by participating pharmacies or through the mail service program

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.

Over-the-counter smoking cessation drugs. 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 obtained from other than a participating pharmacy. **Insured person will have to pay the full cost of the compound drugs 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.

This plan includes custom benefits that may supersede some of the information included in the Limitations and Exclusions provided here. Please see your EOC for full details on your covered benefits.

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Frequently Asked Questions

How do I find a participating network pharmacy?

You can use your EmpiRx Health ID card at over 68,000 pharmacies nationwide including all pharmacy chains. You can find a network pharmacy by logging onto www.empirxhealth.com or calling 877-262-7435.

What is a prior authorization and why is it necessary?

Certain medications require prior authorization (PA) because of their potential side effects, potentially harmful interactions with other prescription medications, or to confirm they are being prescribed in accordance with Food & Drug Administration (FDA) approved indications. This process is designed to help ensure your health and safety. If a PA is needed, EmpiRx Health will work directly with your physician to obtain the necessary information prior to fulfillment.

How do I find out if a particular prescription is covered by my benefits?

Call 877-262-7435 to speak to a representative who can assist you with drug coverage questions or log onto www.empirxhealth.com for details.

How can I find out if generic or lower cost alternatives may be available to me?

Log into the member portal at www.empirxhealth.com and select "Drug Pricing." Search your medication and if there is a generic available, you will see the cost for both the brand as well as the generic. You can also call 877-262-7435 to speak to a representative who can assist you, or consult your physician or pharmacist to determine if generic equivalents are available for your prescription.

Why does my copay change from month to month?

The cost of medications changes regularly and prices are not all the same at each pharmacy. If your copay is based on a percentage rather than a fixed dollar amount then depending on the pharmacy you use and the cost of the medication at the time your prescription is filled, you may see a variation in your copay amount.

This brochure is only a general description of your prescription benefit program and it is not a contract. All benefits described herein are subject to the terms, conditions and limitations of the group master contract and applicable law. All personal health information is kept strictly confidential, as required by the privacy rules of the Health Insurance Portability and Accountability Act.

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Standard Brochure 1.2017

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SJVIA County of Fresno Prescription Benefit Plan



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

Your Prescription Benefit Program

Annual Maximum Out of Pocket Amount

Your plan includes a \$2,000 individual / \$4,000 family annual maximum out of pocket amount.

Retail Pharmacy Copayment

You are responsible to pay the retail pharmacist the copayment per prescription which is listed below:

30-Day Supply	90-Day Supply
\$10.00 for a Generic Medication	\$20.00 for a Generic Medication
\$20.00 for a Preferred Brand Medication	\$40.00 for a Preferred Brand Medication
\$35.00 for a Non-Preferred Brand Medication	\$70.00 for a Non-Preferred Brand Medication

This is a Dispense As Written Plan (DAW), meaning your pharmacist must dispense the generic equivalent drug when one is available unless your physician specifically requests the brand be dispensed. If you request the brand name medication from your pharmacist, you are responsible for the difference in cost between the brand and the generic plus the copayment.

Retail quantities will be dispensed according to your physician's instructions written on the prescription up to a maximum of a 90-day supply.

Please Note: If the cost of your medication is less than your calculated copayment, you will only pay the cost of the medication.

Mail Order Pharmacy Copayment

Maintenance medications can be submitted to Benecard Central Fill, the EmpiRx Health mail order facility. Your plan allows for up to a 90-day supply with three (3) refills, according to your physician's instructions. Your copay amount will be:

\$15.00 for a Generic Medication
\$30.00 for a Preferred Brand Medication
\$60.00 for a Non-Preferred Brand Medication

Specialty Medication Copayment

Specialty medications are high-cost biotechnology drugs requiring special distribution, handling, and administration. These medications are typically designed to treat chronic diseases.

\$10.00 for a Generic Specialty Medication
\$20.00 for a Preferred Brand Specialty Medication
\$35.00 for a Non-Preferred Brand Specialty Medication

Specialty medications can be filled one (1) time at a retail pharmacy. All future prescriptions must be obtained at Benecard Central Fill's Specialty Pharmacy. Please note that specialty medications are limited to a 30-day supply.

Online Member Tools

Maximize your benefit and find out how you can save on your out-of-pocket costs with our valuable member resource tools online at www.empirxhealth.com including:

- Plan coverage details and copay information
- Network pharmacy finder
- Mail service access to request refills and check order status
- Updated preferred medication list
- Drug comparison pricing tool to identify lower cost alternatives
- Drug information
- Recent personal drug utilization history including the amount you have paid and what the plan has paid on your behalf. This is helpful for year-end tax purposes

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



Preferred Medication List

The Preferred Medication List is a guide for selecting clinically and therapeutically appropriate medications. It should not take the place of a physician's or pharmacist's judgment with regard to a patient's pharmaceutical care. Refer to www.empirxhealth.com for the most recent version of the Preferred Medication List.

Exclusions

Your prescription program covers most Medically Necessary, Federal Legend, State Restricted and Compounded Medications which, by law, may not be dispensed without a prescription.

Be sure to present your EmpiRx Health ID card at a participating network pharmacy to receive a discount off the retail price of medications that may not be covered.

Retail Pharmacy Network

Your EmpiRx Health prescription benefit program provides you with access to an extensive national pharmacy network, including all chain pharmacies and most independents. This plan allows for a 90-day supply of maintenance medications. Your ID card provides all the information your pharmacist will need to process your prescription through EmpiRx Health. To locate a participating network pharmacy, log onto www.empirxhealth.com or call EmpiRx Health Member Services toll-free at 877-262-7435 (TDD: 1-888-907-0020).

Mail Order Pharmacy

The EmpiRx Health mail service pharmacy, Benecard Central Fill, is an option for you to obtain maintenance medications. Typically, prescriptions filled through mail service include medications used to treat chronic conditions and are written for up to a 90-day supply, plus refills. Prescriptions that you need to use right away should always be taken to your local pharmacy. You do have the option to obtain 90-day supplies through the retail network.

For your first order, complete the enclosed Mail Service Order Form and mail it along with your original prescription using the pre-addressed envelope provided to Benecard Central Fill. You can also have your physician submit your prescription electronically to Benecard Central Fill or fax your prescription to 1-888-907-0040. Be sure that your physician includes the cardholder name, ID number, shipping address, and patient's date of birth. Only prescriptions faxed from a doctor's office will be accepted via fax.

To order refills you have three options:

- **Internet:** Visit www.empirxhealth.com. If you have not yet registered, click on Register. If you are a registered user, log in and select Mail Order.
- **Phone:** Call Member Services toll-free, 877-262-7435, 24 hours a day, 7 days a week and use the prompts to order your refills. Have your identification number and credit card information ready.
- **Mail:** Send the Refill Request Order Form provided with your last shipment back to Benecard Central Fill mail service in the pre-addressed envelope

EmpiRx Health does NOT automatically refill your prescriptions.

To avoid delays, always include the appropriate copayment (if applicable) when your order is placed. Visa, MasterCard, Discover, or American Express and debit cards are accepted. You may also pay by check or money order made payable to Benecard Central Fill. Please do not send cash. Please allow up to two (2) weeks for delivery. Emergency prescriptions can be expedited at an additional charge.

Specialty Pharmacy

Specialty pharmaceuticals are typically produced through biotechnology, administered by injection, and/or require special handling and patient monitoring.

Through the Specialty Pharmacy, you receive personalized attention to help you manage your medical condition including one-on-one counseling with our team of pharmacists and trained medical professionals.

Our clinical team partners with you and your prescribing doctor to ensure you understand:

- How to manage your condition
- What medications you have been prescribed
- How to take your medication
- What lower cost options may be available
- How to coordinate delivery of your medication
- How to safely handle and store your medication

Shipments will arrive in secure, temperature-controlled packaging (if necessary) and will include everything you will need to take your medication. Due to the sensitive nature of specialty medications, some packages may require a signature.

Where Can I Ship My Medications?

We offer the convenience you need. Your medication can be shipped directly to:

- Your home
- Your work
- Your doctor's office
- Or a convenient location of your choice

Save with Generic Medications

Generic equivalent drugs must meet the same Food & Drug Administration (FDA) standards for purity, strength, and safety as brand name drugs. They also must have the same active ingredients and identical absorption rate within the body as the brand name version. If you wish to take advantage of this savings opportunity, speak with your physician about the use of generics. You may also consult with your pharmacist regarding generic drug options that may be available to you.

ID Cards

If your ID card is lost, you may print a temporary card online at www.empirxhealth.com. If there is an emergency and you need a prescription filled, call EmpiRx Health Member Services toll-free at 877-262-7435 (TDD: 1-888-907-0020) and we will provide your pharmacist with the required information to facilitate processing the claim.

Direct Member Reimbursement

If you must pay out-of-pocket for your medication which is covered by your plan, submit a Direct Member Reimbursement Form, which is available online at www.empirxhealth.com. You will need to provide an itemized receipt showing: the amount charged, prescription number, medication dispensed, manufacturer, dosage form, strength, quantity, and date dispensed. Your pharmacist can assist you if you do not have a detailed receipt. Direct reimbursement is based upon your plan benefits and the amount reimbursed may be significantly lower than the retail price you paid; therefore, always try to use a participating network pharmacy and present your ID card to reduce any unnecessary out-of-pocket expenses.

Proposed Benefit Summary

580 SJVIA - CO OF FRESNO (SAN JOAQUIN VALLEY)

Principal Benefits for Kaiser Permanente Traditional HMO Plan (12/16/19—12/15/20)

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 January 1 through December 31.

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

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

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

Professional Services (Plan Provider office visits)

	You Pay
Most Primary Care Visits and most Non-Physician Specialist Visits.....	\$15 per visit
Most Physician Specialist Visits.....	\$15 per visit
Routine physical maintenance exams, including well-woman exams	No charge
Well-child preventive exams (through age 23 months).....	No charge
Family planning counseling and consultations.....	No charge
Scheduled prenatal care exams	No charge
Routine eye exams with a Plan Optometrist	No charge
Urgent care consultations, evaluations, and treatment	\$15 per visit
Most physical, occupational, and speech therapy.....	\$15 per visit

Outpatient Services

	You Pay
Outpatient surgery and certain other outpatient procedures.....	\$15 per procedure
Allergy injections (including allergy serum)	\$3 per visit
Most immunizations (including the vaccine).....	No charge
Most X-rays and laboratory tests.....	No charge
Covered individual health education counseling	No charge
Covered health education programs	No charge

Hospitalization Services

	You Pay
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs.....	No charge

Emergency Health Coverage

	You Pay
Emergency Department visits.....	\$100 per visit
Note: This Cost Share does not apply if you are admitted directly to the hospital as an inpatient for covered Services (see "Hospitalization Services" for inpatient Cost Share).	

Ambulance Services

	You Pay
Ambulance Services.....	No charge

Prescription Drug Coverage

	You Pay
Covered outpatient items in accord with our drug formulary guidelines:	
Most generic items at a Plan Pharmacy	\$10 for up to a 30-day supply
Most generic refills through our mail-order service.....	\$20 for up to a 100-day supply
Most brand-name items at a Plan Pharmacy	\$20 for up to a 30-day supply
Most brand-name refills through our mail-order service.....	\$40 for up to a 100-day supply
Most specialty items at a Plan Pharmacy	\$20 for up to a 30-day supply

Durable Medical Equipment (DME)

	You Pay
DME items as described in the EOC.....	20% Coinsurance

Mental Health Services

	You Pay
Inpatient psychiatric hospitalization.....	No charge
Individual outpatient mental health evaluation and treatment	\$15 per visit
Group outpatient mental health treatment	\$7 per visit

Proposed Benefit Summary*(continued)*

Substance Use Disorder Treatment	You Pay
Inpatient detoxification	No charge
Individual outpatient substance use disorder evaluation and treatment	\$15 per visit
Group outpatient substance use disorder treatment	\$5 per visit
Home Health Services	You Pay
Home health care (up to 100 visits per Accumulation Period)	No charge
Other	You Pay
Eyeglasses or contact lenses every 24 months	Amount in excess of \$175 Allowance
Hearing aid(s) every 36 months	Amount in excess of \$1,000 Allowance per aid
Skilled nursing facility care (up to 100 days per benefit period)	No charge
Prosthetic and orthotic devices as described in the <i>EOC</i>	No charge
Hospice care	No charge

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

Choosing your plan



 **DELTA DENTAL**

We'll do whatever it takes and then some.

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.

Compare Program Features

Plan Features	Delta Dental PPO	DeltaCare USA
Copayments/coinsurance	<ul style="list-style-type: none"> Covered services paid at applicable percentage — for example, fillings are covered at 80% of allowed amount — you pay the remaining 20% 	<ul style="list-style-type: none"> Covered procedures have predetermined dollar copayments for services provided by network dentists (this means out-of-pocket costs are predictable)
Coverage	<ul style="list-style-type: none"> Wide range of covered services No exclusions for most pre-existing conditions 	<ul style="list-style-type: none"> 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 style="list-style-type: none"> Freedom to choose any licensed dentist No referral required for specialty care 	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> Change dentists any time without contacting Delta Dental 	<ul style="list-style-type: none"> Ability to change selected or assigned network dentists via telephone or Internet
Transitions from previous plan	<ul style="list-style-type: none"> Coverage is provided only for treatment started and completed after your effective date of coverage under the Delta Dental plan 	<ul style="list-style-type: none"> 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)	<ul style="list-style-type: none"> Plan will pay the remaining amount of the total case fee not paid by your former dental plan (when plan includes orthodontic coverage) 	<ul style="list-style-type: none"> Covers new enrollees who, on the effective date of their coverage, are in active treatment started under their previous employer-sponsored dental plan Enrollees are responsible for all copayments and fees subject to the provisions of their prior dental plan
Authorization for specialty care treatment	<ul style="list-style-type: none"> Preauthorization is not required 	<ul style="list-style-type: none"> Preauthorization is required for treatment provided by a specialist Your DeltaCare USA dentist will coordinate your specialty care treatment authorization
Out-of-area coverage	<ul style="list-style-type: none"> Visit any licensed dentist 	<ul style="list-style-type: none"> Limited to emergency care provision
Deductibles and maximums	<ul style="list-style-type: none"> Deductibles and annual maximums apply to most plan designs 	<ul style="list-style-type: none"> No annual deductible or annual dollar maximums
Claims	<ul style="list-style-type: none"> Delta Dental dentists file claim forms and accept payment directly from Delta Dental Non-Delta Dental dentists may require payment up front, and require you to file a claim for reimbursement 	<ul style="list-style-type: none"> No claim forms required You only need to pay the specified copayment at the time of your visit

Delta Dental PPOSM — Benefit highlights

DELTA DENTAL PPOSM

*Easy
Friendly
Accessible*



Greatest potential savings
when you visit a Delta Dental
PPO dentist

OUT-OF-POCKET COSTS



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

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

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

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

DELTA DENTAL PPO

Plan Benefit Highlights for: County of Fresno

Group No: 05879

DELTA DENTAL PPOSM

BENEFIT HIGHLIGHTS

Eligibility	Primary enrollee, spouse (includes domestic partner) and eligible dependent children to the end of the month dependent turns age 26			
Deductibles	\$50 per person / \$150 per family each calendar year			
Deductibles waived for D & P?	PPO-Dentists: Yes Non-PPO Dentists: No			
Maximums	\$2,500 per person each calendar year			
D & P counts toward maximum?	No			
Waiting Period(s)	Basic Benefits None	Major Benefits None	Orthodontics None	Prosthodontics None

Benefits and Covered Services*	Delta Dental PPO dentists**	Non-Delta Dental PPO dentists**
Diagnostic & Preventive Services (D & P) Exams, cleanings and x-rays	100 %	90 %
Basic Services Fillings, simple tooth extractions and sealants	90 %	90 %
Endodontics (root canals) Covered Under Major Services	50 %	50 %
Periodontics (gum treatment) Covered Under Major Services	50 %	50 %
Oral Surgery Covered Under Major Services	50 %	50 %
Major Services Crowns, inlays, onlays and cast restorations	50 %	50 %
Prosthodontics Bridges, dentures and implants	50 %	50 %
Orthodontic Benefits Adults and dependent children	100 % After co-payment	100 % After co-payment
Orthodontic Maximum Adults (age 20 and over) Child(ren) (through age 19) One Orthodontic treatment per lifetime Maximum of 24 months of active orthodontic treatment	\$ 1,880 per case \$ 1,660 per case	\$ 1,880 per case \$ 1,660 per case

* 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.

HLT_PPO_2COL_DDC (Rev.08/052014)

Getting the most from your plan

DELTA DENTAL PPOSM

*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 PPOSM dentist

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

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

Find a Delta Dental PPO dentist

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

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

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

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

Is your dentist a Delta Dental PPO dentist?

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

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

* 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.

Maximum choice

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

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

Easy to use

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

Dual coverage/Coordination of benefits

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

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

Orthodontic treatment in progress

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

Transitioning from another plan?

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

Visit our website: deltadentalins.com

On our website, you can:

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

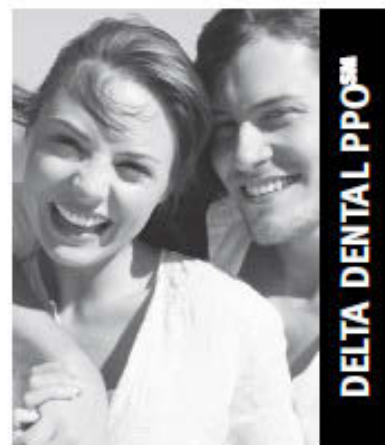
To access some services, you'll need to log in: simply enter your user name and password in the designated boxes and submit. If you are visiting our website for the first time, you'll need to complete a quick one-time registration process by clicking the "Register Today" link.

Talk to your dentist about your health and treatment options

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

Questions about your plan?

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



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

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

DeltaCare[®] USA – provided by Delta Dental of California

DELTA CARE[®] USA

*Quality
Convenience
Predictable
Costs*



We'll do whatever it takes and then some.

Find a DeltaCare USA dentist

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



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

OR

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

Welcome to DeltaCare USA - quality, convenience, predictable costs

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

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

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

Quality

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

Convenience

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

Predictable costs

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

DELTA CARE USA

Administered by Delta Dental Insurance Company

SCHEDULE A

Description of Benefits and Copayments

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

Text that appears in italics below is specifically intended to clarify the delivery of Benefits under the DeltaCare USA Program and is not to be interpreted as CDT-2015 procedure codes, descriptors or nomenclature that are under copyright by the American Dental Association. The American Dental Association may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.

CODE	DESCRIPTION	ENROLLEE PAYS
D0100-D0999	I. DIAGNOSTIC	
D0120	Periodic oral evaluation - established patient	No Cost
D0140	Limited oral evaluation - problem focused	No Cost
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No Cost
D0150	Comprehensive oral evaluation - new or established patient	No Cost
D0160	Detailed and extensive oral evaluation - problem focused, by report	No Cost
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	No Cost
D0171	Re-evaluation - post-operative office visit	No Cost
D0180	Comprehensive periodontal evaluation - new or established patient	No Cost
D0190	Screening of a patient	No Cost
D0191	Assessment of a patient	No Cost
D0210	Intraoral - complete series of radiographic images - <i>limited to 1 series every 24 months</i>	No Cost
D0220	Intraoral - periapical first radiographic image	No Cost
D0230	Intraoral - periapical each additional radiographic image	No Cost
D0240	Intraoral - occlusal radiographic image	No Cost
D0250	Extraoral - first radiographic image	No Cost
D0260	Extraoral - each additional radiographic image	No Cost
D0270	Bitewing - single radiographic image	No Cost
D0272	Bitewings - two radiographic images	No Cost
D0273	Bitewings three radiographic images	No Cost
D0274	Bitewings - four radiographic images - <i>limited to 1 series every 6 months</i>	No Cost
D0277	Vertical bitewings - 7 to 8 radiographic images	No Cost
D0330	Panoramic radiographic image	No Cost
D0415	Collection of microorganisms for culture and sensitivity	No Cost
D0425	Caries susceptibility tests	No Cost
D0460	Pulp vitality tests	No Cost
D0470	Diagnostic casts	No Cost
D0472	Accession of tissue, gross examination, preparation and transmission of written report - <i>available only when performed in conjunction with a covered biopsy</i>	No Cost
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report - <i>available only when performed in conjunction with a covered biopsy</i>	No Cost
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report - <i>available only when performed in conjunction with a covered biopsy</i>	No Cost
D0601	Caries risk assessment and documentation, with a finding of low risk - <i>limited to children age 3 to 19, 1 every 3 years</i>	No Cost
D0602	Caries risk assessment and documentation, with a finding of moderate risk - <i>limited to children age 3 to 19, 1 every 3 years</i>	No Cost
D0603	Caries risk assessment and documentation, with a finding of high risk - <i>limited to children age 3 to 19, 1 every 3 years</i>	No Cost
D0999	Unspecified diagnostic procedure, by report - <i>includes office visit, per visit (in addition to other services)</i>	No Cost
D1000-D1999	II. PREVENTIVE	
D1110	Prophylaxis <i>cleaning</i> - adult - <i>1 per 6 month period</i>	No Cost
D1110	<i>Additional prophylaxis cleaning</i> - adult (<i>within the 6 month period</i>)	\$45.00

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

D2000-D2999 III. RESTORATIVE

- Includes polishing, all adhesives and bonding agents, indirect pulp capping, bases, liners and acid etch procedures.

- When there are more than six crowns in the same treatment plan, an Enrollee may be charged an additional \$125.00 per crown, beyond the 6th unit.

- Replacement of crowns, inlays and onlays requires the existing restoration to be 5+ years old.

* Name brand, laboratory processed or in-office processed crowns/pontics produced through specialized technique or materials are material upgrades. The Contract Dentist may charge an additional fee not to exceed \$325.00 in addition to the listed Copayment. Refer to Limitation of Benefits #4 for additional information.

D2140	Amalgam - one surface, primary or permanent	No Cost
D2150	Amalgam - two surfaces, primary or permanent	No Cost
D2160	Amalgam - three surfaces, primary or permanent	No Cost
D2161	Amalgam - four or more surfaces, primary or permanent	No Cost
D2330	Resin-based composite - one surface, anterior	No Cost
D2331	Resin-based composite - two surfaces, anterior	No Cost
D2332	Resin-based composite - three surfaces, anterior	No Cost
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	No Cost
D2390	Resin-based composite crown, anterior	No Cost
D2391	Resin-based composite - one surface, posterior	\$25.00
D2392	Resin-based composite - two surfaces, posterior	\$30.00
D2393	Resin-based composite - three surfaces, posterior	\$35.00
D2394	Resin-based composite - four or more surfaces, posterior	\$40.00
D2510	Inlay - metallic - one surface	No Cost
D2520	Inlay - metallic - two surfaces	No Cost
D2530	Inlay - metallic - three or more surfaces	No Cost
D2542	Onlay - metallic - two surfaces	No Cost
D2543	Onlay - metallic - three surfaces	No Cost
D2544	Onlay - metallic - four or more surfaces	No Cost
D2610	Inlay - porcelain/ceramic - one surface*	\$50.00
D2620	Inlay - porcelain/ceramic - two surfaces*	\$60.00
D2630	Inlay - porcelain/ceramic - three or more surfaces*	\$65.00
D2642	Onlay - porcelain/ceramic - two surfaces*	\$55.00
D2643	Onlay - porcelain/ceramic - three surfaces*	\$65.00
D2644	Onlay - porcelain/ceramic - four or more surfaces*	\$70.00
D2650	Inlay - resin-based composite - one surface	\$15.00
D2651	Inlay - resin-based composite - two surfaces	\$20.00
D2652	Inlay - resin-based composite - three or more surfaces	\$30.00
D2662	Onlay - resin-based composite - two surfaces	\$25.00
D2663	Onlay - resin-based composite - three surfaces	\$35.00
D2664	Onlay - resin-based composite - four or more surfaces	\$50.00
D2710	Crown - resin-based composite (indirect)	No Cost
D2712	Crown - ¾ resin-based composite (indirect)	No Cost

D2720	Crown - resin with high noble metal	\$30.00
D2721	Crown - resin with predominantly base metal	\$15.00
D2722	Crown - resin with noble metal	\$20.00
D2740	Crown - porcelain/ceramic substrate*	\$85.00
D2750	Crown - porcelain fused to high noble metal*	\$70.00
D2751	Crown - porcelain fused to predominantly base metal	\$55.00
D2752	Crown - porcelain fused to noble metal	\$60.00
D2780	Crown - ¾ cast high noble metal	\$70.00
D2781	Crown - ¾ cast predominantly base metal	\$55.00
D2782	Crown - ¾ cast noble metal	\$60.00
D2783	Crown - ¾ porcelain/ceramic*	\$70.00
D2790	Crown - full cast high noble metal	\$70.00
D2791	Crown - full cast predominantly base metal	\$55.00
D2792	Crown - full cast noble metal	\$60.00
D2794	Crown - titanium	\$70.00
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	No Cost
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	No Cost
D2920	Re-cement or re-bond crown	No Cost
D2921	Reattachment of tooth fragment, incisal edge or cusp (<i>anterior</i>)	No Cost
D2929	Prefabricated porcelain/ceramic crown - primary tooth - <i>anterior</i>	No Cost
D2930	Prefabricated stainless steel crown - primary tooth	No Cost
D2931	Prefabricated stainless steel crown - permanent tooth	No Cost
D2932	Prefabricated resin crown - <i>anterior primary tooth</i>	No Cost
D2933	Prefabricated stainless steel crown with resin window - <i>anterior primary tooth</i>	No Cost
D2940	Protective restoration	No Cost
D2941	Interim therapeutic restoration - primary dentition	No Cost
D2949	Restorative foundation for an indirect restoration	No Cost
D2950	Core buildup, including any pins when required	No Cost
D2951	Pin retention - per tooth, in addition to restoration	No Cost
D2952	Post and core in addition to crown, indirectly fabricated - <i>includes canal preparation</i>	No Cost
D2953	Each additional indirectly fabricated post - same tooth - <i>includes canal preparation</i>	No Cost
D2954	Prefabricated post and core in addition to crown - <i>base metal post; includes canal preparation</i>	No Cost
D2955	Post removal	No Cost
D2957	Each additional prefabricated post - same tooth - <i>base metal post; includes canal preparation</i>	No Cost
D2960	Labial veneer (resin laminate) - chairside - <i>limited to replacement of significant tooth structure loss due to caries or fracture</i>	\$245.00
D2961	Labial veneer (resin laminate) - laboratory - <i>limited to replacement of significant tooth structure loss due to caries or fracture</i>	\$295.00
D2962	Labial veneer (porcelain laminate) - laboratory - <i>limited to replacement of significant tooth structure loss due to caries or fracture</i>	\$345.00
D2970	Temporary crown (fractured tooth) - <i>palliative treatment only</i>	No Cost
D2971	Additional procedures to construct new crown under existing partial denture framework	\$14.00
D2980	Crown repair necessitated by restorative material failure	No Cost
D2981	Inlay repair necessitated by restorative material failure	No Cost
D2982	Onlay repair necessitated by restorative material failure	No Cost
D2983	Veneer repair necessitated by restorative material failure	No Cost
D2990	Resin infiltration of incipient smooth surface lesions - <i>limited to permanent molars through age 15</i>	No Cost
D3000-D3999 IV. ENDODONTICS		
D3110	Pulp cap - direct (excluding final restoration)	No Cost
D3120	Pulp cap - indirect (excluding final restoration)	No Cost
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	No Cost
D3221	Pulpal debridement, primary and permanent teeth	No Cost
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	No Cost
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	No Cost
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	No Cost

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

D4000-D4999 V. PERIODONTICS

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

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	No Cost
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	No Cost
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	No Cost
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	No Cost
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	No Cost
D4245	Apically positioned flap	\$45.00
D4249	Clinical crown lengthening - hard tissue	\$45.00
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	\$75.00
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	\$60.00
D4263	Bone replacement graft - first site in quadrant	\$125.00
D4264	Bone replacement graft - each additional site in quadrant	\$45.00
D4266	Guided tissue regeneration - resorbable barrier, per site	\$100.00
D4267	Guided tissue regeneration - nonresorbable barrier, per site (includes membrane removal)	\$140.00
D4270	Pedicle soft tissue graft procedure	\$125.00
D4273	Subepithelial connective tissue graft procedures, per tooth	\$75.00
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)	No Cost
D4275	Soft tissue allograft	\$115.00
D4277	Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in graft	\$125.00
D4278	Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in same graft site	\$125.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant - limited to 4 quadrants during any 12 consecutive months	No Cost
D4342	Periodontal scaling and root planing - one to three teeth per quadrant - limited to 4 quadrants during any 12 consecutive months	No Cost
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis - limited to 1 treatment in any 12 consecutive months	No Cost
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth - for each of the first two teeth treated within a quadrant following root planing or periodontal maintenance	\$60.00

D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth - for an additional tooth treated in the same quadrant following root planing or periodontal maintenance	No Cost
D4910	Periodontal maintenance - limited to 1 treatment each 6 month period	No Cost
D4910	Additional periodontal maintenance (within the 6 month period)	\$55.00
D4921	Gingival irrigation - per quadrant	No Cost

D5000-D5899 VI. PROSTHODONTICS (removable)

- For all listed dentures and partial dentures, Copayment includes after delivery adjustments and tissue conditioning, if needed, for the first six months after placement. The Enrollee must continue to be eligible, and the service must be provided at the Contract Dentist's facility where the denture was originally delivered.

- Rebases, relines and tissue conditioning are limited to 1 per denture during any 12 consecutive months.

- Replacement of a denture or a partial denture requires the existing denture to be 5+ years old.

D5110	Complete denture - maxillary	\$75.00
D5120	Complete denture - mandibular	\$75.00
D5130	Immediate denture - maxillary	\$85.00
D5140	Immediate denture - mandibular	\$85.00
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	\$80.00
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	\$80.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	\$95.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	\$95.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	\$195.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	\$195.00
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth)	\$80.00
D5410	Adjust complete denture - maxillary	No Cost
D5411	Adjust complete denture - mandibular	No Cost
D5421	Adjust partial denture - maxillary	No Cost
D5422	Adjust partial denture - mandibular	No Cost
D5510	Repair broken complete denture base	No Cost
D5520	Replace missing or broken teeth - complete denture (each tooth)	No Cost
D5610	Repair resin denture base	No Cost
D5620	Repair cast framework	No Cost
D5630	Repair or replace broken clasp	No Cost
D5640	Replace broken teeth - per tooth	No Cost
D5650	Add tooth to existing partial denture	No Cost
D5660	Add clasp to existing partial denture	No Cost
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	\$65.00
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	\$65.00
D5710	Rebase complete maxillary denture	\$30.00
D5711	Rebase complete mandibular denture	\$30.00
D5720	Rebase maxillary partial denture	\$30.00
D5721	Rebase mandibular partial denture	\$30.00
D5730	Reline complete maxillary denture (chairside)	No Cost
D5731	Reline complete mandibular denture (chairside)	No Cost
D5740	Reline maxillary partial denture (chairside)	No Cost
D5741	Reline mandibular partial denture (chairside)	No Cost
D5750	Reline complete maxillary denture (laboratory)	\$25.00
D5751	Reline complete mandibular denture (laboratory)	\$25.00
D5760	Reline maxillary partial denture (laboratory)	\$25.00
D5761	Reline mandibular partial denture (laboratory)	\$25.00
D5820	Interim partial denture (maxillary) - limited to 1 in any 12 consecutive months	No Cost
D5821	Interim partial denture (mandibular) - limited to 1 in any 12 consecutive months	No Cost
D5850	Tissue conditioning, maxillary	No Cost
D5851	Tissue conditioning, mandibular	No Cost

D5900-D5999 VII. MAXILLOFACIAL PROSTHETICS - Not Covered

D6000-D6199 VIII. IMPLANT SERVICES - Not Covered

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

- When a crown and/or pontic exceeds six units in the same treatment plan, an Enrollee may be charged an additional \$125.00 per unit, beyond the 6th unit.

- Replacement of a crown, pontic, inlay, onlay or stress breaker requires the existing bridge to be 5+ years old.

* Name brand, laboratory processed or in-office processed crowns/pontics produced through specialized technique or materials are material upgrades. The Contract Dentist may charge an additional fee not to exceed \$325.00 in addition to the listed Copayment. Refer to Limitation of Benefits #4 for additional information.

D6205	Pontic - indirect resin based composite	\$30.00
D6210	Pontic - cast high noble metal	\$70.00
D6211	Pontic - cast predominantly base metal	\$55.00
D6212	Pontic - cast noble metal	\$60.00
D6214	Pontic - titanium	\$70.00
D6240	Pontic - porcelain fused to high noble metal*	\$70.00
D6241	Pontic - porcelain fused to predominantly base metal	\$55.00
D6242	Pontic - porcelain fused to noble metal	\$60.00
D6245	Pontic - porcelain/ceramic*	\$70.00
D6250	Pontic - resin with high noble metal	\$30.00
D6251	Pontic - resin with predominantly base metal	\$15.00
D6252	Pontic - resin with noble metal	\$20.00
D6600	Inlay - porcelain/ceramic, two surfaces	\$60.00
D6601	Inlay - porcelain/ceramic, three or more surfaces	\$65.00
D6602	Inlay - cast high noble metal, two surfaces	\$70.00
D6603	Inlay - cast high noble metal, three or more surfaces	\$70.00
D6604	Inlay - cast predominantly base metal, two surfaces	No Cost
D6605	Inlay - cast predominantly base metal, three or more surfaces	No Cost
D6606	Inlay - cast noble metal, two surfaces	\$60.00
D6607	Inlay - cast noble metal, three or more surfaces	\$60.00
D6608	Onlay - porcelain/ceramic, two surfaces	\$55.00
D6609	Onlay - porcelain/ceramic, three or more surfaces	\$65.00
D6610	Onlay - cast high noble metal, two surfaces	\$70.00
D6611	Onlay - cast high noble metal, three or more surfaces	\$70.00
D6612	Onlay - cast predominantly base metal, two surfaces	No Cost
D6613	Onlay - cast predominantly base metal, three or more surfaces	No Cost
D6614	Onlay - cast noble metal, two surfaces	\$60.00
D6615	Onlay - cast noble metal, three or more surfaces	\$60.00
D6710	Crown - indirect resin based composite	\$30.00
D6720	Crown - resin with high noble metal	\$30.00
D6721	Crown - resin with predominantly base metal	\$15.00
D6722	Crown - resin with noble metal	\$20.00
D6740	Crown - porcelain/ceramic*	\$70.00
D6750	Crown - porcelain fused to high noble metal*	\$70.00
D6751	Crown - porcelain fused to predominantly base metal	\$55.00
D6752	Crown - porcelain fused to noble metal	\$60.00
D6780	Crown - ¾ cast high noble metal	\$70.00
D6781	Crown - ¾ cast predominantly base metal	\$55.00
D6782	Crown - ¾ cast noble metal	\$60.00
D6783	Crown - ¾ porcelain/ceramic*	\$70.00
D6790	Crown - full cast high noble metal	\$70.00
D6791	Crown - full cast predominantly base metal	\$50.00
D6792	Crown - full cast noble metal	\$60.00
D6794	Crown - titanium	\$70.00
D6930	Re-cement or re-bond fixed partial denture	No Cost

D6940	Stress breaker	No Cost
D6980	Fixed partial denture repair necessitated by restorative material failure	No Cost
D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY		
<i>- Includes preoperative and postoperative evaluations and treatment under a local anesthetic.</i>		
D7111	Extraction, coronal remnants - deciduous tooth	No Cost
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	No Cost
D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	\$10.00
D7220	Removal of impacted tooth - soft tissue	\$15.00
D7230	Removal of impacted tooth - partially bony	\$25.00
D7240	Removal of impacted tooth - completely bony	\$35.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	\$50.00
D7250	Surgical removal of residual tooth roots (cutting procedure)	No Cost
D7251	Coronectomy - intentional partial tooth removal	\$50.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	\$35.00
D7280	Surgical access of an unerupted tooth	\$25.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	\$25.00
D7283	Placement of device to facilitate eruption of impacted tooth	No Cost
D7286	Incisional biopsy of oral tissue - soft - <i>does not include pathology laboratory procedures</i>	No Cost
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	No Cost
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	No Cost
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	No Cost
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	No Cost
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	No Cost
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	No Cost
D7471	Removal of lateral exostosis (maxilla or mandible)	No Cost
D7472	Removal of torus palatinus	No Cost
D7473	Removal of torus mandibularis	No Cost
D7510	Incision and drainage of abscess - intraoral soft tissue	No Cost
D7960	Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure	No Cost
D7970	Excision of hyperplastic tissue - per arch	No Cost
D7971	Excision of pericoronal gingiva	No Cost

D8000-D8999 XI. ORTHODONTICS

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

Pre and post orthodontic records include:

The benefit for pre-treatment records and diagnostic services includes: \$200.00

D0210	Intraoral - complete series of radiographic images
D0322	Tomographic survey
D0330	Panoramic radiographic image
D0340	Cephalometric radiographic image
D0350	2D oral/facial photographic images obtained intraorally or extraorally
D0351	3D photographic image
D0470	Diagnostic casts

The benefit for post-treatment records includes: \$70.00

D0210	Intraoral - complete series of radiographic images	
D0470	Diagnostic casts	
D8010	Limited orthodontic treatment of the primary dentition	\$725.00
D8020	Limited orthodontic treatment of the transitional dentition - <i>child or adolescent to age 19</i>	\$725.00
D8030	Limited orthodontic treatment of the adolescent dentition - <i>adolescent to age 19</i>	\$725.00
D8040	Limited orthodontic treatment of the adult dentition - <i>adults, including covered dependent adult children</i>	\$925.00
D8050	Interceptive orthodontic treatment of the primary dentition	\$725.00
D8060	Interceptive orthodontic treatment of the transitional dentition	\$725.00
D8070	Comprehensive orthodontic treatment of the transitional dentition - <i>child or adolescent to age 19</i>	\$1,700.00

D8080	Comprehensive orthodontic treatment of the adolescent dentition - <i>adolescent to age 19</i>	\$1,700.00
D8090	Comprehensive orthodontic treatment of the adult dentition - <i>adults, including covered dependent adult children</i> ..	\$1,900.00
D8660	Pre-orthodontic treatment examination to monitor growth and development	\$25.00
D8670	Periodic orthodontic treatment visit - <i>included in comprehensive case fee</i>	No Cost
D8680	Orthodontic retention (removal of appliances, construction and placement of <i>removable</i> retainers)	\$275.00
D8693	Re-bond or re-cement fixed retainer - <i>limited to 2 per 6 month period</i>	No Cost
D8694	Repair of fixed retainers, includes reattachment - <i>limited to 2 per 6 month period</i>	No Cost
D8999	Unspecified orthodontic procedure, by report - <i>includes treatment planning session</i>	\$100.00

D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES

D9110	Palliative (emergency) treatment of dental pain - minor procedure	No Cost
D9211	Regional block anesthesia	No Cost
D9212	Trigeminal division block anesthesia	No Cost
D9215	Local anesthesia in conjunction with operative or surgical procedures	No Cost
D9219	Evaluation for deep sedation or general anesthesia	No Cost
D9220	Deep sedation/general anesthesia - first 30 minutes	\$165.00
D9221	Deep sedation/general anesthesia - each additional 15 minutes	\$80.00
D9241	Intravenous moderate (conscious) sedation/analgesia - first 30 minutes	\$165.00
D9242	Intravenous moderate (conscious) sedation/analgesia - each additional 15 minutes	\$80.00
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	No Cost
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	No Cost
D9440	Office visit - after regularly scheduled hours	\$20.00
D9450	Case presentation, detailed and extensive treatment planning	No Cost
D9931	Cleaning and inspection of a removable appliance	No Cost
D9940	Occlusal guard, by report - <i>limited to 1 in 3 years</i>	\$75.00
D9951	Occlusal adjustment, limited	No Cost
D9952	Occlusal adjustment, complete	No Cost
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays - <i>limited to one bleaching tray and gel for two weeks of self-treatment</i>	\$125.00
D9986	Missed appointment - <i>without 24 hour notice - per 15 minutes of appointment time - up to an overall maximum of \$40.00</i>	\$10.00
D9987	Canceled appointment - <i>without 24 hour notice - per 15 minutes of appointment time - up to an overall maximum of \$40.00</i>	\$10.00

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

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

SCHEDULE B

Limitations of Benefits

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

Exclusions of Benefits

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

13. Dental expenses incurred in connection with any dental or orthodontic procedure started before the Enrollee's eligibility with the DeltaCare USA program. Examples include: teeth prepared for crowns, root canals in progress, full or partial dentures for which an impression has been taken and orthodontics unless qualified for the orthodontic treatment in progress provision.
14. Lost, stolen or broken orthodontic appliances.
15. Changes in orthodontic treatment necessitated by accident of any kind.
16. Myofunctional and parafunctional appliances and/or therapies.
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.

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- Set copayments.
- No annual deductibles and no maximums for covered benefits.
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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.

DELTA CARE USA

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.

* 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.

Visit our website: deltadentalins.com

On our website, you can:

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

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

Questions about your plan?

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



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



Expanded business hours/
toll-free customer service



Out-of-area
emergency coverage



Orthodontic treatment
in progress provision

SmileWay™ Wellness Program

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

Connect with us!

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

Delta Dental PPO™ is underwritten by Delta Dental Insurance Company in AL, DC, FL, GA, IA, MS, MT, NV 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.

DeltaCare® 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, FL, GA, KS, TN, WV and Washington, D.C. — Delta Dental Insurance Company; HI, ID, IN, KY, MD, MO, NJ, TX — Alpha Dental Programs, Inc.; UT — Alpha Dental of Utah, Inc.; NY — Delta Dental of New York, Inc.; PA — Delta Dental of Pennsylvania; VA — 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
P.O. Box 1803
Alpharetta, GA 30023



deltadentalins.com



A LOOK AT YOUR VSP VISION COVERAGE



SEE HEALTHY AND LIVE HAPPY WITH HELP FROM COUNTY OF FRESNO AND VSP.

As a VSP® member, you get personalized care from a VSP network doctor at low out-of-pocket costs.

VALUE AND SAVINGS YOU LOVE.



Save on eyewear and eye care when you see a VSP network doctor. Plus, take advantage of Exclusive Member Extras for additional savings.

PROVIDER CHOICES YOU WANT.



With an average of five VSP network doctors within six miles of you, it's easy to find a nearby in-network doctor or retail chain. Plus, maximize your coverage with bonus offers and additional savings that are exclusive to Premier Program locations.

Prefer to shop online? Use your vision benefits on Eyeconic®—the VSP preferred online retailer.

QUALITY VISION CARE YOU NEED.



You'll get great care from a VSP network doctor, including a WellVision Exam®—a comprehensive exam designed to detect eye and health conditions.

PROVIDER NETWORK:

VSP Choice

EFFECTIVE DATE:

01/01/2020

Benefit	Description	Copay
Your Coverage with a VSP Provider		
WellVision Exam	<ul style="list-style-type: none"> Focuses on your eyes and overall wellness Every 12 months 	\$10
Prescription Glasses		
Frame	<ul style="list-style-type: none"> \$150 allowance for a wide selection of frames \$170 allowance for featured frame brands 20% savings on the amount over your allowance \$80 Costco® frame allowance Every 24 months 	Included in Prescription Glasses
Lenses	<ul style="list-style-type: none"> Single vision, lined bifocal, and lined trifocal lenses Polycarbonate lenses for dependent children Every 12 months 	Included in Prescription Glasses
Lens Enhancements	<ul style="list-style-type: none"> Standard progressive lenses Premium progressive lenses Custom progressive lenses Average savings of 20-25% on other lens enhancements Every 12 months 	\$0 \$95 - \$105 \$150 - \$175
Contacts (instead of glasses)	<ul style="list-style-type: none"> \$150 allowance for contacts; copay does not apply Contact lens exam (fitting and evaluation) Every 12 months 	Up to \$60
PRIMARY EYECARE	<ul style="list-style-type: none"> As a VSP member, you can visit your VSP doctor for medical and urgent eyecare. 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. As needed 	\$20
EXTRA SAVINGS	Glasses and Sunglasses <ul style="list-style-type: none"> Extra \$20 to spend on featured frame brands. Go to vsp.com/offers for details. 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam. 	
	Retinal Screening <ul style="list-style-type: none"> No more than a \$39 copay on routine retinal screening as an enhancement to a WellVision Exam 	
	Laser Vision Correction <ul style="list-style-type: none"> Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities 	

Your Coverage with Out-of-Network Providers

Get the most out of your benefits and greater savings with a VSP network doctor. Call Member Services for out-of-network plan details.

VSP guarantees coverage from VSP network providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business.

Contact us:

800.877.7195 or vsp.com



BOARD OF DIRECTORS

STEVE BRANDAU
KUYLER CROCKER
NATHAN MAGSIG
BUDDY MENDES
BRIAN PACHECO
AMY SHUKLIAN
PETE VANDER POEL

Exhibit B

County of Fresno

Plan Year 2020 Rates

SJVIA Rates to be Remitted by the County of Fresno	Monthly Rates Effective January 1, 2020				Bi-Weekly Rates Effective December 16, 2019			
	EE	ES	EC	FA	EE	ES	EC	FA
Anthem PPO \$250	\$1,187.65	\$2,493.10	\$2,258.71	\$3,444.21	\$548.15	\$1,150.66	\$1,042.48	\$1,589.64
Anthem PPO \$1000	\$881.72	\$1,850.91	\$1,676.89	\$2,557.01	\$406.95	\$854.27	\$773.95	\$1,180.16
Anthem PPO \$1,500 Active	\$799.28	\$1,677.83	\$1,520.09	\$2,317.91	\$368.90	\$774.38	\$701.58	\$1,069.80
Anthem PPO \$1,500 Retiree	\$914.24	\$1,618.51	\$1,428.18	\$2,130.68				
Anthem PPO \$3,000	\$653.08	\$1,383.36	\$1,240.23	\$1,889.95	\$301.42	\$638.47	\$572.41	\$872.28
Anthem EPO	\$851.76	\$1,542.84	\$1,350.96	\$2,031.12	\$393.12	\$712.08	\$623.52	\$937.44
Kaiser HMO	\$851.76	\$1,542.84	\$1,350.96	\$2,031.12	\$393.12	\$712.08	\$623.52	\$937.44
Delta Dental PPO	\$50.29	\$80.19	\$69.88	\$102.58	\$23.21	\$37.01	\$32.25	\$47.34
Delta Dental DHMO	\$27.38	\$47.51	\$47.83	\$68.95	\$12.64	\$21.93	\$22.08	\$31.82
VSP Vision	\$7.79	\$14.00	\$13.73	\$20.10	\$3.60	\$6.46	\$6.34	\$9.28

SJVIA PARTICIPATION AGREEMENT

THIS AGREEMENT ("Agreement") is made and entered into as of the 1st day of January 2020, 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, and mental health, 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"); and

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. COUNTY OF TULARE's OBLIGATIONS: The COUNTY OF TULARE acknowledges that this agreement requires a commitment to participate in SJVIA Various Benefits effective January 1, 2020 through December 31, 2020. 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 January 1, 2020. 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 January 1, 2020 through December 31, 2020. 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 uses actuarially based underwriting standards.

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

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

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

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

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

COUNTY OF TULARE

Rhonda Sjostrom
Human Resource Director
2500 West Burrel
Visalia, CA 93291
rsjostro@co.tulare.ca.us

SJVIA

Paul Nerland
SJVIA Assistant Manager
2220 Tulare Street, 16th floor
Fresno, CA 93721
PNerland@fresnocountyca.gov

Any and all notices between the COUNTY OF TULARE and the SJVIA provided for or permitted under this Agreement shall be in writing and delivered either by person service, by first-class United States mail, by an overnight commercial courier service, or by telephonic facsimile transmission. A notice delivered by personal service is effective upon service to the recipient. A notice delivered by first-class United States mail is effective three business days after deposit in the United States mail, postage prepaid, addressed to the recipient. A notice delivered by an

overnight commercial courier service is effective one business day after deposit with the overnight commercial courier service, delivery fees prepaid, with delivery instructions given for next day delivery, addressed to the recipient. A notice delivered by telephonic facsimile is effective when transmission to the recipient is completed (but, if such transmission is completed outside of COUNTY OF TULARE business hours, then such delivery shall be deemed to be effective at the next beginning of a COUNTY OF TULARE business day), provided that the sender maintains a machine record of the completed transmission. For all claims arising out of or related to this Agreement, nothing in this section establishes, waives, or modifies any claims presentation requirements or procedures provided by law, including but not limited to the Government Claims Act (Division 3.6 of Title 1 of the Government Code, beginning with section 810).

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 January 1, 2020 and shall terminate on December 31, 2020.

9. **TERMINATION:**

- a. The terms of this Agreement, and the health insurance programs, Administrative Services, and/or SJVIA Staff Costs to be provided hereunder, are contingent on the approval of funds by the COUNTY OF TULARE. Should sufficient funds not be allocated, the services provided may be modified, or this Agreement terminated at any time by giving SJVIA 120 days advance written notice.
- b. Notwithstanding any other provision of this Article, if the COUNTY OF TULARE fails to make in full any payment when due pursuant to Article 1, the SJVIA shall have the right, in its sole discretion, to terminate this Agreement, without notice, effective at the expiration of the last period for which full premium payment was made. Notwithstanding such termination or suspension, the SJVIA, in its sole discretion, may accept late payment or delinquent amounts and, upon acceptance, this Agreement may be reinstated retroactively to the last date for which full premium payment was made. Any such acceptance of a delinquent payment by the SJVIA shall not be deemed a waiver of this provision for termination of this Agreement in the event of any future failure of the COUNTY OF TULARE to make timely payments of any amounts due under this Agreement.

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

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

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

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

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(Go to next page for signatures)

**AGREEMENT BETWEEN COUNTY OF TULARE AND THE
SAN JOAQUIN VALLEY INSURANCE AUTHORITY**

**SAN JOAQUIN VALLEY INSURANCE
AUTHORITY:**

By _____
Buddy Mendes
SJVIA Board President

Date: _____

REVIEWED &
RECOMMENDED FOR APPROVAL

By _____
Paul Nerland
SJVIA Assistant Manager

COUNTY OF TULARE:

By _____
Kuyler Crocker
Chairman, Board of Supervisors

Date: _____

ATTEST:
Jason T. Britt, County Administrative
Officer/Clerk of the Board of Supervisors

By _____
Deputy

APPROVED AS TO LEGAL FORM:
TULARE COUNTY COUNSEL

By
Deputy

Matter No. 20181701



BOARD OF DIRECTORS

STEVE BRANDAU

KUYLER CROCKER

NATHAN MAGSIG

BUDDY MENDES

BRIAN PACHECO

AMY SHULIAN

PETE VANDER POEL

Exhibit A

County of Tulare

**Plan Year 2020
Benefit Summaries**

- Anthem Blue Cross PPO 0/500/20/90/70
- Anthem Blue Cross PPO 500/35/80/60
- Anthem Blue Cross PPO 750/25/35/80/50
- Anthem Blue Cross HDHP PPO 2500/90/50
- EmpiRx Health Prescription Benefit
- Kaiser Permanente HMO
- Kaiser Permanente DHMO
- Kaiser Permanente Senior Advantage HMO
- Delta Dental PPO
- Delta Dental DHMO
- VSP Vision Benefits



SJVIA County of Tulare Custom Classic PPO 0/500/20/90/70

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

Explanation of Maximum Allowed Amount

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

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

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

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

Calendar year deductible

For PPO Providers & Other Health Providers	None
For non-PPO Providers	\$500/member; \$1,000/family

Deductible for non-Anthem Blue Cross PPO hospital or residential treatment center

None

Deductible for non-Anthem Blue Cross PPO hospital or residential treatment center if utilization review not obtained

\$250/admission (*waived for emergency admission*)

Deductible for emergency room services

\$100/visit (*waived if admitted directly from ER*)

Annual Out-of-Pocket Maximums (*no cross application*)

PPO Providers & Other Health Care Providers	\$2,000/member/year; \$4,000/family/year
Non-PPO Providers	\$5,000/member/year; \$10,000/family/year

The following do not apply to out-of-pocket maximums: non-covered expense. After a member reaches the out-of-pocket maximum, the member remains responsible for non-PPO providers & other health care providers, costs in excess of the covered expense.

Lifetime Maximum

Unlimited

Covered Services

	PPO: Per Member Copay	Non-PPO: Per Member Copay ¹
Hospital Medical Services (<i>subject to utilization review for inpatient services; waived for emergency admissions</i>)		
➤ Semi-private room, meals & special diets, & ancillary services	10%	30% (<i>benefit limited to \$600/day</i>)
➤ Outpatient medical care, surgical services & supplies (<i>hospital care other than emergency room care</i>)	10%	30% (<i>benefit limited to \$600/day</i>)
Ambulatory Surgical Centers		
➤ Outpatient surgery, services & supplies	10%	30% (<i>benefit limited to \$350/day</i>)
Skilled Nursing Facility (<i>subject to utilization review</i>)		
➤ Semi-private room, services & supplies (<i>limited to 100 days/calendar year; limit does not apply to mental health and substance abuse</i>)	10%	10%
Hospice Care (<i>subject to utilization review</i>)		
➤ Inpatient or outpatient services for member with up to one year life expectancy; family bereavement services	No copay ²	

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

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

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

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

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

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

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay ¹
Organ & Tissue Transplants <i>(subject to utilization review; specified organ transplants covered only when performed at a Center of Expertise [COE])</i>		
➤ Inpatient services provided in connection with non-investigative organ or tissue transplants	10%	
➤ Transplant travel expense for an authorized, specified transplant at a COE <i>(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)</i>	No copay	
Bariatric Surgery <i>(subject to utilization review; medically necessary surgery for weight loss, only for morbid obesity, covered only when performed at a Center of Expertise [COE])</i>		
➤ 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 <i>(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)</i>	No copay	
Diabetes Education Programs <i>(requires physician supervision)</i>		
➤ 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 <i>(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)</i>	10%	30%
Related Outpatient Medical Services & Supplies		
➤ Ground or air ambulance transportation, services & disposable supplies	10% ²	
➤ Blood transfusions, blood processing & the cost of unreplaced blood & blood products	10% ²	
➤ Autologous blood <i>(self-donated blood collection, testing, processing & storage for planned surgery)</i>	10% ²	

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

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

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay ¹
Emergency Care		
➤ Emergency room services & supplies (\$100 deductible waived if admitted)	10%	10%
➤ Inpatient hospital services & supplies	10%	10%
➤ Physician services	10%	10%
Mental or Nervous Disorders and Substance Abuse		
➤ Inpatient facility care (<i>subject to utilization review; waived for emergency admissions</i>)	10%	30% (<i>benefit limited to \$600/day</i>)
➤ Inpatient physician visits	10%	30%
➤ Outpatient facility care	10%	30%
➤ Physician office visits (<i>Behavioral Health treatment for Autism & Pervasive Development disorders requires pre-service review</i>)	\$20/visit ²	30%

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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.

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

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Classic PPO Exclusions and Limitations

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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. Any injury, condition or disease arising out of employment for which benefits or payments are covered by any worker's compensation law or similar law. If we provide benefits for such injuries, conditions or diseases we shall be entitled to establish a lien or other recovery under section 4903 of the California Labor Code or any other applicable law, as specified in the EOC/Certificate.

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

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

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

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

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

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

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

Orthodontia. Braces, other orthodontic appliances or orthodontic services.

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

Hearing Aids or Tests

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

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

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

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

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

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

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

Sterilization Reversal.

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

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

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

Air Conditioners. Air purifiers, air conditioners or humidifiers.

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

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

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

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

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

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

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

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

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

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

Outpatient Prescription Drugs and Medications. Outpatient prescription drugs or medications and insulin, except as specified as covered in the Certificate. 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.

Residential accommodations. Residential accommodations to treat medical or behavioral health conditions, except when provided in a hospital, hospice, skilled nursing facility or residential treatment center. This exclusion includes procedures, equipment, services, supplies or charges for the following:

- Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
- Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
- Services or care provided or billed by a school, custodial care center for the developmentally disabled, or outward bound programs, even if psychotherapy is included.

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.

This plan includes custom benefits that may supersede some of the information included in the Limitations and Exclusions provided here. Please see your EOC for full details on your covered benefits.

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.

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

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

Explanation of Maximum Allowed Amount

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

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

Non-Participating Providers & Other Health Care Providers-(includes those not represented in the PPO provider network)-

Reimbursement amount is based on: an Anthem Blue Cross rate or fee schedule, a rate negotiated with the provider, information from a third party vendor, or billed charges. For Medical Emergency care rendered by a Non-Participating Provider or Non-Contracting Hospital, reimbursement may be based on the reasonable and customary value. Members may be responsible for any amount in excess of the reasonable and customary

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

Calendar year deductible for all providers	\$500/member; \$1,000/family	
Deductible for non-Anthem Blue Cross PPO hospital or residential treatment center	\$250/admission (waived for emergency admission)	
Deductible for non-Anthem Blue Cross PPO hospital or residential treatment center if utilization review not obtained	\$250/admission (waived for emergency admission)	
Deductible for emergency room services	\$100/visit (waived if admitted directly from ER)	
Annual Out-of-Pocket Maximums (no cross application)		
PPO Providers & Other Health Care Providers	\$3,000/member/year; \$6,000/family/year	
Non-PPO Providers	\$10,000/member/year; \$20,000/family/year	
The following do not apply to out-of-pocket maximums: non-covered expense. After a member reaches the out-of-pocket maximum, the member remains responsible for non-PPO providers & other health care providers, costs in excess of the covered expense		
Lifetime Maximum	Unlimited	
Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay ¹
Hospital Medical Services (subject to utilization review for inpatient services; waived for emergency admissions)		
➤ Semi-private room, meals & special diets, & ancillary services	\$250/admission + 20%	40% (benefit limited to \$600/day)
➤ Outpatient medical care, surgical services & supplies (hospital care other than emergency room care)	20%	40% (benefit limited to \$600/day)
Ambulatory Surgical Centers		
➤ Outpatient surgery, services & supplies	\$125/surgery + 20%	40% (benefit limited to \$350/day)
Skilled Nursing Facility (subject to utilization review)		
➤ Semi-private room, services & supplies (limited to 100 days/calendar year; limit does not apply to mental health and substance abuse)	20%	20%
Hospice Care (subject to utilization review)		
➤ Inpatient or outpatient services for members with up to one year life expectancy; family bereavement services	No copay ²	

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

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay ¹
Home Health Care <i>(subject to utilization review)</i>		
➤ Services & supplies from a home health agency <i>(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)</i>	20%	20% with authorization
Home Infusion Therapy <i>(subject to utilization review)</i>		
➤ Includes medication, ancillary services & supplies; caregiver training & visits by provider to monitor therapy; durable medical equipment; lab services	20%	20%
Physician Medical Services		
➤ Office & home visits	\$35/visit ² <i>(deductible waived)</i>	40%
➤ Hospital & skilled nursing facility visits	20%	40%
➤ Surgeon & surgical assistant; anesthesiologist or anesthesiologist	20%	40%
➤ Drugs administered by a medical provider <i>(certain drugs are subject to utilization review)</i>	20%	40%
Diagnostic X-ray & Lab		
➤ MRI, CT scan, PET scan & nuclear cardiac scan <i>(subject to utilization review)</i>	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 <i>(deductible waived)</i>	40%
Physical Therapy, Physical Medicine & Occupational Therapy	\$25/visit <i>(deductible waived)</i>	40%
Chiropractic Services <i>(up to 12 visits/calendar year; additional visits may be approved, if medically necessary)</i>	\$25/visit <i>(deductible waived)</i>	40%
Speech Therapy		
➤ Outpatient speech therapy following injury or organic disease	\$35/visit <i>(deductible waived)</i>	40%
Acupuncture		
➤ Services for the treatment of disease, illness or injury <i>(limited to 20 visits/calendar year)</i>	20% ³	40% ³
Temporomandibular Joint Disorders		
➤ Splint therapy & surgical treatment	20%	40%
Pregnancy & Maternity Care		
➤ Physician office visits	\$35/visit ² <i>(deductible waived)</i>	40%
➤ Prescription drug for elective abortion (<i>mifepristone</i>)	20%	Not covered
Normal delivery, cesarean section, complications of pregnancy & abortion		
➤ Inpatient physician services	20%	40%
➤ Hospital & ancillary services	\$250/admission + 20%	40% <i>(benefit limited to \$600/day)</i>
➤ Female Sterilization <i>(including tubal ligation and counseling/consultation)</i>	No copay	Not covered
➤ Male Sterilization	20%	Not covered
➤ Family Planning counseling	\$35/visit <i>(deductible waived)</i>	Not covered

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

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay ¹
Organ & Tissue Transplants <i>(subject to utilization review; specified organ transplants covered only when performed at a Center of Expertise [COE])</i>		
➤ Inpatient services provided in connection with non-investigative organ or tissue transplants		\$250/admission + 20%
➤ Transplant travel expense for an authorized, specified transplant at a COE <i>(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)</i>		No copay <i>(deductible waived)</i>
Bariatric Surgery <i>(subject to utilization review; medically necessary surgery for weight loss, only for morbid obesity, covered only when performed at a Center of Expertise [COE])</i>		
➤ Inpatient services provided in connection with medically necessary surgery for weight loss, only for morbid obesity		\$250/admission + 20%
➤ Bariatric travel expense when member's home is 50 miles or more from the nearest Bariatric CME <i>(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)</i>		No copay <i>(deductible waived)</i>
Diabetes Education Programs <i>(requires physician supervision)</i>		
➤ Teach members & their families about the disease process, the daily management of diabetic therapy & self-management training	\$35/visit <i>(deductible waived)</i>	40%
Prosthetic Devices		
➤ Coverage for breast prostheses; prosthetic devices to restore a method of speaking; surgical implants; artificial limbs or eyes; the first pair of contact lenses or eyeglasses when required as a result of eye surgery; & therapeutic shoes & inserts	20%	40%
Durable Medical Equipment		
➤ Rental or purchase of DME including , dialysis equipment & supplies, home medical equipment, prosthetic/orthotics <i>(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)</i>	20%	20%
Related Outpatient Medical Services & Supplies		
➤ Ground or air ambulance transportation, services & disposable supplies		20% ²
➤ Blood transfusions, blood processing & the cost of unreplaced blood & blood products		20% ²
➤ Autologous blood <i>(self-donated blood collection, testing, processing & storage for planned surgery)</i>		20% ²

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Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay ¹
Emergency Care		
➤ Emergency room services & supplies (<i>\$100 deductible waived if admitted</i>)	20%	20%
➤ Inpatient hospital services & supplies	\$250/admission + 20%	\$250/admission + 20%
➤ Physician services	20%	20%
Mental or Nervous Disorders and Substance Abuse		
➤ Inpatient facility care (<i>subject to utilization review; waived for emergency admissions</i>)	\$250/admission + 20%	40% (<i>benefit limited to \$600/day</i>)
➤ Inpatient physician visits	20%	40%
➤ Outpatient facility care	20%	40%
➤ Physician office visits (<i>Behavioral Health treatment for Autism & Pervasive Development disorders requires pre-service review</i>)	\$35/visit ² (<i>deductible waived</i>)	40%

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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. Any injury, condition or disease arising out of employment for which benefits or payments are covered by any worker's compensation law or similar law. If we provide benefits for such injuries, conditions or diseases we shall be entitled to establish a lien or other recovery under section 4903 of the California Labor Code or any other applicable law, as specified in the EOC/Certificate.

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

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

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

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

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Orthodontia. Braces, other orthodontic appliances or orthodontic services.

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

Hearing Aids or Tests

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

Eyeglasses or contact lenses, except as specified as covered in the EOC.

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

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

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

Commercial Weight Loss Programs. Weight loss programs, whether or not they are pursued under medical or *physician* supervision, unless specifically listed as covered in this *plan*. This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

This exclusion does not apply to *medically necessary* treatments for morbid obesity or dietary evaluations and counseling, and behavioral modification programs for the treatment of anorexia

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.

nervosa or bulimia nervosa. Surgical treatment for morbid obesity is covered as described in the Evidence of Coverage (EOC).

Sterilization Reversal.

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

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

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

Air Conditioners. Air purifiers, air conditioners or humidifiers.

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

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

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

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

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

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

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

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

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

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

Outpatient Prescription Drugs and Medications. Outpatient prescription drugs or medications and insulin, except as specified as covered in the Certificate. 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.

Residential accommodations. Residential accommodations to treat medical or behavioral health conditions, except when provided in a hospital, hospice, skilled nursing facility or residential treatment center. This exclusion includes procedures, equipment, services, supplies or charges for the following:

- Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
- Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmity, school infirmity, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
- Services or care provided or billed by a school, custodial care center for the developmentally disabled, or outward bound programs, even if psychotherapy is included.

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

This plan includes custom benefits that may supersede some of the information included in the Limitations and Exclusions provided here. Please see your EOC for full details on your covered benefits.

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

Explanation of Maximum Allowed Amount

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

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

Calendar year deductible for all providers	\$750/member; \$1,500/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	\$3,500/member/year; \$7,000/family/year	
Non-PPO Providers	\$10,000/member/year; \$20,000/family/year	
The following do not apply to out-of-pocket maximums: non-covered expense. After a member reaches the out-of-pocket maximum, the member remains responsible for non-PPO providers & other health care providers, costs in excess of the covered expense.		
Lifetime Maximum	Unlimited	
Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay ¹
Hospital Medical Services (subject to utilization review for inpatient services; waived for emergency admissions)		
➤ Semi-private room, meals & special diets, & ancillary services	20%	50% (benefit limited to \$600/day)
➤ Outpatient medical care, surgical services & supplies (hospital care other than emergency room care)	20%	50% (benefit limited to \$600/day)
Ambulatory Surgical Centers		
➤ Outpatient surgery, services & supplies	\$250/surgery + 20%	50% (benefit limited to \$350/visit)
Skilled Nursing Facility (subject to utilization review)		
➤ Semi-private room, services & supplies (limited to 100 days/calendar year; limit does not apply to mental health and substance abuse)	20%	20%
Hospice Care (subject to utilization review)		
➤ Inpatient or outpatient services; for members with up to one year life expectancy; family Bereavement services	No copay	

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

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay ¹
Home Health Care <i>(subject to utilization review)</i>		
➤ Services & supplies from a home health agency with authorization <i>(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)</i>	20%	20%
Home Infusion Therapy <i>(subject to utilization review)</i>		
➤ 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	\$25/visit ² <i>(deductible waived)</i>	50%
➤ Specialists	\$35/visit ² <i>(deductible waived)</i>	50%
➤ Hospital & skilled nursing facility visits	20%	50%
➤ Surgeon & surgical assistant; anesthesiologist or anesthetist	20%	50%
➤ Drugs administered by a medical provider <i>(Certain drugs are subject to utilization review)</i>	20%	50%
Diagnostic X-ray & Lab		
➤ MRI, CT scan, PET scan & nuclear cardiac scan <i>(subject to utilization review)</i>	20%	50%
➤ Other diagnostic x-ray & lab	No copay	50%
Preventive Care Services		
Preventive Care Services including*, physical exams, preventive screenings (including screenings for cancer, HPV, diabetes, cholesterol, blood pressure, hearing and vision immunizations, health education, Intervention services, HIV testing), and additional preventive care for women provided for in the guidelines supported by the Health Resources and Services Administration. *This list is not exhaustive. This benefit includes all Preventive Care Services required by federal and state law.	No copay <i>(deductible waived)</i>	50%
Physical Therapy, Physical Medicine & Occupational Therapy	\$25/visit <i>(deductible waived)</i>	50%
Chiropractic Services <i>(up to 12 visits/calendar year; additional visits may be approved, if medically necessary)</i>	\$25/visit <i>(deductible waived)</i>	50%
Speech Therapy		
➤ Outpatient speech therapy following injury or organic disease	\$25/visit <i>(deductible waived)</i>	50%
Acupuncture		
➤ Services for the treatment of disease, illness or injury <i>(limited to 20 visits/calendar year)</i>	20% ³	50% ³
Temporomandibular Joint Disorders		
➤ Splint therapy & surgical treatment	20%	50%
Pregnancy & Maternity Care		
➤ Physician office visits	\$25/visit ² <i>(deductible waived)</i>	50%
➤ Prescription drug for elective abortion <i>(mifepristone)</i>	20%	Not covered
Normal delivery, cesarean section, complications of pregnancy & abortion		
➤ Inpatient physician services	20%	50%
➤ Hospital & ancillary services	20%	50% <i>(benefit limited to \$600/day)</i>
➤ Female Sterilization <i>(including tubal ligation and counseling/consultation)</i>	No copay	Not covered
➤ Male Sterilization	20%	Not covered
➤ Family planning counseling	\$25/visit <i>(deductible waived)</i>	Not covered

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

²The 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.

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

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay ¹
Organ & Tissue Transplants <i>(subject to utilization review; specified organ transplants covered only when performed at a Center of Expertise [COE])</i>		
➤ Inpatient services provided in connection with non-investigative organ or tissue transplants	20%	
➤ Transplant travel expense for an authorized, specified transplant at a COE <i>(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)</i>	No copay <i>(deductible waived)</i>	
Bariatric Surgery <i>(subject to utilization review; medically necessary surgery for weight loss, only for morbid obesity, covered only when performed at a Center of Expertise [COE])</i>		
➤ Inpatient services provided in connection with medically necessary surgery for weight loss, only for morbid obesity	20%	
➤ Bariatric travel expense when member's home is 50 miles or more from the nearest Bariatric COE <i>(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)</i>	No copay <i>(deductible waived)</i>	
Diabetes Education Programs <i>(requires physician supervision)</i>		
➤ Teach members & their families about the disease process, the daily management of diabetic therapy & self-management training	\$25/visit <i>(deductible waived)</i>	50%
Prosthetic Devices		
➤ Coverage for breast prostheses; prosthetic devices to restore a method of speaking; surgical implants; artificial limbs or eyes; the first pair of contact lenses or eyeglasses when required as a result of eye surgery; & therapeutic shoes & inserts	50%	50%
Durable Medical Equipment		
➤ Rental or purchase of DME including dialysis equipment & supplies, home medical equipment, prosthetic/orthotics <i>(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)</i>	50%	50%
Related Outpatient Medical Services & Supplies		
➤ Ground or air ambulance transportation, services & disposable supplies	20% ²	
➤ Blood transfusions, blood processing & the cost of unreplaced blood & blood products	20% ²	
➤ Autologous blood <i>(self-donated blood collection, testing, processing & storage for planned surgery)</i>	20% ²	

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

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

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay ¹
Emergency Care		
➤ Emergency room services & supplies (<i>\$100 deductible waived if admitted</i>)	20%	20%
➤ Inpatient hospital services & supplies	20%	20%
➤ Physician services	20%	20%
Mental or Nervous Disorders and Substance Abuse		
➤ Inpatient facility care (<i>subject to utilization review; waived for emergency admissions</i>)	20%	50% (<i>benefit limited to \$600/day</i>)
➤ Inpatient physician visits	20%	50%
➤ Outpatient facility care	20%	50%
➤ Physician office visits (<i>Behavioral Health treatment for Autism & Pervasive Development disorders requires to pre-service review</i>)	\$25/visit ² (<i>deductible waived</i>)	50%

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

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

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.

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.

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. Any injury, condition or disease arising out of employment for which benefits or payments are covered by any worker's compensation law or similar law. If we provide benefits for such injuries, conditions or diseases we shall be entitled to establish a lien or other recovery under section 4903 of the California Labor Code or any other applicable law, as specified in the EOC/Certificate.

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

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

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

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

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

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

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

Orthodontia. Braces, other orthodontic appliances or orthodontic services.

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

Hearing Aids or Tests.

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

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

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

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

Commercial Weight Loss Programs. Weight loss programs, whether or not they are pursued under medical or *physician* supervision, unless specifically listed as covered in this *plan*. This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

This exclusion does not apply to *medically necessary* treatments for morbid obesity or dietary evaluations and counseling, and behavioral modification programs for the treatment of anorexia

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.

nervosa or bulimia nervosa. Surgical treatment for morbid obesity is covered as described in the Evidence of Coverage (EOC).

Sterilization Reversal.

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

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

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

Air Conditioners. Air purifiers, air conditioners or humidifiers.

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

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

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

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

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

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

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

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

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

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

Outpatient Prescription Drugs and Medications. Outpatient prescription drugs or medications and insulin, except as specified as covered in the Certificate. 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.

Residential accommodations. Residential accommodations to treat medical or behavioral health conditions, except when provided in a hospital, hospice, skilled nursing facility or residential treatment center. This exclusion includes procedures, equipment, services, supplies or charges for the following:

- Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
 - Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
 - Services or care provided or billed by a school, custodial care center for the developmentally disabled, or outward bound programs, even if psychotherapy is included.
- 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.

This plan includes custom benefits that may supersede some of the information included in the Limitations and Exclusions provided here. Please see your EOC for full details on your covered benefits.

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SJVIA County of Tulare Health Savings Account (HSA) Custom Anthem PPO HSA(2500/90/50) Rx Copay after Deductible

This 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 & Home Delivery 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; the family deductible is non-embedded meaning the cost shares of all family members apply to one shared family deductible. The individual deductible only applies to individuals enrolled under single coverage.*)

- | | |
|--|-----------------------------------|
| ➤ Individual insured person | \$2,500/individual insured person |
| ➤ Insured family (<i>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</i>) | \$5,000/insured family |

Deductible for hospital if utilization review not obtained	\$250/admission (<i>waived for emergency admission</i>)
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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; the family out-of-pocket maximum is non-embedded meaning the cost shares of all family members apply to one shared family out-of-pocket. The individual out-of-pocket only applies to individuals enrolled under single coverage.*)

- | | |
|--|--|
| ➤ For all Providers & Other Health Care Providers & all Participating Pharmacies | \$5,000/individual insured person; \$8,150/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
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Covered Services	Traditional Health Coverage	
	In-Network	Out-of-Network (Insured is also responsible for charges in excess of covered expense.)
Hospital Medical Services (subject to utilization review for inpatient services; waived for emergency admissions)		
➤ Semi-private room, meals & special diets, & ancillary services	10%	50% up to \$580 plan payment per day
➤ Outpatient medical care, surgical services & supplies (hospital care other than emergency room care)	10%	50% (benefit limited to \$350/day)
Ambulatory Surgical Centers		
➤ Outpatient surgery, services & supplies	10%	50% (benefit limited to \$350/day)
Skilled Nursing Facility (subject to utilization review)		
➤ Semi-private room, services & supplies (limited to 100 days/calendar year; limit does not apply to mental health or substance abuse)	10%	10%
Hospice Care (subject to utilization review) (\$10,000 combined maximum per member per lifetime)		
➤ Inpatient or outpatient services for insured persons with up to one year life expectancy; family bereavement services	10%	10%
Home Health Care (subject to utilization review)		
➤ Services & supplies from a home health agency (limited to 100 visits/calendar year, one visit by a home health aide equals four hours or less; not covered while insured person receives hospice care)	10%	10%
Home Infusion Therapy		
➤ Includes medication, ancillary services & supplies; caregiver training & visits by provider to monitor therapy; durable medical equipment; lab services	10%	10%
Physician Medical Services		
➤ Office & home visits	10%	50%
➤ Hospital & skilled nursing facility visits	10%	50%
➤ Surgeon & surgical assistant; anesthesiologist or anesthesiologist	10%	50%
➤ Drugs administered by a medical provider (Certain drugs are subject to utilization review)	10%	50%
Diagnostic X-ray & Lab		
➤ MRI, CT scan, PET scan & nuclear cardiac scan (subject to utilization review)	10%	50%
➤ Other diagnostic x-ray & lab	10%	50%
Preventive Care Services		
Preventive Care Services including*, physical exams, preventive screenings (including screenings for cancer, HPV, diabetes, cholesterol, blood pressure, hearing and vision immunizations, health education, Intervention services, HIV testing), and additional preventive care for women provided for in the guidelines supported by the Health Resources and Services Administration. *This list is not exhaustive. This benefit includes all Preventive Care Services required by federal and state law.	No copay (deductible waived)	50%
Physical Therapy, Physical Medicine & Occupational Therapy, including Chiropractic Services (limited to 12 visits/calendar year; additional visits may be approved; if medically necessary)	10%	50%
Speech Therapy		
➤ Outpatient speech therapy following injury or organic disease	10%	50%

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

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

Covered Services	Traditional Health Coverage Insured Person Copay	
	In-Network	Out-of-Network (Insured is also responsible for charges in excess of covered expense.)
Prosthetic Devices		
➤ Coverage for breast prostheses; prosthetic devices to restore a method of speaking; surgical implants; artificial limbs or eyes; the first pair of contact lenses or eyeglasses when required as a result of eye surgery; wigs for alopecia resulting from chemotherapy or radiation therapy; & therapeutic shoes & inserts for insured persons with diabetes	10%	10%
Durable Medical Equipment		
Rental or purchase of DME including dialysis equipment & supplies, home medical equipment, prosthetics/orthotics <i>(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)</i>	10%	10%
Related Outpatient Medical Services & Supplies		
➤ Ground or air ambulance transportation, services & disposable supplies		10% ¹
➤ Blood transfusions, blood processing & the cost of unreplaced blood & blood products		10% ¹
➤ Autologous blood <i>(self-donated blood collection, testing, processing & storage for planned surgery)</i>		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 facility care <i>(subject to utilization review; waived for emergency admissions)</i>	10%	50% <i>(benefit limited to \$580/day)</i>
➤ Inpatient physician visits	10%	50%
➤ Outpatient facility care	10%	50%
➤ Physician office visits <i>(Behavioral Health treatment for Autism & Pervasive Development disorders requires pre-service review)</i>	10%	50%

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

Covered Services (For Outpatient Prescription Drugs)	Traditional Health Coverage Per Insured Person Copay for Each Prescription or Refill
Outpatient Prescription Drug Benefits <i>(Until the calendar year deductible is satisfied, the insured person pays the prescription drug maximum allowed amount and not the copays listed below.)</i>	
➤ Retail Pharmacy	
➤ Preventive immunizations administered by a retail pharmacy -	No copay (<i>deductible waived</i>)
➤ Female oral contraceptives generic and single source brand	No copay (<i>deductible waived</i>)
➤ Generic drugs	\$7
➤ Brand name formulary drugs ^{1,2}	\$25
➤ Self-administered injectable drugs, except insulin	\$25
Home Delivery	
➤ Female oral contraceptives generic and single source brand	No copay
➤ Generic drugs	\$14
➤ Brand name formulary drugs ^{1,2}	\$50
➤ Self-administered injectable drugs, except insulin	\$25
Specialty pharmacy drugs <i>(may only be obtained through the specialty pharmacy program)</i>	
➤ Generic drugs	\$7
➤ Brand name formulary drugs ¹	\$25
➤ Self-administered injectable drugs, except insulin	\$25
Non-participating Pharmacies <i>(compound drugs & specialty pharmacy drugs not covered at retail participating pharmacies)</i>	<i>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</i>
Supply Limits³	
➤ Retail Pharmacy (<i>participating and non-participating</i>)	30-day supply; 60-day supply for federally classified Schedule II attention deficit disorder drugs that require a triplicate prescription form, but require a double copay; 6 tablets or units/30-day period for impotence and/or sexual dysfunction drugs (available only at retail pharmacies)
➤ Home Delivery	90-day supply
➤ Specialty Pharmacy	30-day supply

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

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

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

The Outpatient Prescription Drug Benefit covers the following:

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

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

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.

Anthem PPO 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. Any injury, condition or disease arising out of employment for which benefits or payments are covered by any worker's compensation law or similar law. If we provide benefits for such injuries, conditions or diseases we shall be entitled to establish a lien or other recovery under section 4903 of the California Labor Code or any other applicable law, as specified in the EOC/Certificate.

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

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

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

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

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

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

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

Orthodontia. Braces, other orthodontic appliances or orthodontic services.

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

Hearing Aids or Tests unless otherwise noted

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

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

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

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

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

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

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

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

Sterilization Reversal.

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

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

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

Air Conditioners. Air purifiers, air conditioners or humidifiers.

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

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

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

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

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

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

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

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

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

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

Outpatient Prescription Drugs and Medications Outpatient prescription drugs or medications and insulin, except as specified as covered in the Certificate. 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. **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.

Residential accommodations. Residential accommodations to treat medical or behavioral health conditions, except when provided in a hospital, hospice, skilled nursing facility or residential treatment center. This exclusion includes procedures, equipment, services, supplies or charges for the following:

- Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
- Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
- Services or care provided or billed by a school, custodial care center for the developmentally disabled, or outward bound programs, even if psychotherapy is included.

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

Anthem PPO 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:

- 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.

This plan includes custom benefits that may supersede some of the information included in the Limitations and Exclusions provided here. Please see your EOC for full details on your covered benefits.

Anthem PPO HSA plans provided by Anthem Blue Cross Life and Health Insurance Company. 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.

Frequently Asked Questions

How do I find a participating network pharmacy?

You can use your EmpiRx Health ID card at over 68,000 pharmacies nationwide including all pharmacy chains. You can find a network pharmacy by logging onto www.empirxhealth.com or calling 877-262-7435.

What is a prior authorization and why is it necessary?

Certain medications require prior authorization (PA) because of their potential side effects, potentially harmful interactions with other prescription medications, or to confirm they are being prescribed in accordance with Food & Drug Administration (FDA) approved indications. This process is designed to help ensure your health and safety. If a PA is needed, EmpiRx Health will work directly with your physician to obtain the necessary information prior to fulfillment.

How do I find out if a particular prescription is covered by my benefits?

Call 877-262-7435 to speak to a representative who can assist you with drug coverage questions or log onto www.empirxhealth.com for details.

How can I find out if generic or lower cost alternatives may be available to me?

Log into the member portal at www.empirxhealth.com and select "Drug Pricing." Search your medication and if there is a generic available, you will see the cost for both the brand as well as the generic. You can also call 877-262-7435 to speak to a representative who can assist you, or consult your physician or pharmacist to determine if generic equivalents are available for your prescription.

Why does my copay change from month to month?

The cost of medications changes regularly and prices are not all the same at each pharmacy. If your copay is based on a percentage rather than a fixed dollar amount then depending on the pharmacy you use and the cost of the medication at the time your prescription is filled, you may see a variation in your copay amount.

This brochure is only a general description of your prescription benefit program and it is not a contract. All benefits described herein are subject to the terms, conditions and limitations of the group master contract and applicable law. All personal health information is kept strictly confidential, as required by the privacy rules of the Health Insurance Portability and Accountability Act.

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Standard Brochure 1.2017

CDPK.90.1800.000



SJVIA County of Tulare Prescription Benefit Plan

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

Your Prescription Benefit Program

Retail Pharmacy Copayment

You are responsible to pay the retail pharmacist the copayment per prescription which is listed below:

30-Day Supply	90-Day Supply
\$10.00 for a Generic Medication	\$20.00 for a Generic Medication
\$20.00 for a Preferred Brand Medication	\$40.00 for a Preferred Brand Medication
\$35.00 for a Non-Preferred Brand Medication	\$60.00 for a Non-Preferred Brand Medication

This is a Dispense As Written Plan (DAW), meaning your pharmacist must dispense the generic equivalent drug when one is available unless your physician specifically requests the brand be dispensed. If you request the brand name medication from your pharmacist, you are responsible for the difference in cost between the brand and the generic plus the copayment.

Retail quantities will be dispensed according to your physician's instructions written on the prescription up to a maximum of a 90-day supply.

Please Note: If the cost of your medication is less than your calculated copayment, you will only pay the cost of the medication.

Mail Order Pharmacy Copayment

Maintenance medications can be submitted to Benecard Central Fill, the EmpiRx Health mail order facility. Your plan allows for up to a 90-day supply with three (3) refills, according to your physician's instructions. Your co-pay amount will be:

\$15.00 for a Generic Medication
\$30.00 for a Preferred Brand Medication
\$50.00 for a Non-Preferred Brand Medication

Specialty Medication Copayment

Specialty medications are high-cost biotechnology drugs requiring special distribution, handling, and administration. These medications are typically designed to treat chronic diseases.

30% (\$100 max) for a Generic Specialty Medication
30% (\$100 max) for a Preferred Brand Specialty Medication
30% (\$100 max) for a Non-Preferred Brand Specialty Medication

Specialty medications can be filled one (1) time at a retail pharmacy. All future prescriptions must be obtained at Benecard Central Fill's Specialty Pharmacy. Please note that specialty medications are limited to a 30-day supply.

Online Member Tools

Maximize your benefit and find out how you can save on your out-of-pocket costs with our valuable member resource tools online at www.empirxhealth.com including:

- Plan coverage details and copay information
- Network pharmacy finder
- Mail service access to request refills and check order status
- Updated preferred medication list
- Drug comparison pricing tool to identify lower cost alternatives
- Drug information
- Recent personal drug utilization history including the amount you have paid and what the plan has paid on your behalf. This is helpful for year-end tax purposes

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



Preferred Medication List

The Preferred Medication List is a guide for selecting clinically and therapeutically appropriate medications. It should not take the place of a physician's or pharmacist's judgment with regard to a patient's pharmaceutical care. Refer to www.empirxhealth.com for the most recent version of the Preferred Medication List.

Exclusions

Your prescription program covers most Medically Necessary, Federal Legend, State Restricted and Compounded Medications which, by law, may not be dispensed without a prescription.

Be sure to present your EmpiRx Health ID card at a participating network pharmacy to receive a discount off the retail price of medications that may not be covered.

Retail Pharmacy Network

Your EmpiRx Health prescription benefit program provides you with access to an extensive national pharmacy network, including all chain pharmacies and most independents. This plan allows for a 90-day supply of maintenance medications. Your ID card provides all the information your pharmacist will need to process your prescription through EmpiRx Health. To locate a participating network pharmacy, log onto www.empirxhealth.com or call EmpiRx Health Member Services toll-free at 877-262-7435 (TDD: 1-888-907-0020).

Mail Order Pharmacy

The EmpiRx Health mail service pharmacy, Benecard Central Fill, is an option for you to obtain maintenance medications. Typically, prescriptions filled through mail service include medications used to treat chronic conditions and are written for up to a 90-day supply, plus refills. Prescriptions that you need to use right away should always be taken to your local pharmacy. You do have the option to obtain 90-day supplies through the retail network.

For your first order, complete the enclosed Mail Service Order Form and mail it along with your original prescription using the pre-addressed envelope provided to Benecard Central Fill. You can also have your physician submit your prescription electronically to Benecard Central Fill or fax your prescription to 1-888-907-0040. Be sure that your physician includes the cardholder name, ID number, shipping address, and patient's date of birth. Only prescriptions faxed from a doctor's office will be accepted via fax.

To order refills you have three options:

- **Internet:** Visit www.empirxhealth.com. If you have not yet registered, click on Register. If you are a registered user, log in and select Mail Order.
- **Phone:** Call Member Services toll-free, 877-262-7435, 24 hours a day, 7 days a week and use the prompts to order your refills. Have your identification number and credit card information ready.
- **Mail:** Send the Refill Request Order Form provided with your last shipment back to Benecard Central Fill mail service in the pre-addressed envelope

EmpiRx Health does NOT automatically refill your prescriptions.

To avoid delays, always include the appropriate copayment (if applicable) when your order is placed. Visa, MasterCard, Discover, or American Express and debit cards are accepted. You may also pay by check or money order made payable to Benecard Central Fill. Please do not send cash. Please allow up to two (2) weeks for delivery. Emergency prescriptions can be expedited at an additional charge.

Specialty Pharmacy

Specialty pharmaceuticals are typically produced through biotechnology, administered by injection, and/or require special handling and patient monitoring.

Through the Specialty Pharmacy, you receive personalized attention to help you manage your medical condition including one-on-one counseling with our team of pharmacists and trained medical professionals.

Our clinical team partners with you and your prescribing doctor to ensure you understand:

- How to manage your condition
- What medications you have been prescribed
- How to take your medication
- What lower cost options may be available
- How to coordinate delivery of your medication
- How to safely handle and store your medication

Shipments will arrive in secure, temperature-controlled packaging (if necessary) and will include everything you will need to take your medication. Due to the sensitive nature of specialty medications, some packages may require a signature.

Where Can I Ship My Medications?

We offer the convenience you need. Your medication can be shipped directly to:

- Your home
- Your work
- Your doctor's office
- Or a convenient location of your choice

Save with Generic Medications

Generic equivalent drugs must meet the same Food & Drug Administration (FDA) standards for purity, strength, and safety as brand name drugs. They also must have the same active ingredients and identical absorption rate within the body as the brand name version. If you wish to take advantage of this savings opportunity, speak with your physician about the use of generics. You may also consult with your pharmacist regarding generic drug options that may be available to you.

ID Cards

If your ID card is lost, you may print a temporary card online at www.empirxhealth.com. If there is an emergency and you need a prescription filled, call EmpiRx Health Member Services toll-free at 877-262-7435 (TDD: 1-888-907-0020) and we will provide your pharmacist with the required information to facilitate processing the claim.

Direct Member Reimbursement

If you must pay out-of-pocket for your medication which is covered by your plan, submit a Direct Member Reimbursement Form, which is available online at www.empirxhealth.com. You will need to provide an itemized receipt showing: the amount charged, prescription number, medication dispensed, manufacturer, dosage form, strength, quantity, and date dispensed. Your pharmacist can assist you if you do not have a detailed receipt. Direct reimbursement is based upon your plan benefits and the amount reimbursed may be significantly lower than the retail price you paid; therefore, always try to use a participating network pharmacy and present your ID card to reduce any unnecessary out-of-pocket expenses.

Proposed Benefit Summary

229275 SJVIA-COUNTY OF TULARE

Principal Benefits for Kaiser Permanente Traditional HMO Plan (1/1/20—12/31/20)

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 January 1 through December 31.

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

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

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

Professional Services (Plan Provider office visits)

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

Outpatient Services

	You Pay
Outpatient surgery and certain other outpatient procedures.....	\$25 per procedure
Allergy injections (including allergy serum)	\$3 per visit
Most immunizations (including the vaccine)	No charge
Most X-rays and laboratory tests.....	No charge

Hospitalization Services

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

Emergency Health Coverage

	You Pay
Emergency Department visits.....	\$100 per visit
Note: This Cost Share does not apply if you are admitted directly to the hospital as an inpatient for covered Services (see "Hospitalization Services" for inpatient Cost Share).	

Ambulance Services

	You Pay
Ambulance Services.....	\$50 per trip

Prescription Drug Coverage

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

Durable Medical Equipment (DME)

	You Pay
DME items as described in the EOC.....	20% Coinsurance

Mental Health Services

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

Substance Use Disorder Treatment

	You Pay
Inpatient detoxification	\$250 per admission
Individual outpatient substance use disorder evaluation and treatment.....	\$25 per visit

Proposed Benefit Summary*(continued)*

Substance Use Disorder Treatment	You Pay
Group outpatient substance use disorder treatment	\$5 per visit
Home Health Services	You Pay
Home health care (up to 100 visits per Accumulation Period)	No charge
Other	You Pay
Eyeglasses or contact lenses every 24 months	Amount in excess of \$150 Allowance
Skilled nursing facility care (up to 100 days per benefit period)	No charge
Prosthetic and orthotic devices as described in the <i>EOC</i>	No charge
Diagnosis and treatment of infertility and artificial insemination (such as outpatient procedures or laboratory tests) as described in the <i>EOC</i>	50% Coinsurance
Assisted reproductive technology ("ART") Services	Not covered
Hospice care	No charge

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

Proposed Benefit Summary

229275 SJVIA-COUNTY OF TULARE

Principal Benefits for Kaiser Permanente Deductible HMO Plan (1/1/20—12/31/20)

Accumulation Period

The Accumulation Period for this plan is January 1 through December 31.

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

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

For Services that are subject to the Plan Deductible or the Drug Deductible, you must pay Charges for covered Services you receive during the Accumulation Period until you reach the deductible amounts listed below. All payments you make toward your deductible(s) apply to the Plan Out-of-Pocket Maximum amounts listed below.

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

Professional Services (Plan Provider office visits)

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

Outpatient Services

	You Pay
Outpatient surgery and certain other outpatient procedures.....	20% Coinsurance after Plan Deductible
Allergy injections (including allergy serum)	No charge after Plan Deductible
Most immunizations (including the vaccine)	No charge (Plan Deductible doesn't apply)
Most X-rays and laboratory tests.....	\$10 per encounter after Plan Deductible
Preventive X-rays, screenings, and laboratory tests as described in the EOC.....	No charge (Plan Deductible doesn't apply)
MRI, most CT, and PET scans.....	20% Coinsurance up to a maximum of \$50 per procedure after Plan Deductible

Hospitalization Services

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

Emergency Health Coverage

	You Pay
Emergency Department visits.....	20% Coinsurance after Plan Deductible
Note: This Cost Share does not apply if you are admitted directly to the hospital as an inpatient for covered Services (see "Hospitalization Services" for inpatient Cost Share).	

Ambulance Services

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

Prescription Drug Coverage

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

Proposed Benefit Summary*(continued)***Durable Medical Equipment (DME)****You Pay**

DME items as described in the *EOC* 20% Coinsurance (Plan Deductible doesn't apply)

Mental Health Services**You Pay**

Inpatient psychiatric hospitalization 20% Coinsurance after Plan Deductible

Individual outpatient mental health evaluation and treatment \$20 per visit (Plan Deductible doesn't apply)

Group outpatient mental health treatment \$10 per visit (Plan Deductible doesn't apply)

Substance Use Disorder Treatment**You Pay**

Inpatient detoxification 20% Coinsurance after Plan Deductible

Individual outpatient substance use disorder evaluation and treatment \$20 per visit (Plan Deductible doesn't apply)

Group outpatient substance use disorder treatment \$5 per visit (Plan Deductible doesn't apply)

Home Health Services**You Pay**

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

Other**You Pay**

Skilled nursing facility care (up to 100 days per benefit period) 20% Coinsurance after Plan Deductible

Prosthetic and orthotic devices as described in the *EOC* No charge (Plan Deductible doesn't apply)

Diagnosis and treatment of infertility and artificial insemination (such as outpatient procedures or laboratory tests) as described in the *EOC* 50% Coinsurance (Plan Deductible doesn't apply)

Assisted reproductive technology ("ART") Services Not covered

Hospice care No charge (Plan Deductible doesn't apply)

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

229275 SJVIA-COUNTY OF TULARE

Principal Benefits for Kaiser Permanente Senior Advantage (HMO) with Part D (1/1/20—12/31/20)

Plan Out-of-Pocket Maximum

For Services subject to the maximum, you will not pay any more Cost Share for the rest of the calendar year if the Copayments and Coinsurance you pay for those Services add up to the following amount:

For any one Member \$1,500 per calendar year

Plan Deductible None

Professional Services (Plan Provider office visits) You Pay

Most Primary Care Visits and most Non-Physician Specialist Visits \$15 per visit
 \$15 per visit
 Most Physician Specialist Visits \$15 per visit
 Annual Wellness visit and the "Welcome to Medicare" preventive visit No charge
 Routine physical exams No charge
 Routine eye exams with a Plan Optometrist \$15 per visit
 Urgent care consultations, evaluations, and treatment \$15 per visit
 Physical, occupational, and speech therapy \$15 per visit

Outpatient Services You Pay

Outpatient surgery and certain other outpatient procedures \$15 per procedure
 Allergy injections (including allergy serum) \$3 per visit
 Most immunizations (including the vaccine) No charge
 Most X-rays and laboratory tests No charge
 Manual manipulation of the spine \$15 per visit

Hospitalization Services You Pay

Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs \$200 per admission

Emergency Health Coverage You Pay

Emergency Department visits \$50 per visit

Ambulance Services You Pay

Ambulance Services \$50 per trip

Prescription Drug Coverage You Pay

Covered outpatient items in accord with our drug formulary guidelines:

Most generic items \$10 for up to a 100-day supply
 Most brand-name items \$25 for up to a 100-day supply

Durable Medical Equipment (DME) You Pay

Covered durable medical equipment for home use 20 percent Coinsurance

Mental Health Services You Pay

Inpatient psychiatric hospitalization \$200 per admission
 Individual outpatient mental health evaluation and treatment \$15 per visit
 Group outpatient mental health treatment \$7 per visit

Substance Use Disorder Treatment		You Pay
Inpatient detoxification		\$200 per admission
Individual outpatient substance use disorder evaluation and treatment.....		\$15 per visit
Group outpatient substance use disorder treatment.....		\$5 per visit
Home Health Services		You Pay
Home health care (part-time, intermittent)		No charge
Other		You Pay
Eyeglasses or contact lenses every 24 months		Amount in excess of \$150 Allowance
Skilled nursing facility care (up to 100 days per benefit period).....		No charge
External prosthetic and orthotic devices		20 percent Coinsurance
Ostomy and urological supplies		20 percent Coinsurance

This chart does not explain benefits, Cost Share, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Share amounts. For more information, please refer to the *Summary of Benefits* booklet enclosed.

Choose Your Plan

Love your smile



Delta Dental PPOSM & DeltaCare[®] USA* County of Tulare, Group #16128, DCUSA #76744

Your company lets you choose between two dental plans from Delta Dental. Either way, you'll get reliable dentist networks, affordable preventive care and a healthy smile that you'll love to show. Your options are:

Delta Dental PPO¹

This preferred provider plan offers the convenience and flexibility of visiting any licensed dentist, anywhere. Covered services are paid based on a percentage — if, for example, fillings are covered at 80%, you pay the remaining 20%. Get the most plan value by choosing a Delta Dental PPO dentist. PPO network dentists complete claim forms for you and can help advise you on questions regarding your share of the payment.

DeltaCare USA

Under this HMO-type plan, you'll have your choice of skilled primary care dentists from the DeltaCare USA network. Select a primary care dentist, who will then coordinate any needed referrals to a specialist.² Covered services provided by your DeltaCare USA dentist have preset copayments (dollar amounts), which are listed in your plan booklet. There are no maximums or deductibles for covered services.³

*See the back page of this brochure of the underwriters and administrators of these plans in your state.

Newly covered?
Visit deltadentalins.com/welcome.

LEGAL NOTICES: Access federal and state legal notices related to your plan: deltadentalins.com/about/legal/index-enrollee.html

¹ In Texas, Delta Dental Insurance Company offers a Dental Provider Organization (DPO) plan.

² In WY, you do not need to select a primary care dentist, but you must visit a network dentist to receive benefits. In the following states, you can maximize your savings when you visit a network dentist, although you may visit any licensed dentist and receive out-of-network coverage: AK, CT, LA, ME, MS, MT, NC, ND, NH, OK, SD, VT. Refer to your plan booklet for details about your out-of-network benefits.

³ Refer to your plan booklet for more information about covered services, deductibles and maximums.



We keep you smiling[®]
deltadentalins.com/enrollees

Delta Dental PPOSM

Maximize your savings

Visit a dentist in the PPO¹ network to maximize your savings.² These dentists have agreed to reduced fees, and you won't get charged more than your expected share of the bill.³

Set up an online account

Get information about your plan anytime, anywhere by signing up for an Online Services account at deltadentalins.com. This free service, available once your coverage kicks in, lets you check benefits and eligibility information, find a PPO dentist⁴ and more.

Check in without an ID card

You don't need a Delta Dental ID card when you visit the dentist. Just provide your name, birth date and enrollee ID or social security number. If your family members are covered under your plan, they will need your information. Prefer to take a paper or electronic ID card with you?

Simply sign in to Online Services, where you can view or print your card with the click of a button.

Coordinate dual coverage

If you're covered under two plans, ask your dental office to include information about both plans with your claim, and we'll handle the rest.

Understand transition of care

Did you start on a dental treatment plan before your PPO coverage kicked in? Generally, multi-stage procedures are only covered under your current plan if treatment began after your plan's effective date of coverage.⁵ You can find this date by logging in to Online Services.

Save with a PPO dentist



PPO



NON-PPO

¹ In Texas, Delta Dental Insurance Company offers a Dental Provider Organization (DPO) plan.

² You can still visit any licensed dentist, but your out-of-pocket costs may be higher if you choose a non-PPO dentist. Network dentists are paid contracted fees.

³ You are responsible for any applicable deductibles, coinsurance, amounts over plan maximums and charges for non-covered services.

⁴ We recommend that before each appointment you verify online that your dentist is a PPO dentist.

⁵ Applies only to procedures covered under your plan. If you began treatment prior to your effective date of coverage, you or your prior carrier is responsible for any costs. Group- and state-specific exceptions may apply. Enrollees currently undergoing active orthodontic treatment may be eligible to continue treatment under Delta Dental PPO. Review your Evidence of Coverage, Summary Plan Description or Group Dental Service Contract for specific details about your plan.

Plan Benefit Highlights for: County of Tulare

Group No: 16128

DELTA DENTAL PPOSM

BENEFIT HIGHLIGHTS

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

Benefits and Covered Services*	Delta Dental PPO dentists**	Non-Delta Dental PPO dentists**
Diagnostic & Preventive Services (D & P) Exams, cleanings and x-rays	100 %	100 %
Basic Services Fillings	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)	

* 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
560 Mission St., Suite 1300
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.

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DeltaCare[®] USA

Dental benefits made easy

When you enroll in a DeltaCare USA¹ plan, you'll choose a primary care dentist from our network of carefully screened, private practice dentists. You must visit your primary care dentist to receive benefits.²

Convenient services

We make it easy for you — there are no claim forms to complete, and no plan ID card is required to receive treatment.

- No restrictions on pre-existing conditions (except work in progress)
- Access to specialty care and out-of-area emergency care

A partner in oral health

Your DeltaCare USA plan encourages regular dental care with an extensive list of covered services to help you stay healthy.

- Low or no copayments for services like cleanings and exams

Budget-friendly costs

With your DeltaCare USA plan, there are no surprises. You know your copayments, and your out-of-pocket costs are clearly defined before treatment begins.

- No deductibles or maximums³ for covered services
- Pay only your copayment (if any) at the time of treatment

Set up an online account

Sign up for an Online Services account at **deltadentalins.com**. Available once your coverage kicks in, this free service lets you:

- Access plan information online
- Change your primary care dentist online — and more

Simple steps to get started



¹ See the inside back page of this brochure for the underwriter of this plan in your state.

² We recommend that you verify online that the dentist is your selected DeltaCare USA primary care dentist before each appointment.

³ Plans with an Accidental Injury Rider have a \$1600 annual maximum for accidental injury. Consult your Evidence/Certificate of Coverage.

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 Current Dental Terminology ("CDT"), CDT-2018 procedure codes, descriptors or nomenclature that are under copyright by the American Dental Association ("ADA"). The ADA may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.

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

D1000-D1999**II. PREVENTIVE**

D1110	Prophylaxis <i>cleaning</i> - adult - 1 D1110, D1120 or D4346 per 6 month period	No Cost
D1110	<i>Additional prophylaxis cleaning</i> - adult (within the 6 month period)	\$45.00
D1120	Prophylaxis <i>cleaning</i> - child - 1 D1110, D1120 or D4346 per 6 month period	No Cost
D1120	<i>Additional prophylaxis cleaning</i> - child (within the 6 month period)	\$35.00
D1206	Topical application of fluoride varnish - 1 D1206 or D1208 per 6 month period	No Cost
D1208	Topical application of fluoride - excluding varnish - 1 D1206 or D1208 per 6 month period	No Cost
D1310	Nutritional counseling for control of dental disease	No Cost
D1320	Tobacco counseling for the control and prevention of oral disease	No Cost
D1330	Oral hygiene instructions	No Cost
D1351	Sealant - per tooth - <i>limited to permanent molars through age 15</i>	No Cost
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth - <i>limited to permanent molars through age 15</i>	No Cost
D1353	Sealant repair - per tooth - <i>limited to permanent molars through age 15</i>	No Cost
D1354	Interim caries arresting medicament application - per tooth - 1 per 6 month period	No Cost
D1510	Space maintainer - fixed - unilateral	No Cost
D1515	Space maintainer - fixed - bilateral	No Cost
D1520	Space maintainer - removable - unilateral	No Cost
D1525	Space maintainer - removable - bilateral	No Cost
D1550	Re-cement or re-bond space maintainer	No Cost
D1555	Removal of fixed space maintainer	No Cost
D1575	Distal shoe space maintainer - fixed - unilateral - <i>child to age 9</i>	No Cost

D2000-D2999**III. RESTORATIVE**

- Includes polishing, all adhesives and bonding agents, indirect pulp capping, bases, liners and acid etch procedures.

- When there are more than six crowns in the same treatment plan, an Enrollee may be charged an additional \$125.00 per crown, beyond the 6th unit.

- Replacement of crowns, inlays and onlays requires the existing restoration to be 5+ years old.

* Name brand, laboratory processed or in-office processed crowns/pontics produced through specialized technique or materials are material upgrades. The Contract Dentist may charge an additional fee not to exceed \$325.00 in addition to the listed Copayment. Refer to Limitation of Benefits #4 for additional information.

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

D2651	Inlay - resin-based composite - two surfaces	\$20.00
D2652	Inlay - resin-based composite - three or more surfaces	\$30.00
D2662	Onlay - resin-based composite - two surfaces	\$25.00
D2663	Onlay - resin-based composite - three surfaces	\$35.00
D2664	Onlay - resin-based composite - four or more surfaces	\$50.00
D2710	Crown - resin-based composite (indirect)	No Cost
D2712	Crown - 3/4 resin-based composite (indirect)	No Cost
D2720	Crown - resin with high noble metal	\$30.00
D2721	Crown - resin with predominantly base metal	\$15.00
D2722	Crown - resin with noble metal	\$20.00
D2740	Crown - porcelain/ceramic*	\$85.00
D2750	Crown - porcelain fused to high noble metal*	\$70.00
D2751	Crown - porcelain fused to predominantly base metal	\$55.00
D2752	Crown - porcelain fused to noble metal	\$60.00
D2780	Crown - 3/4 cast high noble metal	\$70.00
D2781	Crown - 3/4 cast predominantly base metal	\$55.00
D2782	Crown - 3/4 cast noble metal	\$60.00
D2783	Crown - 3/4 porcelain/ceramic*	\$70.00
D2790	Crown - full cast high noble metal	\$70.00
D2791	Crown - full cast predominantly base metal	\$55.00
D2792	Crown - full cast noble metal	\$60.00
D2794	Crown - titanium	\$70.00
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	No Cost
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	No Cost
D2920	Re-cement or re-bond crown	No Cost
D2921	Reattachment of tooth fragment, incisal edge or cusp (<i>anterior</i>)	No Cost
D2929	Prefabricated porcelain/ceramic crown - primary tooth - <i>anterior</i>	No Cost
D2930	Prefabricated stainless steel crown - primary tooth	No Cost
D2931	Prefabricated stainless steel crown - permanent tooth	No Cost
D2932	Prefabricated resin crown - <i>anterior primary tooth</i>	No Cost
D2933	Prefabricated stainless steel crown with resin window - <i>anterior primary tooth</i>	No Cost
D2940	Protective restoration	No Cost
D2941	Interim therapeutic restoration - primary dentition	No Cost
D2949	Restorative foundation for an indirect restoration	No Cost
D2950	Core buildup, including any pins when required	No Cost
D2951	Pin retention - per tooth, in addition to restoration	No Cost
D2952	Post and core in addition to crown, indirectly fabricated - <i>includes canal preparation</i>	No Cost
D2953	Each additional indirectly fabricated post - same tooth - <i>includes canal preparation</i>	No Cost
D2954	Prefabricated post and core in addition to crown - <i>base metal post; includes canal preparation</i>	No Cost
D2955	Post removal	No Cost
D2957	Each additional prefabricated post - same tooth - <i>base metal post; includes canal preparation</i>	No Cost
D2960	Labial veneer (resin laminate) - chairside - <i>limited to replacement of significant tooth structure loss due to caries or fracture</i>	\$245.00
D2961	Labial veneer (resin laminate) - laboratory - <i>limited to replacement of significant tooth structure loss due to caries or fracture</i>	\$295.00
D2962	Labial veneer (porcelain laminate) - laboratory - <i>limited to replacement of significant tooth structure loss due to caries or fracture</i>	\$345.00
D2971	Additional procedures to construct new crown under existing partial denture framework	\$14.00
D2980	Crown repair necessitated by restorative material failure	No Cost
D2981	Inlay repair necessitated by restorative material failure	No Cost
D2982	Onlay repair necessitated by restorative material failure	No Cost
D2983	Veneer repair necessitated by restorative material failure	No Cost
D2990	Resin infiltration of incipient smooth surface lesions - <i>limited to permanent molars through age 15</i> .	No Cost

D3000-D3999**IV. ENDODONTICS**

D3110	Pulp cap - direct (excluding final restoration)	No Cost
D3120	Pulp cap - indirect (excluding final restoration)	No Cost

D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	No Cost
D3221	Pulpal debridement, primary and permanent teeth	No Cost
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	No Cost
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	No Cost
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	No Cost
D3310	Root canal - endodontic therapy, anterior tooth (excluding final restoration)	\$20.00
D3320	Root canal - endodontic therapy, premolar tooth (excluding final restoration)	\$40.00
D3330	Root canal - endodontic therapy, molar tooth (excluding final restoration)	\$60.00
D3331	Treatment of root canal obstruction; non-surgical access	\$40.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	\$40.00
D3333	Internal root repair of perforation defects	\$40.00
D3346	Retreatment of previous root canal therapy - anterior	\$35.00
D3347	Retreatment of previous root canal therapy - premolar	\$50.00
D3348	Retreatment of previous root canal therapy - molar	\$95.00
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	\$55.00
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)	\$45.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	\$45.00
D3410	Apicoectomy - anterior	No Cost
D3421	Apicoectomy - premolar (first root)	No Cost
D3425	Apicoectomy - molar (first root)	No Cost
D3426	Apicoectomy (each additional root)	No Cost
D3427	Periradicular surgery without apicoectomy	No Cost
D3430	Retrograde filling - per root	No Cost
D3450	Root amputation - per root	No Cost
D3920	Hemisection (including any root removal), not including root canal therapy	No Cost

D4000-D4999 V. PERIODONTICS

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

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

D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft	\$125.00
D4278	Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant, or edentulous tooth position in same graft site	\$125.00
D4283	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) - each additional contiguous tooth, implant or edentulous tooth position in same graft site	\$45.00
D4285	Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) - each additional contiguous tooth, implant or edentulous tooth position in same graft site	\$69.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant - <i>limited to 4 quadrants during any 12 consecutive months</i>	No Cost
D4342	Periodontal scaling and root planing - one to three teeth per quadrant - <i>limited to 4 quadrants during any 12 consecutive months</i>	No Cost
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation - <i>1 D1110, D1120 or D4346 per 6 month period</i>	No Cost
D4355	Full mouth debridement to enable comprehensive oral evaluation and diagnosis on subsequent visit - <i>limited to 1 treatment in any 12 consecutive months</i>	No Cost
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth - <i>for each of the first two teeth treated within a quadrant following root planing or periodontal maintenance</i>	\$60.00
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth - <i>for an additional tooth treated in the same quadrant following root planing or periodontal maintenance</i>	No Cost
D4910	Periodontal maintenance - <i>limited to 1 treatment each 6 month period</i>	No Cost
D4910	Additional periodontal maintenance (within the 6 month period)	\$55.00
D4921	Gingival irrigation - per quadrant	No Cost

D5000-D5899 VI. PROSTHODONTICS (removable)

- For all listed dentures and partial dentures, Copayment includes after delivery adjustments and tissue conditioning, if needed, for the first six months after placement. The Enrollee must continue to be eligible, and the service must be provided at the Contract Dentist's facility where the denture was originally delivered.

- Rebases, relines and tissue conditioning are limited to 1 per denture during any 12 consecutive months.

- Replacement of a denture or a partial denture requires the existing denture to be 5+ years old.

D5110	Complete denture - maxillary	\$75.00
D5120	Complete denture - mandibular	\$75.00
D5130	Immediate denture - maxillary	\$85.00
D5140	Immediate denture - mandibular	\$85.00
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	\$80.00
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	\$80.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	\$95.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	\$95.00
D5221	Immediate maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	\$80.00
D5222	Immediate mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	\$80.00
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	\$95.00
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	\$95.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	\$195.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	\$195.00
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth)	\$80.00
D5410	Adjust complete denture - maxillary	No Cost
D5411	Adjust complete denture - mandibular	No Cost
D5421	Adjust partial denture - maxillary	No Cost
D5422	Adjust partial denture - mandibular	No Cost
D5511	Repair broken complete denture base, mandibular	No Cost

D5512	Repair broken complete denture base, maxillary	No Cost
D5520	Replace missing or broken teeth - complete denture (each tooth)	No Cost
D5611	Repair resin partial denture base, mandibular	No Cost
D5612	Repair resin partial denture base, maxillary	No Cost
D5621	Repair cast partial framework, mandibular	No Cost
D5622	Repair cast partial framework, maxillary	No Cost
D5630	Repair or replace broken clasp - per tooth	No Cost
D5640	Replace broken teeth - per tooth	No Cost
D5650	Add tooth to existing partial denture	No Cost
D5660	Add clasp to existing partial denture - per tooth	No Cost
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	\$65.00
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	\$65.00
D5710	Rebase complete maxillary denture	\$30.00
D5711	Rebase complete mandibular denture	\$30.00
D5720	Rebase maxillary partial denture	\$30.00
D5721	Rebase mandibular partial denture	\$30.00
D5730	Reline complete maxillary denture (chairside)	No Cost
D5731	Reline complete mandibular denture (chairside)	No Cost
D5740	Reline maxillary partial denture (chairside)	No Cost
D5741	Reline mandibular partial denture (chairside)	No Cost
D5750	Reline complete maxillary denture (laboratory)	\$25.00
D5751	Reline complete mandibular denture (laboratory)	\$25.00
D5760	Reline maxillary partial denture (laboratory)	\$25.00
D5761	Reline mandibular partial denture (laboratory)	\$25.00
D5820	Interim partial denture (maxillary) - <i>limited to 1 in any 12 consecutive months</i>	No Cost
D5821	Interim partial denture (mandibular) - <i>limited to 1 in any 12 consecutive months</i>	No Cost
D5850	Tissue conditioning, maxillary	No Cost
D5851	Tissue conditioning, mandibular	No Cost

D5900-D5999 VII. MAXILLOFACIAL PROSTHETICS - Not Covered**D6000-D6199 VIII. IMPLANT SERVICES - Not Covered****D6200-D6999 IX. PROSTHODONTICS, fixed (each retainer and each pontic constitutes a unit in a fixed partial denture [bridge])**

- When a crown and/or pontic exceeds six units in the same treatment plan, an Enrollee may be charged an additional \$125.00 per unit, beyond the 6th unit.

- Replacement of a crown, pontic, inlay, onlay or stress breaker requires the existing bridge to be 5+ years old.

* Name brand, laboratory processed or in-office processed crowns/pontics produced through specialized technique or materials are material upgrades. The Contract Dentist may charge an additional fee not to exceed \$325.00 in addition to the listed Copayment. Refer to Limitation of Benefits #4 for additional information.

D6205	Pontic - indirect resin based composite	\$30.00
D6210	Pontic - cast high noble metal	\$70.00
D6211	Pontic - cast predominantly base metal	\$55.00
D6212	Pontic - cast noble metal	\$60.00
D6214	Pontic - titanium	\$70.00
D6240	Pontic - porcelain fused to high noble metal*	\$70.00
D6241	Pontic - porcelain fused to predominantly base metal	\$55.00
D6242	Pontic - porcelain fused to noble metal	\$60.00
D6245	Pontic - porcelain/ceramic*	\$70.00
D6250	Pontic - resin with high noble metal	\$30.00
D6251	Pontic - resin with predominantly base metal	\$15.00
D6252	Pontic - resin with noble metal	\$20.00
D6600	Retainer inlay - porcelain/ceramic, two surfaces	\$60.00
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces	\$65.00
D6602	Retainer inlay - cast high noble metal, two surfaces	\$70.00
D6603	Retainer inlay - cast high noble metal, three or more surfaces	\$70.00
D6604	Retainer inlay - cast predominantly base metal, two surfaces	No Cost

D6605	Retainer inlay - cast predominantly base metal, three or more surfaces	No Cost
D6606	Retainer inlay - cast noble metal, two surfaces	\$60.00
D6607	Retainer inlay - cast noble metal, three or more surfaces	\$60.00
D6608	Retainer onlay - porcelain/ceramic, two surfaces	\$55.00
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces	\$65.00
D6610	Retainer onlay - cast high noble metal, two surfaces	\$70.00
D6611	Retainer onlay - cast high noble metal, three or more surfaces	\$70.00
D6612	Retainer onlay - cast predominantly base metal, two surfaces	No Cost
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	No Cost
D6614	Retainer onlay - cast noble metal, two surfaces	\$60.00
D6615	Retainer onlay - cast noble metal, three or more surfaces	\$60.00
D6710	Retainer crown - indirect resin based composite	\$30.00
D6720	Retainer crown - resin with high noble metal	\$30.00
D6721	Retainer crown - resin with predominantly base metal	\$15.00
D6722	Retainer crown - resin with noble metal	\$20.00
D6740	Retainer crown - porcelain/ceramic*	\$70.00
D6750	Retainer crown - porcelain fused to high noble metal*	\$70.00
D6751	Retainer crown - porcelain fused to predominantly base metal	\$55.00
D6752	Retainer crown - porcelain fused to noble metal	\$60.00
D6780	Retainer crown - 3/4 cast high noble metal	\$70.00
D6781	Retainer crown - 3/4 cast predominantly base metal	\$55.00
D6782	Retainer crown - 3/4 cast noble metal	\$60.00
D6783	Retainer crown - 3/4 porcelain/ceramic*	\$70.00
D6790	Retainer crown - full cast high noble metal	\$70.00
D6791	Retainer crown - full cast predominantly base metal	\$50.00
D6792	Retainer crown - full cast noble metal	\$60.00
D6794	Retainer crown - titanium	\$70.00
D6930	Re-cement or re-bond fixed partial denture	No Cost
D6940	Stress breaker	No Cost
D6980	Fixed partial denture repair necessitated by restorative material failure	No Cost

D7000-D7999**X. ORAL AND MAXILLOFACIAL SURGERY**

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

D7111	Extraction, coronal remnants - primary tooth	No Cost
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	No Cost
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	\$10.00
D7220	Removal of impacted tooth - soft tissue	\$15.00
D7230	Removal of impacted tooth - partially bony	\$25.00
D7240	Removal of impacted tooth - completely bony	\$35.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	\$50.00
D7250	Removal of residual tooth roots (cutting procedure)	No Cost
D7251	Coronectomy - intentional partial tooth removal	\$50.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	\$35.00
D7280	Exposure of an unerupted tooth	\$25.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	\$25.00
D7283	Placement of device to facilitate eruption of impacted tooth	No Cost
D7286	Incisional biopsy of oral tissue - soft - <i>does not include pathology laboratory procedures</i>	No Cost
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant ...	No Cost
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant ...	No Cost
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	No Cost
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	No Cost
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	No Cost
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	No Cost
D7471	Removal of lateral exostosis (maxilla or mandible)	No Cost

D7472	Removal of torus palatinus	No Cost
D7473	Removal of torus mandibularis	No Cost
D7510	Incision and drainage of abscess - intraoral soft tissue	No Cost
D7960	Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure	No Cost
D7970	Excision of hyperplastic tissue - per arch	No Cost
D7971	Excision of pericoronal gingiva	No Cost

D8000-D8999 XI. ORTHODONTICS

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

Pre and post orthodontic records include:

The benefit for pre-treatment records and diagnostic services includes: \$200.00

D0210	Intraoral - complete series of radiographic images	
D0322	Tomographic survey	
D0330	Panoramic radiographic image	
D0340	2D cephalometric radiographic image - acquisition, measurement and analysis	
D0350	2D oral/facial photographic images obtained intraorally or extraorally	
D0351	3D photographic image	
D0470	Diagnostic casts	
	The benefit for post-treatment records includes:	\$70.00
D0210	Intraoral - complete series of radiographic images	
D0470	Diagnostic casts	
D8010	Limited orthodontic treatment of the primary dentition	\$725.00
D8020	Limited orthodontic treatment of the transitional dentition - child or adolescent to age 19	\$725.00
D8030	Limited orthodontic treatment of the adolescent dentition - adolescent to age 19	\$725.00
D8040	Limited orthodontic treatment of the adult dentition - adults, including covered dependent adult children	\$925.00
D8050	Interceptive orthodontic treatment of the primary dentition	\$725.00
D8060	Interceptive orthodontic treatment of the transitional dentition	\$725.00
D8070	Comprehensive orthodontic treatment of the transitional dentition - child or adolescent to age 19 .	\$1,700.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition - adolescent to age 19	\$1,700.00
D8090	Comprehensive orthodontic treatment of the adult dentition - adults, including covered dependent adult children	\$1,900.00
D8660	Pre-orthodontic treatment examination to monitor growth and development	\$25.00
D8670	Periodic orthodontic treatment visit - included in comprehensive case fee	No Cost
D8680	Orthodontic retention (removal of appliances, construction and placement of removable retainers)	\$275.00
D8681	Removable orthodontic retainer adjustment	No Cost
D8693	Re-bond or re-cement fixed retainer - limited to 2 per 6 month period	No Cost
D8694	Repair of fixed retainers, includes reattachment - limited to 2 per 6 month period	No Cost
D8999	Unspecified orthodontic procedure, by report - includes treatment planning session	\$100.00

D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES

D9110	Palliative (emergency) treatment of dental pain - minor procedure	No Cost
D9211	Regional block anesthesia	No Cost
D9212	Trigeminal division block anesthesia	No Cost
D9215	Local anesthesia in conjunction with operative or surgical procedures	No Cost
D9219	Evaluation for deep sedation or general anesthesia	No Cost
D9222	Deep sedation/general anesthesia - first 15 minutes	\$80.00
D9223	Deep sedation/general anesthesia - each subsequent 15 minute increment	\$80.00
D9239	Intravenous moderate (conscious) sedation/analgesia - first 15 minutes	\$80.00
D9243	Intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment	\$80.00
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	No Cost
D9311	Consultation with medical health care professional	No Cost

D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	No Cost
D9440	Office visit - after regularly scheduled hours	\$20.00
D9450	Case presentation, detailed and extensive treatment planning	No Cost
D9932	Cleaning and inspection of removable complete denture, maxillary	No Cost
D9933	Cleaning and inspection of removable complete denture, mandibular	No Cost
D9934	Cleaning and inspection of removable partial denture, maxillary	No Cost
D9935	Cleaning and inspection of removable partial denture, mandibular	No Cost
D9940	Occlusal guard, by report - <i>limited to 1 in 3 years</i>	\$75.00
D9943	Occlusal guard adjustment	\$10.00
D9951	Occlusal adjustment, limited	No Cost
D9952	Occlusal adjustment, complete	No Cost
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays - <i>limited to one bleaching tray and gel for two weeks of self-treatment</i>	\$125.00
D9986	Missed appointment - <i>without 24 hour notice - per 15 minutes of appointment time - up to an overall maximum of \$40.00</i>	\$10.00
D9987	Canceled appointment - <i>without 24 hour notice - per 15 minutes of appointment time - up to an overall maximum of \$40.00</i>	\$10.00
D9991	Dental case management - addressing appointment compliance barriers	No Cost
D9992	Dental case management - care coordination	No Cost
D9995	Teledentistry - synchronous; real-time encounter	No Cost
D9996	Teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review ..	No Cost

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.

SCHEDULE B

Limitations of Benefits

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

Exclusions of Benefits

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

9. Consultations for non-covered benefits.
10. Dental services received from any dental facility other than the assigned Contract Dentist, a preauthorized dental specialist, or a Contract Orthodontist except for *Emergency Services* as described in the Contract and/or Evidence of Coverage.
11. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.
12. Prescription drugs.
13. Dental expenses incurred in connection with any dental or orthodontic procedure started before the Enrollee's eligibility with the DeltaCare USA Program. Examples include: teeth prepared for crowns, root canals in progress, full or partial dentures for which an impression has been taken and orthodontics unless qualified for the orthodontic treatment in progress provision.
14. Lost, stolen or broken orthodontic appliances.
15. Changes in orthodontic treatment necessitated by accident of any kind.
16. Myofunctional and parafunctional appliances and/or therapies, with the exception of procedure D9940 (occlusal guard, per report).
17. Composite or ceramic brackets, lingual adaptation of orthodontic bands and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances.
18. Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services.

Compare Plan Features¹

	Delta Dental PPO	DeltaCare USA
Can I go to any dentist?	You can visit any licensed dentist to receive coverage, but you'll save the most at an in-network dentist.	You must select a DeltaCare USA primary care dentist and visit this dentist to receive benefits. ²
What procedures are covered?	Your plan covers a wide range of services, with no exclusions for most pre-existing conditions. Preventive care, like routine cleanings and exams, is offered at low or no cost.	Your plan covers over 300 procedures, with no exclusions for most pre-existing conditions. Preventive care, like routine cleanings and exams, has low or no copayments.
Are there deductibles and maximums?	Yes, most plans have an annual deductible and maximum.	No, there are no annual deductibles or maximums. ³
Am I covered for treatment I began under a different employer-sponsored dental plan?	Coverage is provided only for treatment started and completed after your effective date. Orthodontic treatment may be an exception to this rule.	Coverage is provided only for treatment started and completed after your effective date. ⁴ Orthodontic treatment may be an exception to this rule.
What if I started orthodontic treatment under my previous dental plan?	Typically, Delta Dental pays the remaining benefit not paid by your prior dental plan.	You are responsible for the copayments and fees subject to the provisions of your prior dental plan.
What happens if I need to see a specialist?	You do not need a referral from your dentist.	Contact your DeltaCare USA primary care dentist to coordinate your referral. ⁵
What is my out-of-area coverage?	You can visit any licensed dentist.	You have a limited benefit to go out of network for emergency care.
How do I change my dentist?	You can change your dentist at any time without contacting us.	You can change your selected or assigned primary care dentist online or by telephone. ⁶
Do I need to fill out claims?	If you visit a Delta Dental dentist, the dental office will file the claim for you. If you go to a non-Delta Dental dentist, you may have to submit the claim yourself.	There are generally no claim forms under your plan. ⁷

¹ This comparison is based on the coverage of a typical plan. Please refer to your plan booklet for specific benefits, limitations, exclusions, waiting periods and other coverage details.

² In WY, you do not need to select a primary care dentist, but you must visit a network dentist to receive benefits. In the following states, you can maximize your savings when you visit a network dentist, although you may visit any licensed dentist and receive out-of-network coverage: AK, CT, LA, ME, MS, MT, NC, ND, NH, OK, SD, VT. Refer to your plan booklet for details about your out-of-network benefits.

³ In AK, CT, ND and SD, you have an out-of-network calendar year maximum of \$500 when you visit an out-of-network dentist.

⁴ Except in Texas; please refer to your plan booklet for details.

⁵ Most services not performed by your primary care dentist must be authorized by Delta Dental. In some states, specialty care benefits are only available for services performed by an in-network specialist. Refer to your plan booklet for details.

⁶ In the following states, you can change your dentist any time without contacting Delta Dental: AK, CT, LA, ME, MS, MT, NC, ND, NH, OK, SD, VT, WY.

⁷ You may have to complete a claim form if you visit an out-of-network dentist, such as for limited emergency treatment or in the following states: AK, CT, LA, ME, MS, MT, NC, ND, NH, OK, SD, VT.

Useful information once you're enrolled

Check out our SmileWay® Wellness program

Find oral health resources, including a risk self-assessment tool, quizzes, articles, videos and a subscription to *Grin!*, our free dental wellness e-magazine, at mysmileway.com.

Find a network dentist near you

Use our convenient "Find a Dentist" tool and select your network.

- Find a dentist near your home or office
- Narrow your search by location, specialty, languages spoken — and more

Sign up for an online account

Use your mobile device or desktop to sign up for a free, secure Online Services account.

- Review your plan benefits
- Access your ID card

Go paperless

Save paper by viewing all your documents online instead of receiving them in the mail. Once you've registered for an online account, visit your My Profile page to select "Online" for your document delivery preference.

NOTE: THIS IS ONLY A BRIEF SUMMARY OF YOUR PLAN. This brochure provides highlights about both dental plans to help you choose the best option for your needs. This brochure is not intended to replace your legally required plan booklet. Your Group Dental Service Contract or Evidence/Certificate of Coverage determines the exact terms and conditions of your coverage. Please refer to your plan booklet for a complete list of covered procedures, copayments, plan limitations and exclusions. Your Evidence/Certificate of Coverage will be mailed to you upon enrollment. If you wish to review an Evidence/Certificate of Coverage prior to enrollment, you may request a copy by calling the Customer Service number for each plan listed on the back page of this brochure.

PRODUCT ADMINISTRATION

DeltaCare USA is underwritten in these states by these entities: AL — Alpha Dental of Alabama, Inc.; AZ — Alpha Dental of Arizona, Inc.; CA — Delta Dental of California; AR, CO, IA, MA, ME, MI, MN, NC, ND, NE, NH, OK, OR, RI, SC, SD, VT, WA, WI, WY — Dentegra Insurance Company; AK, CT, DC, DE, FL, GA, KS, LA, MS, MT, TN, WV — Delta Dental Insurance Company; HI, ID, IL, IN, KY, MD, MO, NJ, OH, TX — Alpha Dental Programs, Inc.; NV — Alpha Dental of Nevada, Inc.; UT — Alpha Dental of Utah, Inc.; NM — Alpha Dental of New Mexico, Inc.; NY — Delta Dental of New York, Inc.; PA — Delta Dental of Pennsylvania; VA — 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.

Delta Dental PPO is underwritten by Delta Dental Insurance Company in AL, DC, FL, GA, LA, MS, MT, NV 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, Inc. In Texas, Delta Dental Insurance Company provides a Dental Provider Organization (DPO) plan.

Need help? Let us know.

Online:

Visit deltadentalins.com/about/contact and select the company through which you receive benefits.

Call toll free:

Customer Service agents are available Monday through Friday, during business hours. Or, use our interactive automated phone system, available 24/7.

Delta Dental PPO: 800-765-6003

DeltaCare USA: 800-422-4234

Write to:

Delta Dental PPO:

Delta Dental Customer Service
P.O. Box 997330
Sacramento, CA 95899-7330

DeltaCare USA:

DeltaCare USA Customer Service
P.O. Box 1803
Alpharetta, GA 30023

A LOOK AT YOUR VSP VISION COVERAGE



SEE HEALTHY AND LIVE HAPPY WITH HELP FROM COUNTY OF TULARE AND VSP.

As a VSP® member, you get personalized care from a VSP network doctor at low out-of-pocket costs.

VALUE AND SAVINGS YOU LOVE.

\$ Save on eyewear and eye care when you see a VSP network doctor. Plus, take advantage of Exclusive Member Extras for additional savings.

PROVIDER CHOICES YOU WANT.

PREMIER PROGRAM With an average of five VSP network doctors within six miles of you, it's easy to find a nearby in-network doctor or retail chain. Plus, maximize your coverage with bonus offers and additional savings that are exclusive to Premier Program locations.

Prefer to shop online? Use your vision benefits on Eyeconic®—the VSP preferred online retailer.

QUALITY VISION CARE YOU NEED.

🕒 You'll get great care from a VSP network doctor, including a WellVision Exam®—a comprehensive exam designed to detect eye and health conditions.

PROVIDER NETWORK:

VSP Choice

Contact us:

800.877.7195 or **vsp.com**

Benefit	Description	Copay
Your Coverage with a VSP Provider		
WellVision Exam	<ul style="list-style-type: none"> Focuses on your eyes and overall wellness Every 12 months 	\$10
Prescription Glasses		\$25
Frame	<ul style="list-style-type: none"> \$130 allowance for a wide selection of frames \$150 allowance for featured frame brands 20% savings on the amount over your allowance \$70 Costco® frame allowance Every 24 months 	Included in Prescription Glasses
Lenses	<ul style="list-style-type: none"> Single vision, lined bifocal, and lined trifocal lenses Polycarbonate lenses for dependent children Every 12 months 	Included in Prescription Glasses
Lens Enhancements	<ul style="list-style-type: none"> Standard progressive lenses Premium progressive lenses Custom progressive lenses Average savings of 20-25% on other lens enhancements Every 12 months 	\$0 \$95 - \$105 \$150 - \$175
Contacts (instead of glasses)	<ul style="list-style-type: none"> \$120 allowance for contacts and contact lens exam (fitting and evaluation) 15% savings on a contact lens exam (fitting and evaluation) Every 12 months 	\$0
Primary EyeCare	<ul style="list-style-type: none"> As a VSP member, you can visit your VSP doctor for medical and urgent eyecare. 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. As needed 	\$20
Glasses and Sunglasses		
<ul style="list-style-type: none"> Extra \$20 to spend on featured frame brands. Go to vsp.com/offers for details. 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam. 		
Extra Savings		
Retinal Screening		
<ul style="list-style-type: none"> No more than a \$39 copay on routine retinal screening as an enhancement to a WellVision Exam 		
Laser Vision Correction		
<ul style="list-style-type: none"> Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities 		

Your Coverage with Out-of-Network Providers

Get the most out of your benefits and greater savings with a VSP network doctor. Call Member Services for out-of-network plan details.

VSP guarantees coverage from VSP network providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business.



BOARD OF DIRECTORS

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KUYLER CROCKER
NATHAN MAGSIG
BUDDY MENDES
BRIAN PACHECO
AMY SHUKLIAN
PETE VANDER POEL

Exhibit B **County of Tulare** **Plan Year 2020** **Rates**

County of Tulare	2020			
Anthem SJVIA Rates	EE	ES	EC	FA
Anthem \$0	\$ 964.22	\$ 1,927.41	\$ 1,759.43	\$ 2,922.12
Anthem \$500	\$ 726.08	\$ 1,452.87	\$ 1,330.65	\$ 2,291.53
Anthem \$750	\$ 646.22	\$ 1,291.52	\$ 1,185.06	\$ 1,968.82
Anthem \$2,500	\$ 604.49	\$ 1,208.00	\$ 1,108.42	\$ 1,841.54
Kaiser SJVIA Rates	EE	ES	EC	FA
County of Tulare HMO	\$808.29	\$1,605.82	\$1,454.29	\$2,403.36
County of Tulare DHMO	\$622.70	\$1,234.64	\$1,118.38	\$1,846.59
Delta Dental SJVIA Rates	EE	ES	EC	FA
County of Tulare PPO	\$35.43	\$61.42	\$69.60	\$103.32
County of Tulare DHMO	\$27.38	\$47.51	\$47.83	\$68.95
VSP SJVIA Rates	EE	ES	EC	FA
County of Tulare VSP	\$4.96	\$8.36	\$8.85	\$13.19

County of Tulare	2020		
Kaiser Senior Advantage	Carrier Rates	SJVIA Fee	Total SJVIA Rates
Subscriber with Medicare	\$310.42	\$10.75	\$321.17
Subscriber with Medicare + Spouse Non-Medicare	\$1,061.22	\$10.75	\$1,071.97
Subscriber with Non-Medicare + Spouse with Medicare	\$1,060.80	\$10.75	\$1,071.55
Subscriber with Medicare + Spouse with Medicare	\$620.42	\$10.75	\$631.17
Subscriber with Medicare + Child Non-Medicare	\$918.56	\$10.75	\$929.31
Subscriber with Medicare + Children Non-Medicare	\$918.56	\$10.75	\$929.31
Subscriber with Medicare + Spouse with Medicare + Child Non-Medicare	\$1,371.22	\$10.75	\$1,381.97
Subscriber with Medicare + Spouse with Non-Medicare + Child Non-Medicare	\$1,812.02	\$10.75	\$1,822.77
Subscriber with Non-Medicare + Spouse with Medicare + Child Non-Medicare	\$1,811.60	\$10.75	\$1,822.35
Subscriber with Medicare + Spouse with Medicare + Children Non-Medicare	\$1,371.22	\$10.75	\$1,381.97
Subscriber with Medicare + Spouse Non-Medicare + Children Non-Medicare	\$1,812.02	\$10.75	\$1,822.77
Subscriber with Non-Medicare + Spouse with Medicare + Children Non-Medicare	\$1,811.60	\$10.75	\$1,822.35



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BRIAN PACHECO

AMY SHUKLIAN

PETE VANDER POEL

Meeting Location:
County of Fresno
Board of Supervisors Chambers
2281 Tulare Street, #301
Fresno, CA 93721
November 8, 2019 9:00 AM

AGENDA DATE: November 8, 2019

ITEM NUMBER: Item 16

SUBJECT: Receive Consultant's Medical, Dental, and Vision Experience Reports through September 2019 with Update on Reserve Accumulation and Projections (I)

REQUEST(S): That the Board receive the Consultant's Medical, Dental, and Vision Experience Reports through September 2019 and update on Reserve Accumulation and Projections.

DESCRIPTION:

The report shows that on a total cost basis from January through September 2019, the medical premium of \$59,826,516 exceeded total cost of \$59,523,922 for a surplus position of \$302,593 or a 99.5% loss ratio.

The dental PPO plan became self-insured with the 2019 plan year. The report shows that on a total cost basis, the dental premium of \$3,426,319 exceeded total cost of \$3,110,420 for a surplus position of \$315,899 or a 90.8% loss ratio.

The vision plan remains fully-insured and is in a surplus position of \$7,217. Under the fully-insured arrangement all deficit or surplus positions stay with the carrier.

The SJVIA is projecting a \$4,798,979 surplus position for the 2019 plan year. The surplus is built from plan premium exceeding plan costs, built in margin on the Kaiser plan, the transference of the Delta Dental Premium Stabilization Reserve (PSR), and prescription drug rebates and other funds realized from the prescription drug program. In total \$3,445,013 (71.8%) has been realized through September 2019.

AGENDA: San Joaquin Valley Insurance Authority

DATE: November 8, 2019

FISCAL IMPACT/FINANCING:

The 2019 plan year experience through September developed a \$302,593 medical surplus and a \$315,899 dental surplus for a total of \$618,492. These numbers include the realization of IBNR as paid claims for groups and coverage that have terminated. The addition of the prescription drug rebates of \$1,338,510, Kaiser Surcharge of \$539,378 and the Delta Dental PSR transfer of \$948,664 brings the collective total reserve accumulation up to \$3,445,013.

ADMINISTRATIVE SIGN-OFF:



Rhonda Sjostrom
SJVIA Manager



Paul Nerland
SJVIA Assistant Manager

November 8, 2019

SJVIA Board Meeting: Consultant's Report on Medical, Dental, and Vision Experience Through September 2019

The following pages provide a summary of the plan experience from January 1 through September 30, 2019. The Anthem self-funded medical plan showed a surplus of \$302,592 for a 99.5% Total Cost loss ratio. This includes paying the second-year runout claims on the discontinued Anthem HMO and the two cities which terminated effective January 1, 2018.

Buildup	COF	COT	COM	Total
Medical	\$ (791,108)	\$ 987,193	\$ 106,508	\$ 302,592
Dental	\$ 237,031	\$ 78,867	\$ -	\$ 315,900
Total	\$ (554,077)	\$ 1,066,060	\$ 106,508	\$ 618,491
Loss Ratio				
Medical	102.1%	95.3%	81.7%	99.5%
Dental	90.3%	91.9%	n/a	90.8%

The County of Fresno's EPO is the loss leader increasing its deficit position from -\$1,589,767 as reported through June 2019, to -\$3,700,657 deficit position.

For 2019, the County of Fresno elected to pass on a common renewal among its EPO, PPO and HDHP plans. The EPO plan received a common 6.54% increase in lieu of the 11.85% specific EPO renewal. The expectation for 2019 was that the EPO plan would perform at a -\$883,971 deficit position while the PPO and HDHP plans would make up the deficit difference. Through September these two plans contributed \$2,983,152 towards reserve accumulation.

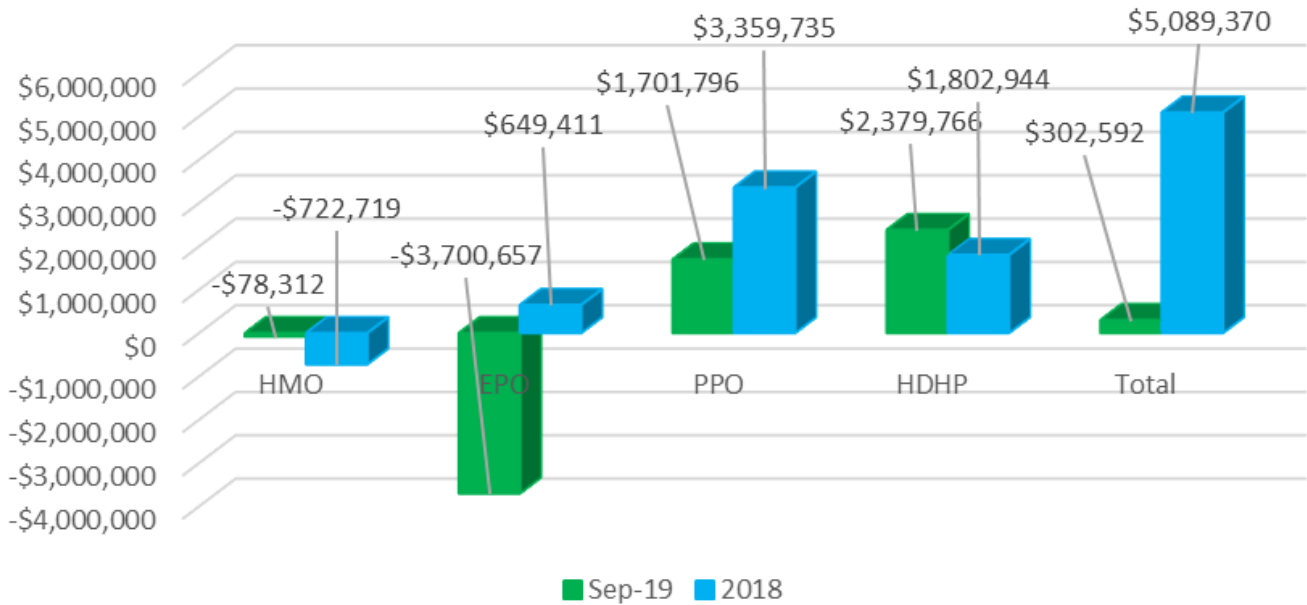
The County of Fresno has realized 10 claimants (less than 0.2% of the population) with claims above \$200,000 making up 12.2% of the claim cost. Keenan will be reviewing the large claims in greater detail to determine trends and cost reduction strategies. However, it appears based on 2019, claims to date (specifically in the third quarter), 2020 renewal projections may understate plan performance.

For 2020, the County of Fresno has elected a parity strategy which sets the EPO and Kaiser rates the same. This strategy will attempt to draw healthier lives back into the EPO and have the Kaiser plan contribute reserves towards the adverse selection currently within the EPO plan. Keenan will prepare a migration report and analysis based on post-open enrollment results to determine the overall cost impact.

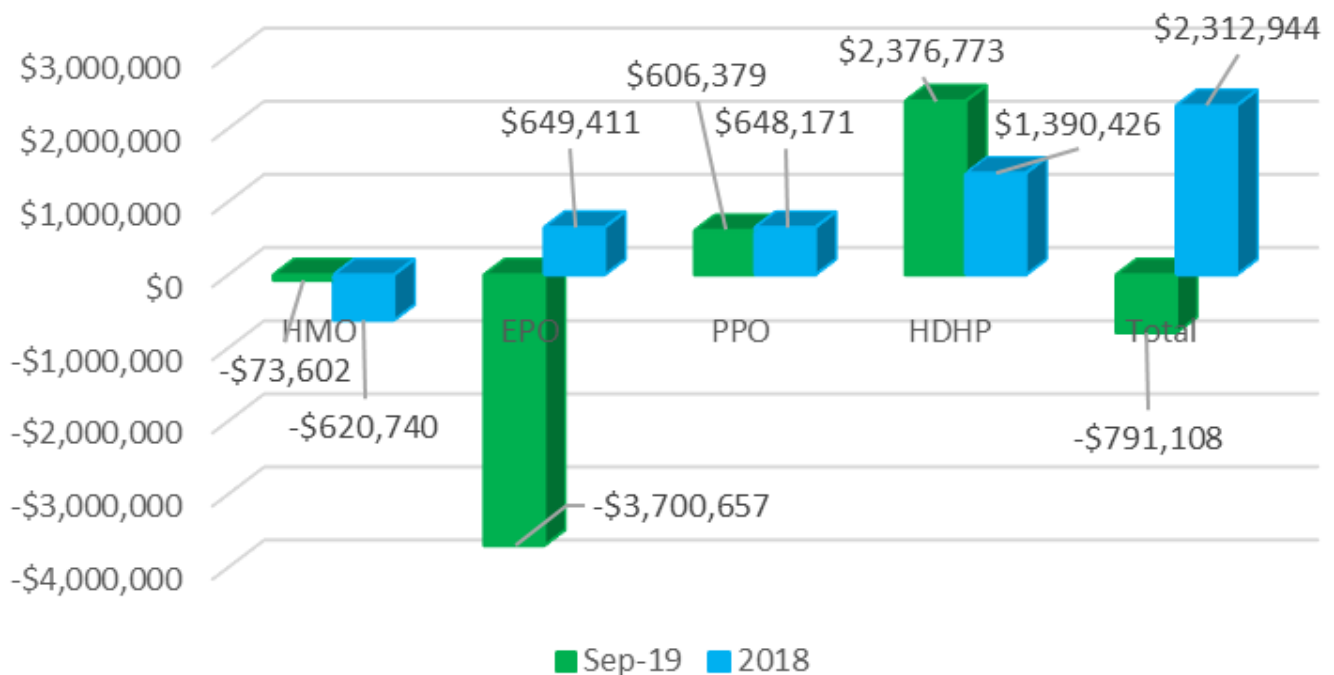
For the 2019 Plan year, the SJVIA changed the dental PPO plan to self-funding. Through September 2019, the dental program has accumulated \$315,900 in surplus or a 90.8% Total cost loss ratio. Please note that the cumulative report includes IBNR reserve build up, and claims for January through September should be considered mature.

The SJVIA has been able to accumulate a reserve buildup of \$3,445,013 or 71.8% through September 2019, of the \$4.8 million projected reserve buildup for the year.

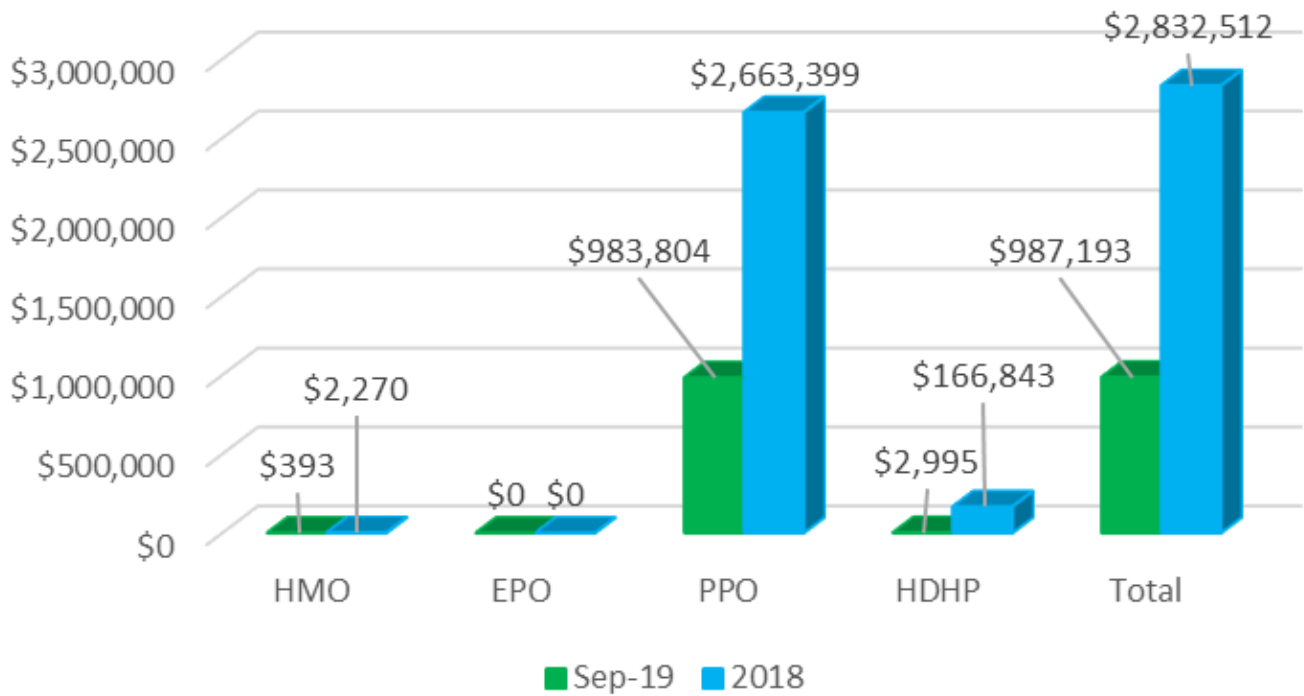
SJVIA - September 2019 vs. 2018



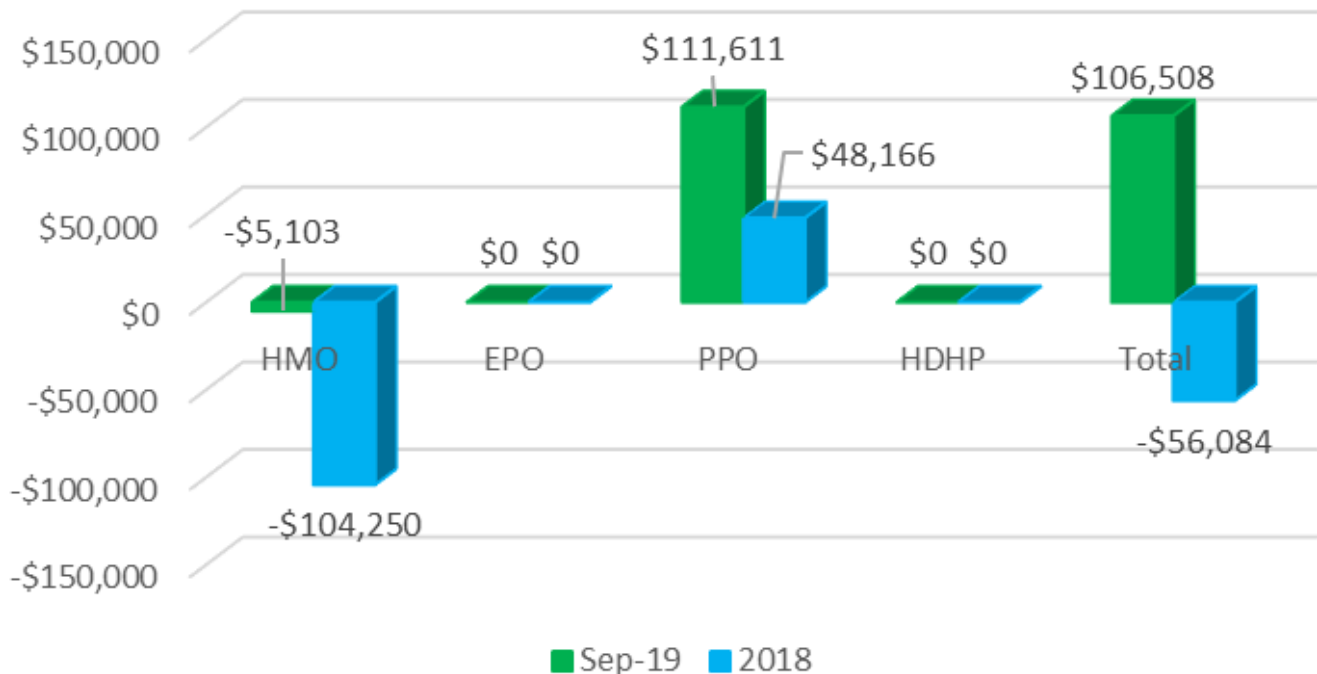
County of Fresno - September 2019 vs. 2018



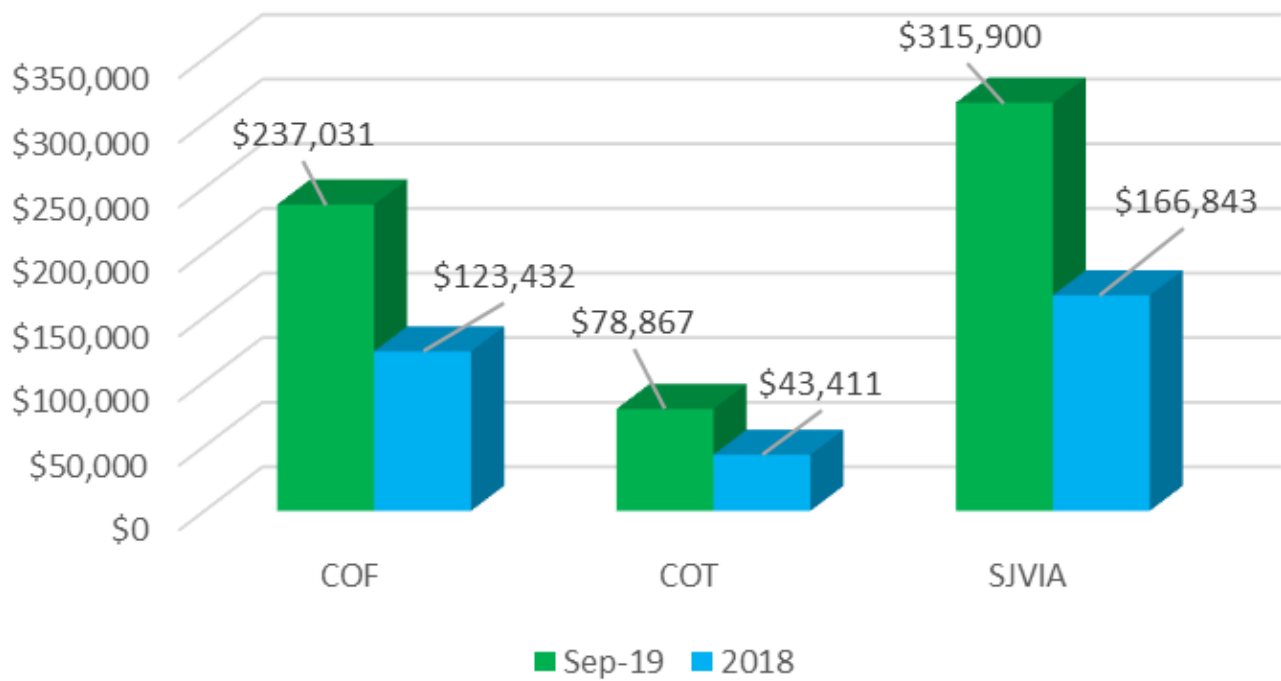
County of Tulare - September 2019 vs. 2018



City of Marysville - September 2019 vs. 2018



Dental - September 2019 vs. 2018



Reserve Accumulation /Funding Model													
2018	January	February	March	April	May	June	July	August	September	October	November	December	Total
Budget													
Medical Plan Experience	\$ 240,122	\$ 240,122	\$ 240,122	\$ 240,122	\$ 240,122	\$ 240,122	\$ 240,122	\$ 240,122	\$ 240,122	\$ 240,122	\$ 240,122	\$ 240,122	\$ 2,881,460
Kaiser Rate Surcharge	\$ 96,329	\$ 96,329	\$ 96,329	\$ 96,329	\$ 96,329	\$ 96,329	\$ 96,329	\$ 96,329	\$ 96,329	\$ 96,329	\$ 96,329	\$ 96,329	\$ 1,155,952
Delta Dental Premium Holiday	\$ 362,752	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 362,752
Delta Dental 2% Rate Subsidy	\$ 7,389	\$ 7,389	\$ 7,389	\$ 7,389	\$ 7,389	\$ 7,389	\$ 7,389	\$ 7,389	\$ 7,389	\$ 7,389	\$ 7,389	\$ 7,389	\$ 88,672
2018 Budgeted Reserve Buildup	\$ 706,592	\$ 343,840	\$ 343,840	\$ 343,840	\$ 343,840	\$ 343,840	\$ 343,840	\$ 343,840	\$ 343,840	\$ 343,840	\$ 343,840	\$ 343,840	\$ 4,488,836
Actual													
Medical Plan Experience	\$ 1,534,858	\$ 1,400,750	\$ (989,574)	\$ 480,446	\$ 8,084	\$ 578,056	\$ 255,195	\$ (80,220)	\$ 1,069,414	\$ (6,979)	\$ 164,822	\$ 674,518	\$ 5,089,370
Kaiser Rate Surcharge	\$ 96,329	\$ 96,329	\$ 96,329	\$ 96,329	\$ 96,329	\$ 96,329	\$ 96,329	\$ 96,329	\$ 96,329	\$ 96,329	\$ 96,329	\$ 96,329	\$ 1,155,952
Prescription Drug Rebates*	\$ -	\$ -	\$ 231,170	\$ 3,705	\$ -	\$ 173,044	\$ -	\$ -	\$ -	\$ 112	\$ -	\$ -	\$ 408,031
Delta Dental Premium Holiday	\$ 362,752	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 362,752
Delta Dental 2% Rate Subsidy	\$ 7,389	\$ 7,389	\$ 7,389	\$ 7,389	\$ 7,389	\$ 7,389	\$ 7,389	\$ 7,389	\$ 7,389	\$ 7,389	\$ 7,389	\$ 7,389	\$ 88,672
2018 Actual Reserve Buildup	\$ 2,001,329	\$ 1,504,469	\$ (654,685)	\$ 587,869	\$ 111,803	\$ 854,819	\$ 358,914	\$ 23,499	\$ 1,173,133	\$ 96,852	\$ 268,541	\$ 778,237	\$ 7,104,777
2019	January	February	March	April	May	June	July	August	September	October	November	December	Total
Budget													
Plan Experience	\$ 273,618	\$ 273,618	\$ 273,618	\$ 273,618	\$ 273,618	\$ 273,618	\$ 273,618	\$ 273,618	\$ 273,618	\$ 273,618	\$ 273,618	\$ 273,618	\$ 3,283,410
Kaiser Rate Surcharge	\$ 59,931	\$ 59,931	\$ 59,931	\$ 59,931	\$ 59,931	\$ 59,931	\$ 59,931	\$ 59,931	\$ 59,931	\$ 59,931	\$ 59,931	\$ 59,931	\$ 719,171
Delta Dental PSR Transfer	\$ 398,199	\$ 265,466	\$ 132,733	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 796,398
2019 Budgeted Reserve Buildup	\$ 731,747	\$ 599,014	\$ 466,281	\$ 333,548	\$ 333,548	\$ 333,548	\$ 333,548	\$ 333,548	\$ 333,548	\$ 333,548	\$ 333,548	\$ 333,548	\$ 4,798,979
Actual													
Plan Experience (Medical)	\$ 266,540	\$ 571,444	\$ (526,484)	\$ (116,911)	\$ 556,905	\$ 555,716	\$ (807,303)	\$ 9,423	\$ (206,738)	\$ -	\$ -	\$ -	\$ 302,592
Plan Experience (Dental)	\$ 69,763	\$ 25,643	\$ 41,648	\$ 27,807	\$ (4,548)	\$ 56,661	\$ 72,159	\$ (21,223)	\$ 47,959	\$ -	\$ -	\$ -	\$ 315,869
Prescription Drug Rebates*	\$ 382,100	\$ -	\$ 303,186	\$ 343,529	\$ -	\$ -	\$ 309,695	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 1,338,510
Kaiser Rate Surcharge	\$ 59,931	\$ 59,931	\$ 59,931	\$ 59,931	\$ 59,931	\$ 59,931	\$ 59,931	\$ 59,931	\$ 59,931	\$ -	\$ -	\$ -	\$ 539,378
Delta Dental PSR Transfer	\$ 379,822	\$ 379,190	\$ 189,652	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 948,664
2019 Actual Reserve Buildup	\$ 1,158,156	\$ 1,036,208	\$ 67,932	\$ 314,356	\$ 612,288	\$ 672,308	\$ (365,518)	\$ 48,131	\$ (98,848)	\$ -	\$ -	\$ -	\$ 3,445,013
* 2018 - 3/18 2017 Final Rebate, 4/18 Audit Recovery, 6/18 Performance Guarantee Recovery, 10/18 Audit Recovery													
2019 - 1/19 1st Qtr 2018, 3/19 2nd Qtr 2018, 4/19 3rd Qtr 2018, 7/19 4th Qtr 2018, 10/19 1st Qtr 2019 (\$400,385)													

The chart above shows budgeted reserve buildup to realized buildup based on plan experience for 2018 and 2019. For 2019, the SJVIA has realized \$3,445,013 or 71.8% of the \$4.8 million projected reserve buildup.

Past exhibits excluded the inclusion of prescription drug rebates and other prescription drug settlements. This exhibit includes the prescription drug rebates and other prescription drug funds realized during each plan year.

Please note that this is the consultant's report and prior to allocating funds for IBNR, the stabilization reserve, and to provide loan repayment, the SJVIA Auditor will validate actual reserve accumulation.



San Joaquin Valley Insurance Authority (SJVIA)
Anthem Blue Cross Premium and Claims Report as of September 2019
All Districts Combined - All Medical

MONTH-YEAR	ENROLLED	FUNDING / PREMIUM	CLAIMS EXPENSE						SURPLUS / (DEFICIT)	AVERAGE CLAIM COST PEPM	TOTAL EXPENSE LOSS RATIO
			MEDICAL	CAPITATION	RX	FIXED	POOLED CLAIMS	TOTAL EXPENSE			
Jan-17	7,224	\$6,815,134	\$2,700,833	\$995,935	\$1,572,397	\$550,166	\$0	\$5,819,332	\$995,802	\$729.40	85.4%
Feb-17	7,200	\$6,787,681	\$3,258,550	\$991,948	\$1,441,160	\$548,152	\$0	\$6,239,810	\$547,871	\$790.51	91.9%
Mar-17	7,179	\$6,761,387	\$3,322,923	\$987,343	\$1,715,926	\$546,268	\$0	\$6,572,459	\$188,928	\$839.42	97.2%
Apr-17	7,013	\$6,592,653	\$3,063,951	\$977,033	\$1,503,577	\$532,822	\$0	\$6,077,383	\$515,271	\$790.61	92.2%
May-17	7,053	\$6,615,501	\$3,931,378	\$977,081	\$1,650,758	\$535,601	\$0	\$7,094,819	-\$479,318	\$929.99	107.2%
Jun-17	7,172	\$6,728,288	\$3,913,208	\$972,474	\$1,831,804	\$545,175	\$0	\$7,262,662	-\$534,374	\$936.63	107.9%
Jul-17	7,194	\$6,722,354	\$2,828,118	\$991,172	\$1,575,369	\$546,146	\$0	\$5,940,805	\$781,549	\$749.88	88.4%
Aug-17	7,188	\$6,713,191	\$3,679,724	\$988,909	\$1,864,173	\$545,668	\$0	\$7,078,475	-\$365,284	\$908.85	105.4%
Sep-17	7,198	\$6,710,435	\$2,832,780	\$985,584	\$1,817,473	\$546,161	\$0	\$6,181,998	\$528,436	\$782.97	92.1%
Oct-17	7,160	\$6,672,823	\$4,137,958	\$979,410	\$1,810,591	\$543,054	-\$75,682	\$7,395,330	-\$722,508	\$957.02	110.8%
Nov-17	7,193	\$6,689,463	\$3,302,717	\$974,921	\$1,692,587	\$545,451	-\$1,520	\$6,514,156	\$175,308	\$829.79	97.4%
Dec-17	7,112	\$6,646,325	\$2,856,439	\$976,822	\$1,642,821	\$847,464	\$0	\$6,323,546	\$322,779	\$769.98	95.1%
Jan-18	6,958	\$6,521,019	\$2,767,312	\$1,303	\$1,592,760	\$511,928	\$0	\$4,873,303	\$1,647,716	\$626.81	74.7%
Feb-18	6,955	\$6,519,818	\$2,974,163	\$392	\$1,519,979	\$511,748	\$0	\$5,006,282	\$1,513,536	\$646.23	76.8%
Mar-18	6,953	\$6,512,291	\$5,141,710	\$0	\$1,735,958	\$511,464	\$0	\$7,389,132	-\$876,840	\$989.17	113.5%
Apr-18	6,935	\$6,483,938	\$3,792,571	\$0	\$1,588,684	\$509,864	\$0	\$5,891,120	\$592,818	\$775.96	90.9%
May-18	6,963	\$6,487,562	\$4,141,750	\$0	\$1,713,470	\$511,511	\$0	\$6,366,732	\$120,830	\$840.90	98.1%
Jun-18	6,992	\$6,505,413	\$3,695,905	\$0	\$1,604,344	\$513,826	\$0	\$5,814,075	\$691,338	\$758.04	89.4%
Jul-18	7,002	\$6,502,601	\$3,881,831	\$0	\$1,767,041	\$514,556	-\$29,545	\$6,133,883	\$368,718	\$802.53	94.3%
Aug-18	6,995	\$6,491,104	\$4,156,725	\$0	\$1,852,242	\$513,756	-\$64,707	\$6,458,016	\$33,088	\$849.79	99.5%
Sep-18	6,971	\$6,470,451	\$3,385,210	\$0	\$1,668,259	\$512,209	-\$277,620	\$5,288,057	\$1,182,394	\$685.10	81.7%
Oct-18	7,003	\$6,486,328	\$4,220,918	\$0	\$1,653,635	\$514,287	-\$8,976	\$6,379,863	\$106,465	\$837.58	98.4%
Nov-18	6,999	\$6,462,864	\$4,258,631	\$0	\$1,575,529	\$513,557	-\$162,708	\$6,184,809	\$278,055	\$810.29	95.7%
Dec-18	6,972	\$6,632,447	\$3,837,959	\$0	\$1,502,326	\$512,066	-\$7,748	\$5,845,202	\$787,244	\$764.94	88.1%
Jan-19	6,998	\$6,711,076	\$4,250,197	\$0	\$1,603,216	\$591,122	\$0	\$6,444,536	\$266,540	\$836.44	96.0%
Feb-19	6,990	\$6,704,171	\$4,015,598	\$0	\$1,526,591	\$590,538	\$0	\$6,132,727	\$571,444	\$792.87	91.5%
Mar-19	6,992	\$6,696,701	\$5,024,955	\$0	\$1,607,858	\$590,371	\$0	\$7,223,184	-\$526,484	\$948.63	107.9%
Apr-19	6,989	\$6,685,890	\$4,480,531	\$0	\$1,732,384	\$589,886	\$0	\$6,802,801	-\$116,911	\$888.96	101.7%
May-19	7,002	\$6,695,636	\$3,939,166	\$0	\$1,608,548	\$591,018	\$0	\$6,138,731	\$556,905	\$792.30	91.7%
Jun-19	6,990	\$6,686,857	\$4,061,961	\$0	\$1,478,969	\$590,211	\$0	\$6,131,141	\$555,716	\$792.69	91.7%
Jul-19	6,976	\$6,666,100	\$5,152,534	\$0	\$1,731,920	\$588,950	\$0	\$7,473,403	-\$807,303	\$986.88	112.1%
Aug-19	6,971	\$6,662,438	\$4,509,035	\$0	\$1,555,619	\$588,361	\$0	\$6,653,015	\$9,423	\$869.98	99.9%
Sep-19	6,941	\$6,317,646	\$4,524,199	\$0	\$1,414,144	\$586,041	\$0	\$6,524,384	-\$206,738	\$855.55	103.3%
2015	7,857	\$73,183,304	\$43,280,340	\$15,057,894	\$18,042,745	\$7,747,452	-\$335,568	\$83,792,863	-\$10,609,560	\$806.54	114.5%
2016	7,425	\$75,041,054	\$41,229,048	\$13,597,868	\$18,516,456	\$6,776,025	-\$867,487	\$79,251,910	-\$4,210,855	\$813.38	105.6%
2017	7,157	\$80,455,233	\$39,828,579	\$11,798,633	\$20,118,638	\$6,832,128	-\$77,202	\$78,500,774	\$1,954,459	\$834.46	97.6%
2018	6,975	\$78,075,836	\$46,254,684	\$1,695	\$19,774,626	\$6,150,772	-\$551,304	\$71,630,473	\$6,445,363	\$782.33	91.7%
2019 YTD	6,983	\$59,826,516	\$39,958,176	\$0	\$14,259,248	\$5,306,498	\$0	\$59,523,922	\$302,593	\$862.66	99.5%
Current 12 Months	6,985	\$79,408,154	\$52,275,684	\$0	\$18,991,137	\$6,846,408	-\$179,432	\$77,933,797	\$1,474,357	\$848.07	98.1%

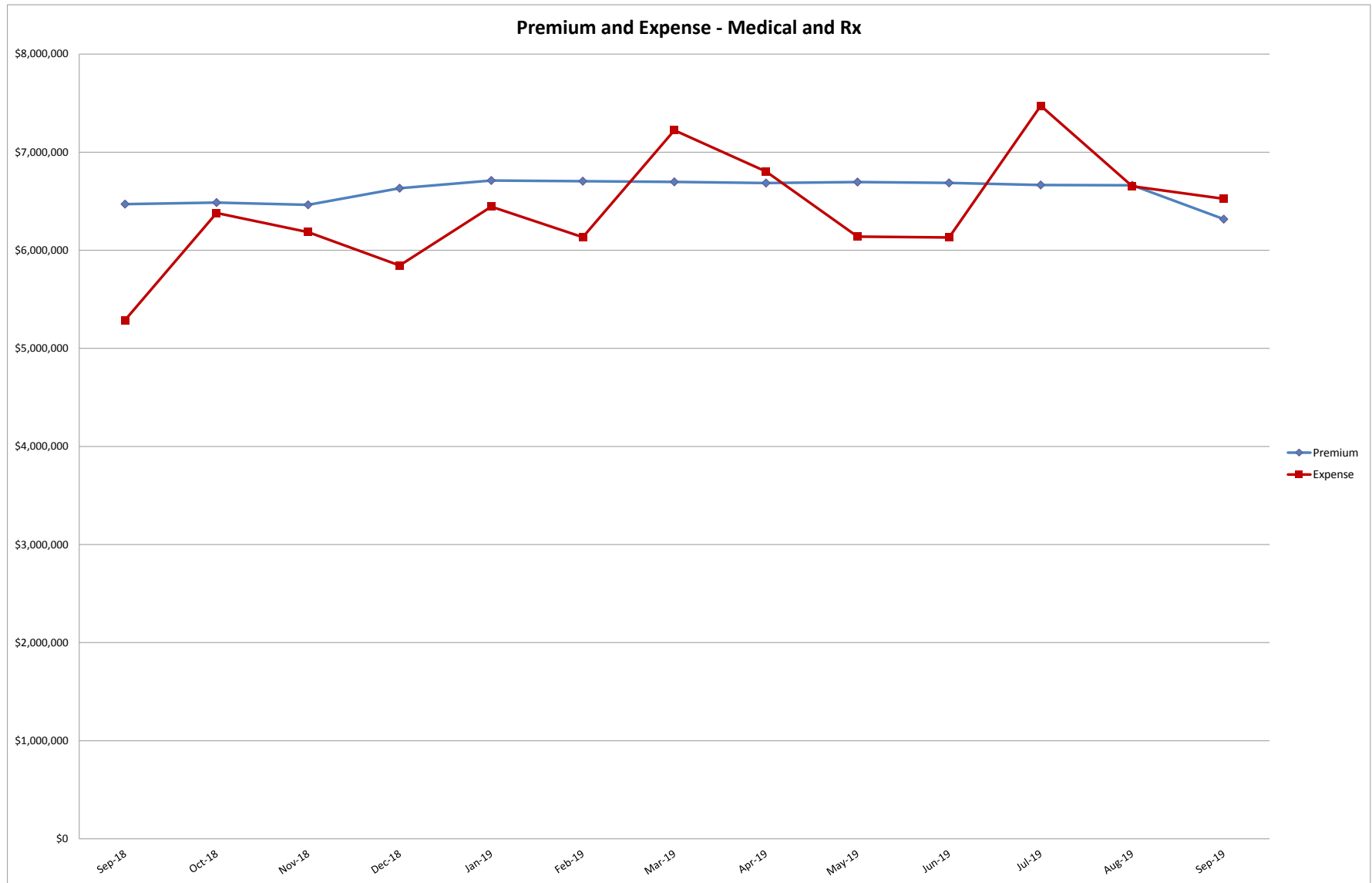
Data Sources:

Enrollment & Premium: Hourglass; Medical Claims & Capitation: Anthem CII, Anthem CLR, Anthem MDP; Rx Claims: Envelope, EmpiRx, Anthem MDP; Fixed Cost Schedule: Appendix

Notes:

1. Fixed Cost Schedule: Appendix
2. Pooling Points: HMO = \$400,000 and EPO/PPO/HDHP = \$450,000.
3. EmpiRx PBM replaced Envelope PBM effective 1/1/2018
4. Fresno converted HMO to EPO plan effective 12/18/2017
5. Waterford and Ceres terminated from SJVIA effective 1/1/2018
6. All Others Claims include runout for Ceres and Waterford

San Joaquin Valley Insurance Authority (SJVIA)
Anthem Blue Cross Premium and Claims Report as of September 2019
All Districts Combined - All Medical





San Joaquin Valley Insurance Authority (SJVIA)
Anthem Blue Cross Premium and Claims Report as of September 2019
All Districts Combined - HMO

MONTH-YEAR	ENROLLED	FUNDING / PREMIUM	CLAIMS EXPENSE						SURPLUS / (DEFICIT)	AVERAGE CLAIM COST PEPM	TOTAL EXPENSE LOSS RATIO
			MEDICAL	CAPITATION	RX	FIXED	POOLED CLAIMS	TOTAL EXPENSE			
Jan-17	3,391	\$3,857,853	\$1,231,705	\$995,935	\$868,003	\$296,428	\$0	\$3,392,072	\$465,781	\$912.90	87.9%
Feb-17	3,371	\$3,829,484	\$1,695,358	\$991,948	\$778,716	\$294,679	\$0	\$3,760,701	\$68,783	\$1,028.19	98.2%
Mar-17	3,348	\$3,805,170	\$1,892,093	\$987,343	\$944,379	\$292,668	\$0	\$4,116,483	-\$311,314	\$1,142.12	108.2%
Apr-17	3,232	\$3,680,296	\$1,204,293	\$977,033	\$838,545	\$282,531	\$0	\$3,302,402	\$377,894	\$934.37	89.7%
May-17	3,238	\$3,685,382	\$2,117,425	\$977,081	\$922,366	\$283,059	\$0	\$4,299,931	-\$614,550	\$1,240.54	116.7%
Jun-17	3,318	\$3,768,088	\$1,533,203	\$972,474	\$987,256	\$290,050	\$0	\$3,782,983	-\$14,895	\$1,052.72	100.4%
Jul-17	3,295	\$3,733,939	\$1,257,109	\$991,172	\$817,251	\$288,039	\$0	\$3,353,572	\$380,367	\$930.36	89.8%
Aug-17	3,291	\$3,723,250	\$1,765,938	\$988,909	\$924,076	\$287,694	\$0	\$3,966,617	-\$243,367	\$1,117.87	106.5%
Sep-17	3,283	\$3,712,476	\$1,490,702	\$985,584	\$854,131	\$286,993	\$0	\$3,617,411	\$95,065	\$1,014.44	97.4%
Oct-17	3,255	\$3,681,354	\$2,128,613	\$979,410	\$905,280	\$284,550	-\$75,682	\$4,222,171	-\$540,818	\$1,209.71	114.7%
Nov-17	3,265	\$3,684,062	\$1,509,653	\$974,921	\$893,657	\$285,425	-\$1,520	\$3,662,136	\$21,926	\$1,034.21	99.4%
Dec-17	3,280	\$2,197,812	\$1,203,354	\$976,822	\$468,244	\$286,737	\$0	\$2,935,157	-\$737,345	\$807.45	133.5%
Jan-18	1	\$1,593	\$484,140	\$1,303	\$804	\$80	\$0	\$486,327	-\$484,734	\$486,246.58	30533.6%
Feb-18	1	\$1,593	\$267,307	\$392	\$0	\$80	\$0	\$267,779	-\$266,187	\$267,699.00	16812.3%
Mar-18	1	\$1,593	\$10,083	\$0	\$0	\$80	\$0	\$10,163	-\$8,571	\$10,083.00	638.1%
Apr-18	1	\$1,593	-\$142,685	\$0	\$0	\$80	\$0	-\$142,605	\$144,198	-\$142,685.00	-8953.3%
May-18	1	\$1,593	-\$9,714	\$0	\$0	\$80	\$0	-\$9,634	\$11,227	-\$9,714.00	-604.8%
Jun-18	1	\$1,593	-\$86	\$0	\$0	\$80	\$0	-\$6	\$1,599	-\$86.00	-0.4%
Jul-18	0	\$0	-\$29,862	\$0	\$0	\$0	\$0	-\$29,862	\$29,862	\$0.00	0.0%
Aug-18	0	\$0	-\$29,755	\$0	\$0	\$0	\$0	-\$29,755	\$29,755	\$0.00	0.0%
Sep-18	0	\$0	\$17,867	\$0	\$0	\$0	\$0	\$17,867	-\$17,867	\$0.00	0.0%
Oct-18	0	\$0	\$52,930	\$0	\$0	\$0	\$0	\$52,930	-\$52,930	\$0.00	0.0%
Nov-18	0	\$0	\$83,883	\$0	\$0	\$0	\$0	\$83,883	-\$83,883	\$0.00	0.0%
Dec-18	0	\$0	\$25,108	\$0	\$0	\$0	\$0	\$25,108	-\$25,108	\$0.00	0.0%
Jan-19	0	\$0	\$7,092	\$0	\$0	\$0	\$0	\$7,092	-\$7,092	\$0.00	0.0%
Feb-19	0	\$0	\$290	\$0	\$0	\$0	\$0	\$290	-\$290	\$0.00	0.0%
Mar-19	0	\$0	\$858	\$0	\$0	\$0	\$0	\$858	-\$858	\$0.00	0.0%
Apr-19	0	\$0	\$8,224	\$0	\$0	\$0	\$0	\$8,224	-\$8,224	\$0.00	0.0%
May-19	0	\$0	\$119	\$0	\$0	\$0	\$0	\$119	-\$119	\$0.00	0.0%
Jun-19	0	\$0	\$10,267	\$0	\$0	\$0	\$0	\$10,267	-\$10,267	\$0.00	0.0%
Jul-19	0	\$0	\$51,462	\$0	\$0	\$0	\$0	\$51,462	-\$51,462	\$0.00	0.0%
Aug-19	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0.00	0.0%
Sep-19	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0.00	0.0%
2015	4,605	\$47,200,812	\$27,086,366	\$15,057,894	\$10,956,150	\$5,003,196	-\$335,568	\$57,768,037	-\$10,567,225	\$954.76	122.4%
2016	4,016	\$46,749,016	\$23,084,871	\$13,597,868	\$10,777,527	\$4,133,848	-\$848,093	\$50,746,021	-\$3,997,005	\$967.20	108.5%
2017	3,297	\$43,359,166	\$19,029,446	\$11,798,633	\$10,201,906	\$3,458,854	-\$77,202	\$44,411,636	-\$1,052,471	\$1,035.02	102.4%
2018	1	\$9,557	\$729,216	\$1,695	\$804	\$482	\$0	\$732,196	-\$722,640	\$121,952.43	7661.7%
2019 YTD	0	\$0	\$78,312	\$0	\$0	\$0	\$0	\$78,312	-\$78,312	\$0.00	0.0%
Current 12 Months	0	\$0	\$240,233	\$0	\$0	\$0	\$0	\$240,233	-\$240,233	#DIV/0!	0.0%

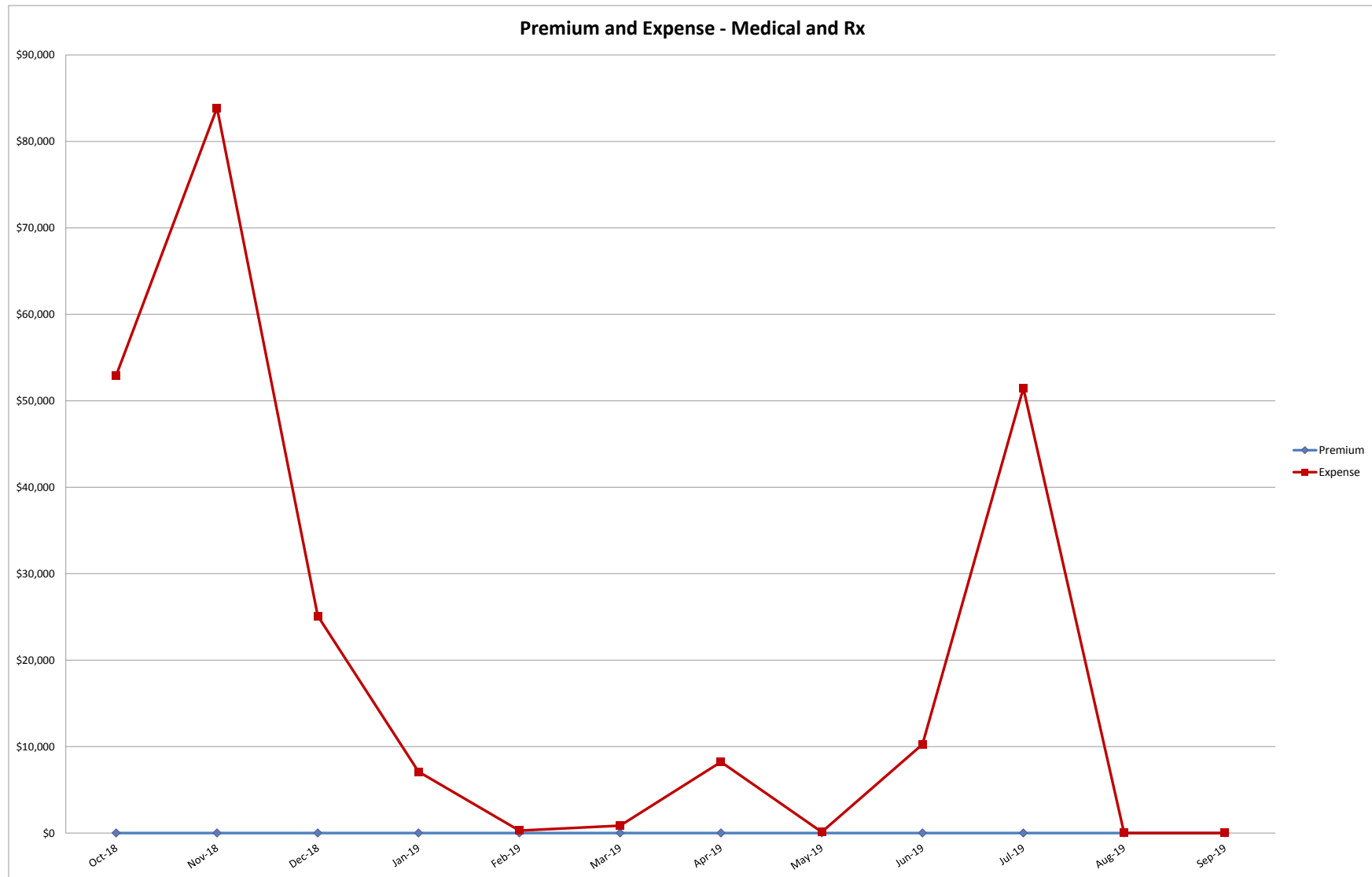
Data Sources:

Enrollment & Premium: Hourglass; Medical Claims & Capitation: Anthem CII, Anthem CLR, Anthem MDP; Rx Claims: Envelope, EmpiRx, Anthem MDP; Fixed Cost Schedule: Appendix

Notes:

1. Fixed Cost Schedule: Appendix
2. Pooling Points: HMO = \$400,000 and EPO/PPO/HDHP = \$450,000.
3. EmpiRx PBM replaced Envelope PBM effective 1/1/2018
4. Fresno converted HMO to EPO plan effective 12/18/2017
5. Waterford and Ceres terminated from SJVIA effective 1/1/2018
6. All Others Claims include runout for Ceres and Waterford

**San Joaquin Valley Insurance Authority (SJVIA)
Anthem Blue Cross Premium and Claims Report as of September 2019
All Districts Combined - HMO**





San Joaquin Valley Insurance Authority (SJVIA)
Anthem Blue Cross Premium and Claims Report as of September 2019
All Districts Combined - EPO

MONTH-YEAR	ENROLLED	FUNDING / PREMIUM	CLAIMS EXPENSE					SURPLUS / (DEFICIT)	AVERAGE CLAIM COST PEPM	TOTAL EXPENSE LOSS RATIO
			MEDICAL	RX	FIXED	POOLED CLAIMS	TOTAL EXPENSE			
Jan-17	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0.00	0.0%
Feb-17	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0.00	0.0%
Mar-17	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0.00	0.0%
Apr-17	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0.00	0.0%
May-17	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0.00	0.0%
Jun-17	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0.00	0.0%
Jul-17	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0.00	0.0%
Aug-17	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0.00	0.0%
Sep-17	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0.00	0.0%
Oct-17	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0.00	0.0%
Nov-17	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0.00	0.0%
Dec-17	3,048	\$1,471,887	\$68,189	\$251,226	\$307,056	\$0	\$626,470	\$845,417	\$104.79	42.6%
Jan-18	3,121	\$3,460,514	\$743,187	\$867,858	\$256,733	\$0	\$1,867,779	\$1,592,735	\$516.20	54.0%
Feb-18	3,122	\$3,463,479	\$1,542,101	\$789,699	\$256,816	\$0	\$2,588,616	\$874,863	\$746.89	74.7%
Mar-18	3,112	\$3,451,850	\$3,301,710	\$924,970	\$255,993	\$0	\$4,482,673	-\$1,030,823	\$1,358.19	129.9%
Apr-18	3,087	\$3,423,792	\$2,596,335	\$801,696	\$253,937	\$0	\$3,651,967	-\$228,175	\$1,100.76	106.7%
May-18	3,074	\$3,408,456	\$2,670,046	\$883,943	\$252,867	\$0	\$3,806,856	-\$398,400	\$1,156.14	111.7%
Jun-18	3,098	\$3,429,672	\$2,361,578	\$767,589	\$254,841	\$0	\$3,384,008	\$45,664	\$1,010.06	98.7%
Jul-18	3,101	\$3,429,177	\$2,413,373	\$911,839	\$255,088	-\$29,545	\$3,550,755	-\$121,578	\$1,062.78	103.5%
Aug-18	3,080	\$3,407,283	\$2,623,941	\$946,096	\$253,361	-\$64,707	\$3,758,691	-\$351,408	\$1,138.09	110.3%
Sep-18	3,084	\$3,412,914	\$2,122,966	\$813,696	\$253,690	-\$277,620	\$2,912,732	\$500,182	\$862.21	85.3%
Oct-18	3,080	\$3,405,753	\$2,177,898	\$850,790	\$253,361	-\$8,976	\$3,273,073	\$132,681	\$980.43	96.1%
Nov-18	3,051	\$3,370,639	\$2,299,743	\$823,630	\$250,975	-\$754	\$3,373,595	-\$2,956	\$1,023.47	100.1%
Dec-18	3,076	\$3,562,357	\$2,256,483	\$730,643	\$253,032	\$224	\$3,240,382	\$321,975	\$971.18	91.0%
Jan-19	3,073	\$3,559,246	\$2,604,617	\$879,905	\$294,240	\$0	\$3,778,762	-\$219,516	\$1,133.92	106.2%
Feb-19	3,073	\$3,560,485	\$2,724,566	\$785,480	\$294,240	\$0	\$3,804,286	-\$243,801	\$1,142.22	106.8%
Mar-19	3,062	\$3,544,198	\$3,384,517	\$821,110	\$293,187	\$0	\$4,498,813	-\$954,615	\$1,373.49	126.9%
Apr-19	3,049	\$3,530,743	\$2,630,414	\$901,971	\$291,942	\$0	\$3,824,327	-\$293,583	\$1,158.54	108.3%
May-19	3,059	\$3,541,346	\$2,295,464	\$788,293	\$292,899	\$0	\$3,376,656	\$164,690	\$1,008.09	95.3%
Jun-19	3,060	\$3,545,756	\$2,650,766	\$789,556	\$292,995	\$0	\$3,733,317	-\$187,561	\$1,124.29	105.3%
Jul-19	3,054	\$3,534,380	\$3,391,960	\$823,278	\$292,421	\$0	\$4,507,658	-\$973,278	\$1,380.24	127.5%
Aug-19	3,049	\$3,530,743	\$2,755,785	\$799,532	\$291,942	\$0	\$3,847,258	-\$316,515	\$1,166.06	109.0%
Sep-19	3,046	\$3,255,421	\$2,908,388	\$731,856	\$291,655	\$0	\$3,931,898	-\$676,478	\$1,195.09	120.8%
2015	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0.00	0.0%
2017	3,048	\$1,471,887	\$68,189	\$251,226	\$307,056	\$0	\$626,470	\$845,417	\$104.79	42.6%
2018	3,091	\$41,225,886	\$27,109,361	\$10,112,448	\$3,050,694	-\$381,378	\$39,891,126	\$1,334,760	\$993.38	96.8%
2019 YTD	3,058	\$31,602,319	\$25,346,477	\$7,320,981	\$2,635,519	\$0	\$35,302,977	-\$3,700,657	\$1,186.83	111.7%
Current 12 Months	3,061	\$41,941,069	\$32,080,601	\$9,726,045	\$3,392,887	-\$9,506	\$45,190,026	-\$3,248,957	\$1,137.89	107.7%

Data Sources:

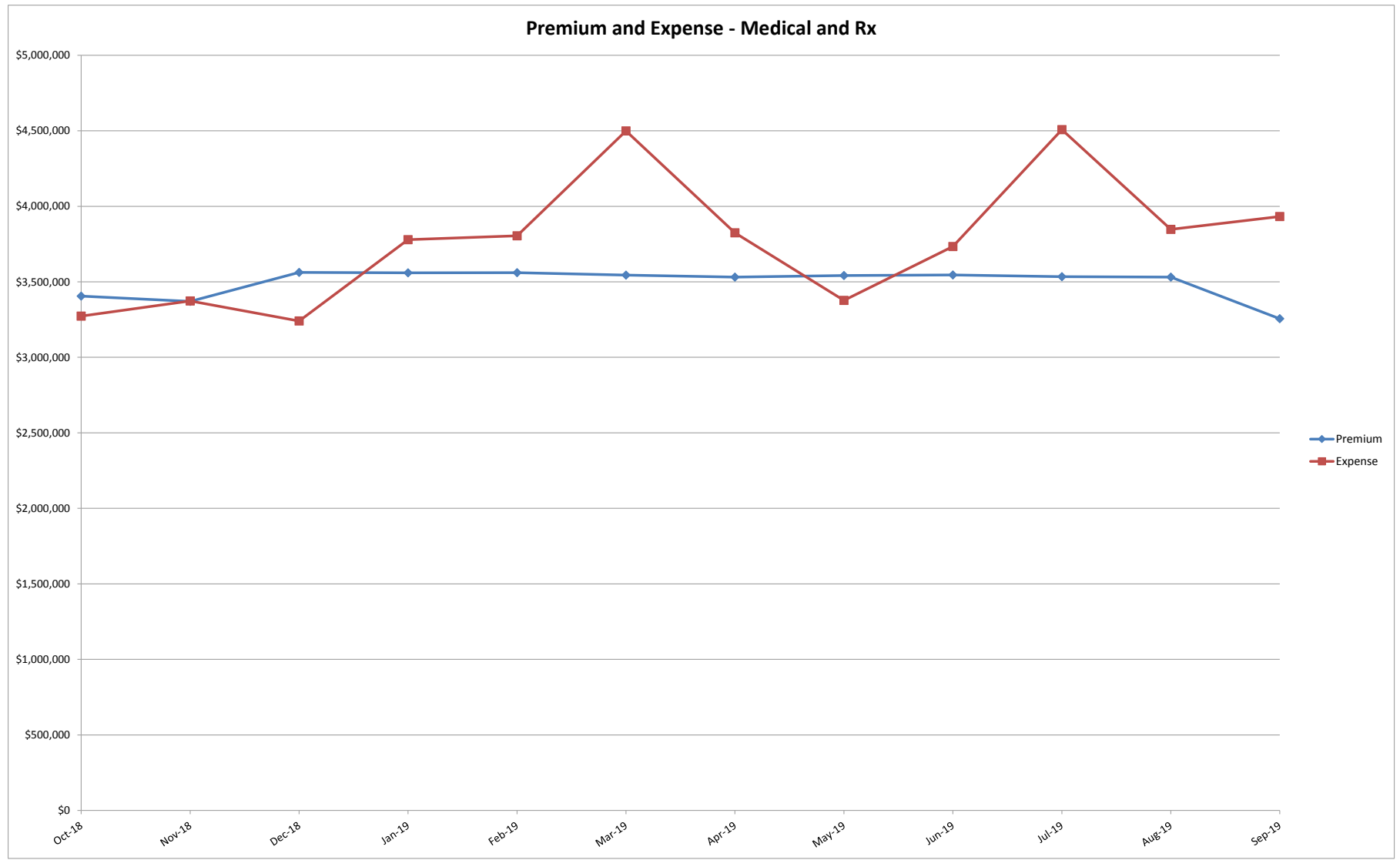
Enrollment & Premium: Hourglass; **Medical Claims & Capitation:** Anthem CII, Anthem CLR, Anthem MDP; **Rx Claims:** Envelope, EmpiRx, Anthem MDP; **Fixed Cost Schedule:** Appendix

Notes:

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4. Fresno converted HMO to EPO plan effective 12/18/2017
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San Joaquin Valley Insurance Authority (SJVIA)
Anthem Blue Cross Premium and Claims Report as of September 2019
All Districts Combined - EPO





San Joaquin Valley Insurance Authority (SJVIA)
Anthem Blue Cross Premium and Claims Report as of September 2019
All Districts Combined - PPO

MONTH-YEAR	ENROLLED	FUNDING / PREMIUM	CLAIMS EXPENSE					SURPLUS / (DEFICIT)	AVERAGE CLAIM COST PEPM	TOTAL EXPENSE LOSS RATIO
			MEDICAL	RX	FIXED	POOLED CLAIMS	TOTAL EXPENSE			
Jan-17	3,049	\$2,408,045	\$1,167,779	\$658,355	\$201,852	\$0	\$2,027,986	\$380,059	\$598.93	84.2%
Feb-17	3,040	\$2,404,910	\$1,173,087	\$611,471	\$201,257	\$0	\$1,985,815	\$419,096	\$587.03	82.6%
Mar-17	3,051	\$2,409,004	\$1,139,347	\$651,192	\$201,977	\$0	\$1,992,516	\$416,488	\$586.87	82.7%
Apr-17	3,024	\$2,381,103	\$1,441,495	\$580,274	\$200,190	\$0	\$2,221,959	\$159,144	\$668.57	93.3%
May-17	3,011	\$2,368,076	\$1,628,318	\$610,381	\$199,332	\$0	\$2,438,031	-\$69,955	\$743.51	103.0%
Jun-17	3,016	\$2,375,163	\$2,038,616	\$702,737	\$199,665	\$0	\$2,941,018	-\$565,855	\$908.94	123.8%
Jul-17	3,046	\$2,396,547	\$1,230,206	\$628,628	\$201,654	\$0	\$2,060,488	\$336,059	\$610.25	86.0%
Aug-17	3,083	\$2,426,551	\$1,596,397	\$794,992	\$204,102	\$0	\$2,595,491	-\$168,940	\$775.67	107.0%
Sep-17	3,099	\$2,435,486	\$1,049,152	\$781,883	\$205,163	\$0	\$2,036,198	\$399,288	\$590.85	83.6%
Oct-17	3,092	\$2,430,771	\$1,715,373	\$751,177	\$204,696	\$0	\$2,671,246	-\$240,475	\$797.72	109.9%
Nov-17	3,105	\$2,441,299	\$1,617,686	\$655,311	\$205,556	\$0	\$2,478,553	-\$37,254	\$732.04	101.5%
Dec-17	3,070	\$2,421,402	\$1,249,063	\$767,492	\$203,238	\$0	\$2,219,793	\$201,609	\$656.86	91.7%
Jan-18	3,056	\$2,474,747	\$1,416,549	\$653,413	\$202,141	\$0	\$2,272,103	\$202,645	\$677.34	91.8%
Feb-18	3,050	\$2,466,814	\$932,401	\$663,106	\$201,739	\$0	\$1,797,245	\$669,569	\$523.12	72.9%
Mar-18	3,054	\$2,468,391	\$1,362,590	\$697,817	\$202,005	\$0	\$2,262,412	\$205,979	\$674.66	91.7%
Apr-18	3,058	\$2,465,659	\$1,106,965	\$691,104	\$202,258	\$0	\$2,000,327	\$465,332	\$587.99	81.1%
May-18	3,092	\$2,481,385	\$1,182,191	\$711,644	\$204,498	\$0	\$2,098,333	\$383,052	\$612.50	84.6%
Jun-18	3,090	\$2,475,265	\$1,183,141	\$692,047	\$204,362	\$0	\$2,079,549	\$395,715	\$606.86	84.0%
Jul-18	3,076	\$2,461,369	\$1,210,462	\$733,450	\$203,432	\$0	\$2,147,344	\$314,025	\$631.96	87.2%
Aug-18	3,092	\$2,475,036	\$1,345,548	\$773,067	\$204,493	\$0	\$2,323,108	\$151,928	\$685.19	93.9%
Sep-18	3,074	\$2,457,481	\$1,053,032	\$745,201	\$203,295	\$0	\$2,001,527	\$455,953	\$584.98	81.4%
Oct-18	3,096	\$2,472,113	\$1,647,435	\$681,425	\$204,752	\$0	\$2,533,612	-\$61,499	\$752.22	102.5%
Nov-18	3,115	\$2,480,850	\$1,624,319	\$620,240	\$206,001	-\$161,954	\$2,288,606	\$192,244	\$668.57	92.3%
Dec-18	3,104	\$2,465,080	\$1,151,196	\$637,381	\$205,242	-\$7,972	\$1,985,847	\$479,233	\$573.65	80.6%
Jan-19	3,122	\$2,533,962	\$1,486,339	\$662,076	\$232,066	\$0	\$2,380,480	\$153,482	\$688.15	93.9%
Feb-19	3,116	\$2,530,587	\$1,213,587	\$666,114	\$231,637	\$0	\$2,111,337	\$419,250	\$603.24	83.4%
Mar-19	3,135	\$2,543,443	\$1,512,907	\$684,802	\$233,009	\$0	\$2,430,717	\$112,726	\$701.02	95.6%
Apr-19	3,139	\$2,544,467	\$1,588,960	\$741,058	\$233,290	\$0	\$2,563,309	-\$18,842	\$742.28	100.7%
May-19	3,144	\$2,547,741	\$1,423,089	\$706,316	\$233,626	\$0	\$2,363,032	\$184,709	\$677.29	92.8%
Jun-19	3,125	\$2,533,098	\$1,292,592	\$603,070	\$232,223	\$0	\$2,127,884	\$405,214	\$606.61	84.0%
Jul-19	3,128	\$2,529,360	\$1,313,309	\$802,451	\$232,428	\$0	\$2,348,187	\$181,172	\$676.39	92.8%
Aug-19	3,141	\$2,540,736	\$1,533,515	\$656,565	\$233,371	\$0	\$2,423,451	\$117,285	\$697.26	95.4%
Sep-19	3,118	\$2,506,993	\$1,513,921	\$614,616	\$231,656	\$0	\$2,360,193	\$146,800	\$682.66	94.1%
2015	2,634	\$21,395,949	\$13,739,706	\$6,143,677	\$2,222,984	\$0	\$22,106,367	-\$710,418	\$629.06	103.3%
2016	2,720	\$23,079,432	\$14,603,446	\$6,545,718	\$2,108,061	-\$19,394	\$23,237,832	-\$158,400	\$647.38	100.7%
2017	3,057	\$28,898,357	\$17,046,519	\$8,193,894	\$2,428,681	\$0	\$27,669,093	\$1,229,264	\$688.01	95.7%
2018	3,080	\$29,644,190	\$15,215,829	\$8,299,894	\$2,444,216	-\$169,926	\$25,790,013	\$3,854,177	\$631.70	87.0%
2019 YTD	3,130	\$22,810,387	\$12,878,218	\$6,137,068	\$2,093,305	\$0	\$21,108,590	\$1,701,796	\$675.07	92.5%
Current 12 Months	3,124	\$30,228,430	\$17,301,168	\$8,076,114	\$2,709,300	-\$169,926	\$27,916,655	\$2,311,774	\$672.50	92.4%

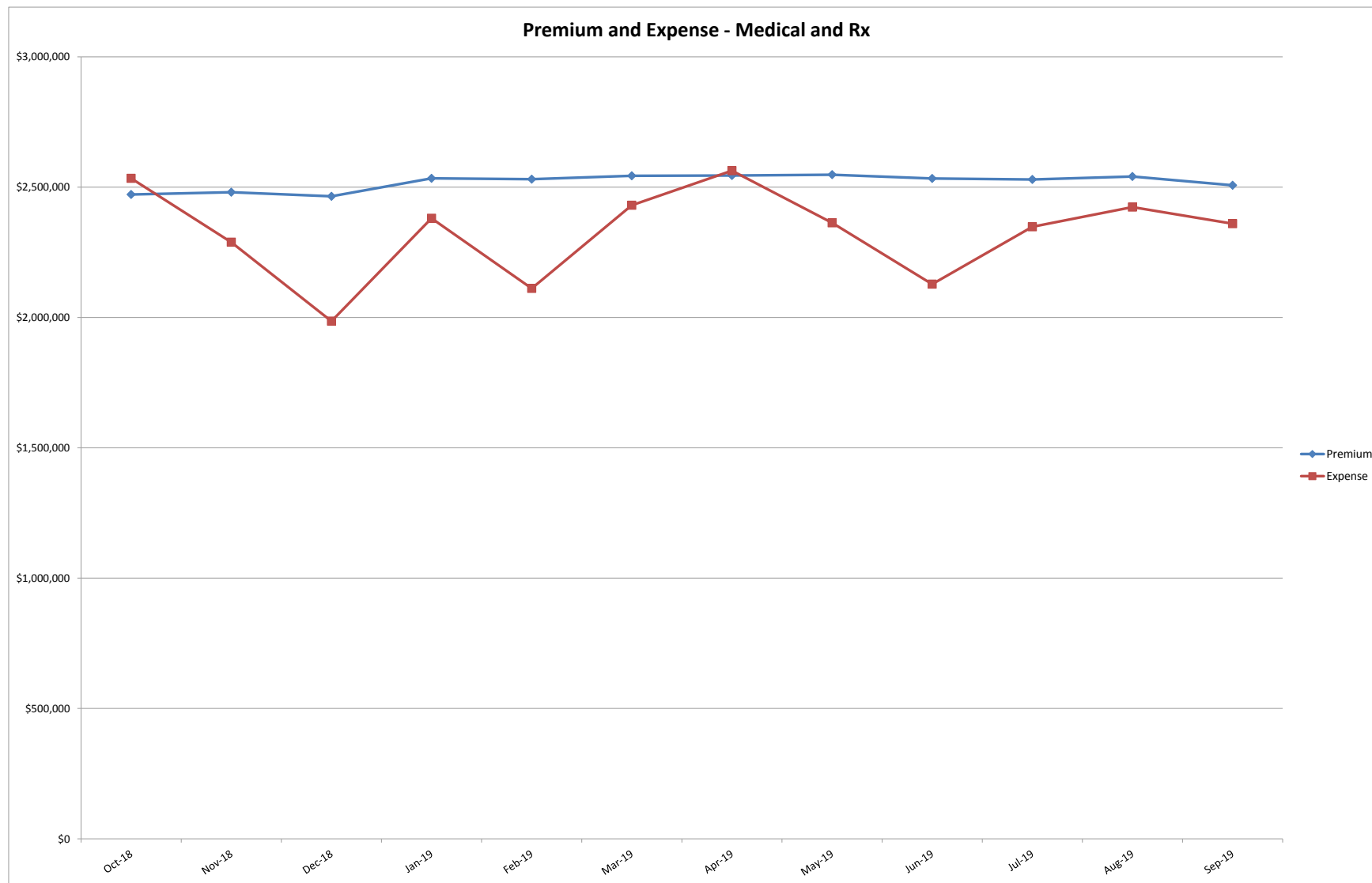
Data Sources:

Enrollment & Premium: Hourglass; Medical Claims & Capitation: Anthem CIL, Anthem CLR, Anthem MDP; Rx Claims: Enroll, EmpiRx, Anthem MDP; Fixed Cost Schedule: Appendix

Notes:

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Anthem Blue Cross Premium and Claims Report as of September 2019
All Districts Combined - PPO





San Joaquin Valley Insurance Authority (SJVIA)
Anthem Blue Cross Premium and Claims Report as of September 2019
All Districts Combined - HDHP

MONTH-YEAR	ENROLLED	FUNDING / PREMIUM	CLAIMS EXPENSE					SURPLUS / (DEFICIT)	AVERAGE CLAIM COST PEPM	TOTAL EXPENSE LOSS RATIO
			MEDICAL	RX	FIXED	POOLED CLAIMS	TOTAL EXPENSE			
Jan-17	784	\$549,235	\$301,349	\$46,039	\$51,885	\$0	\$399,273	\$149,962	\$443.10	72.7%
Feb-17	789	\$553,287	\$390,105	\$50,974	\$52,216	\$0	\$493,295	\$59,992	\$559.04	89.2%
Mar-17	780	\$547,213	\$291,483	\$120,354	\$51,623	\$0	\$463,460	\$83,754	\$528.00	84.7%
Apr-17	757	\$531,254	\$418,163	\$84,758	\$50,101	\$0	\$553,022	-\$21,768	\$664.36	104.1%
May-17	804	\$562,043	\$185,635	\$118,011	\$53,211	\$0	\$356,857	\$205,187	\$377.67	63.5%
Jun-17	838	\$585,036	\$341,389	\$141,811	\$55,460	\$0	\$538,660	\$46,376	\$576.61	92.1%
Jul-17	853	\$591,868	\$340,803	\$129,489	\$56,453	\$0	\$526,745	\$65,123	\$551.34	89.0%
Aug-17	814	\$563,390	\$317,389	\$145,106	\$53,872	\$0	\$516,367	\$47,023	\$568.18	91.7%
Sep-17	816	\$562,473	\$292,926	\$181,459	\$54,005	\$0	\$528,390	\$34,083	\$581.35	93.9%
Oct-17	813	\$560,698	\$293,972	\$154,133	\$53,808	\$0	\$501,913	\$58,784	\$551.17	89.5%
Nov-17	823	\$564,103	\$175,378	\$143,619	\$54,470	\$0	\$373,467	\$190,636	\$387.60	66.2%
Dec-17	762	\$555,223	\$335,833	\$155,859	\$50,434	\$0	\$542,126	\$13,098	\$645.27	97.6%
Jan-18	780	\$584,165	\$123,436	\$70,685	\$52,974	\$0	\$247,095	\$337,070	\$248.87	42.3%
Feb-18	782	\$587,933	\$232,354	\$67,174	\$53,114	\$0	\$352,642	\$235,291	\$383.03	60.0%
Mar-18	786	\$590,458	\$467,327	\$113,171	\$53,386	\$0	\$633,884	-\$43,426	\$738.55	107.4%
Apr-18	789	\$592,894	\$231,956	\$95,884	\$53,590	\$0	\$381,430	\$211,464	\$415.51	64.3%
May-18	796	\$596,128	\$299,227	\$117,883	\$54,066	\$0	\$471,176	\$124,952	\$524.01	79.0%
Jun-18	803	\$598,883	\$151,272	\$144,709	\$54,542	\$0	\$350,523	\$248,360	\$368.59	58.5%
Jul-18	825	\$612,055	\$287,858	\$121,752	\$56,036	\$0	\$465,646	\$146,409	\$496.50	76.1%
Aug-18	823	\$608,785	\$216,991	\$133,079	\$55,902	\$0	\$405,972	\$202,813	\$425.36	66.7%
Sep-18	813	\$600,057	\$191,345	\$109,362	\$55,224	\$0	\$355,931	\$244,126	\$369.87	59.3%
Oct-18	827	\$608,462	\$342,655	\$121,420	\$56,174	\$0	\$520,249	\$88,214	\$561.15	85.5%
Nov-18	833	\$611,374	\$250,686	\$131,459	\$56,580	\$0	\$438,725	\$172,649	\$458.76	71.8%
Dec-18	792	\$605,010	\$405,172	\$134,902	\$53,792	\$0	\$593,866	\$11,144	\$681.91	98.2%
Jan-19	803	\$617,868	\$152,149	\$61,235	\$64,817	\$0	\$278,201	\$339,666	\$265.73	45.0%
Feb-19	801	\$613,099	\$77,155	\$74,997	\$64,662	\$0	\$216,814	\$396,285	\$189.95	35.4%
Mar-19	795	\$609,060	\$126,673	\$101,947	\$64,176	\$0	\$292,796	\$316,264	\$287.57	48.1%
Apr-19	801	\$610,680	\$252,933	\$89,354	\$64,655	\$0	\$406,942	\$203,738	\$427.32	66.6%
May-19	799	\$606,549	\$220,493	\$113,938	\$64,492	\$0	\$398,924	\$207,625	\$418.56	65.8%
Jun-19	805	\$608,004	\$108,337	\$86,343	\$64,993	\$0	\$259,673	\$348,331	\$241.84	42.7%
Jul-19	794	\$602,361	\$395,802	\$106,192	\$64,102	\$0	\$566,095	\$36,265	\$632.23	94.0%
Aug-19	781	\$590,958	\$219,736	\$99,521	\$63,048	\$0	\$382,305	\$208,653	\$408.78	64.7%
Sep-19	777	\$555,233	\$101,890	\$67,672	\$62,731	\$0	\$232,293	\$322,939	\$218.23	41.8%
2015	618	\$4,586,543	\$2,454,268	\$942,919	\$521,272	\$0	\$3,918,459	\$668,084	\$458.27	85.4%
2016	689	\$5,212,607	\$3,540,731	\$1,193,210	\$534,116	\$0	\$5,268,057	-\$55,451	\$572.22	101.1%
2017	803	\$6,725,823	\$3,684,425	\$1,471,612	\$637,538	\$0	\$5,793,575	\$932,249	\$535.25	86.1%
2018	804	\$7,196,204	\$3,200,278	\$1,361,480	\$655,380	\$0	\$5,217,138	\$1,979,065	\$472.77	72.5%
2019 YTD	795	\$5,413,810	\$1,655,170	\$801,199	\$577,675	\$0	\$3,034,043	\$2,379,766	\$343.26	56.0%
Current 12 Months	801	\$7,238,656	\$2,653,682	\$1,188,979	\$744,221	\$0	\$4,586,883	\$2,651,773	\$399.94	63.4%

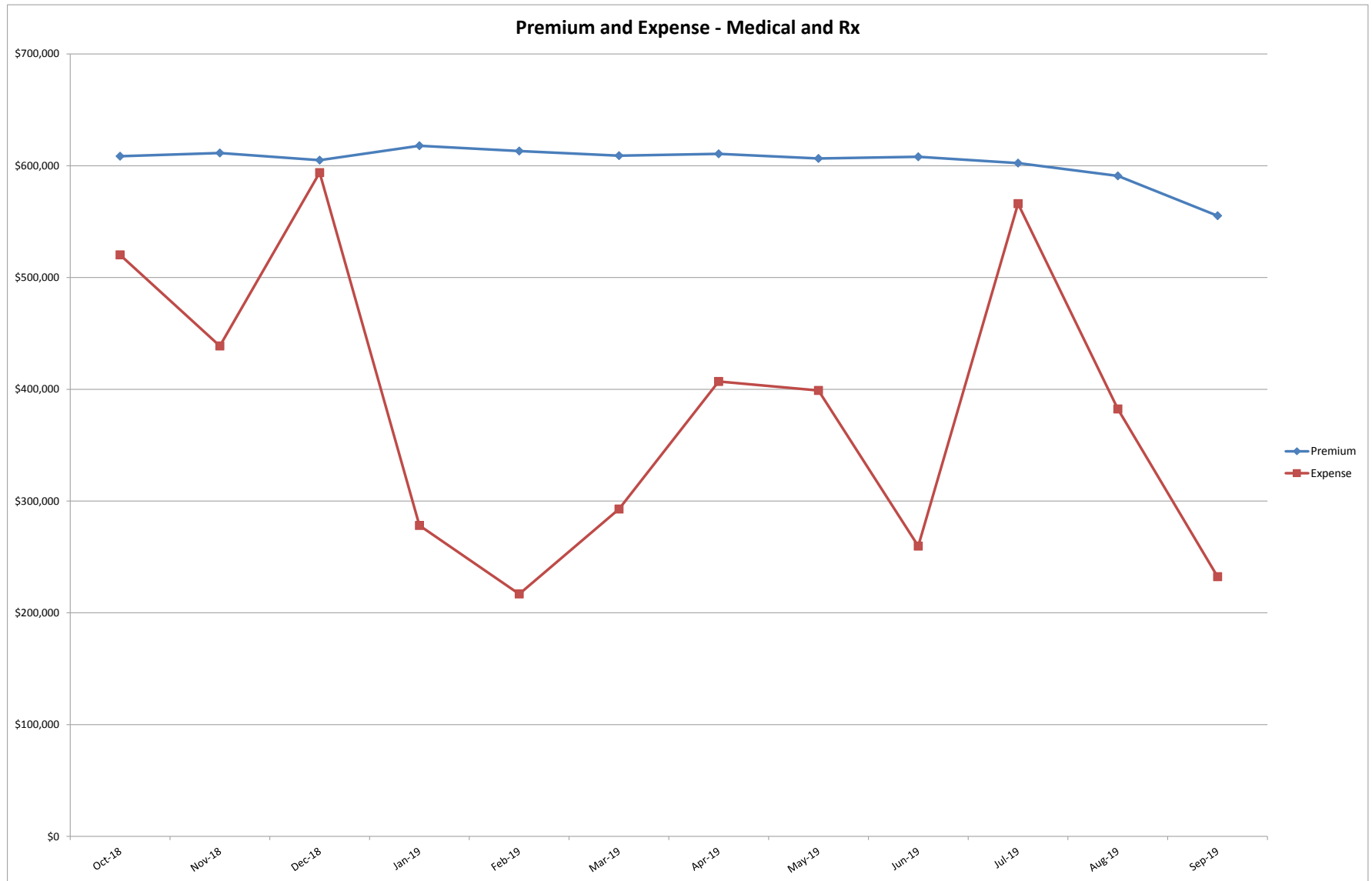
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San Joaquin Valley Insurance Authority (SJVIA)
Anthem Blue Cross Premium and Claims Report as of September 2019
All Districts Combined - HDHP





San Joaquin Valley Insurance Authority (SJVIA)
Anthem Blue Cross Premium and Claims Report as of September 2019
County of Fresno - All Medical

MONTH-YEAR	ENROLLED	FUNDING / PREMIUM	CLAIMS EXPENSE						SURPLUS / (DEFICIT)	AVERAGE CLAIM COST PEPM	TOTAL EXPENSE LOSS RATIO
			MEDICAL	CAPITATION	RX	FIXED	POOLED CLAIMS	TOTAL EXPENSE			
Jan-17	4,217	\$4,418,172	\$1,323,742	\$943,781	\$947,744	\$348,074	\$0	\$3,563,341	\$854,830	\$762.45	80.7%
Feb-17	4,204	\$4,395,734	\$1,975,135	\$939,983	\$869,746	\$346,812	\$0	\$4,131,676	\$264,057	\$900.30	94.0%
Mar-17	4,176	\$4,366,453	\$2,266,845	\$935,255	\$1,109,568	\$344,493	\$0	\$4,656,161	-\$289,708	\$1,032.49	106.6%
Apr-17	4,022	\$4,207,039	\$1,938,565	\$926,167	\$939,788	\$331,911	\$0	\$4,136,430	\$70,609	\$945.93	98.3%
May-17	4,046	\$4,218,545	\$2,134,703	\$925,137	\$1,087,642	\$333,584	\$0	\$4,481,065	-\$262,520	\$1,025.08	106.2%
Jun-17	4,169	\$4,336,268	\$1,841,158	\$920,448	\$1,162,113	\$343,374	\$0	\$4,267,092	\$69,175	\$941.17	98.4%
Jul-17	4,161	\$4,309,129	\$1,657,044	\$939,122	\$971,215	\$342,379	\$0	\$3,909,759	\$399,369	\$857.34	90.7%
Aug-17	4,151	\$4,291,222	\$2,105,120	\$936,084	\$1,122,204	\$341,590	\$0	\$4,504,998	-\$213,776	\$1,002.99	105.0%
Sep-17	4,148	\$4,286,191	\$1,702,653	\$932,821	\$1,058,635	\$341,243	\$0	\$4,035,352	\$250,839	\$890.58	94.1%
Oct-17	4,115	\$4,252,762	\$2,450,589	\$927,014	\$1,106,328	\$338,446	-\$75,682	\$4,746,695	-\$493,933	\$1,071.26	111.6%
Nov-17	4,134	\$4,260,644	\$1,660,657	\$922,220	\$1,080,003	\$339,894	-\$1,520	\$4,001,254	\$259,391	\$885.67	93.9%
Dec-17	4,037	\$4,205,988	\$1,518,938	\$923,518	\$910,669	\$640,827	\$0	\$3,993,952	\$212,036	\$830.60	95.0%
Jan-18	4,014	\$4,216,453	\$1,343,582	\$1,303	\$981,088	\$317,466	\$0	\$2,643,439	\$1,573,014	\$579.47	62.7%
Feb-18	4,013	\$4,214,950	\$2,067,824	\$392	\$885,589	\$317,413	\$0	\$3,271,218	\$943,732	\$736.06	77.6%
Mar-18	4,008	\$4,206,695	\$3,917,235	\$0	\$1,081,214	\$316,930	\$0	\$5,315,379	-\$1,108,685	\$1,247.12	126.4%
Apr-18	3,982	\$4,176,812	\$2,742,323	\$0	\$946,806	\$314,806	\$0	\$4,003,935	\$172,877	\$926.45	95.9%
May-18	3,977	\$4,165,557	\$3,014,792	\$0	\$1,049,876	\$314,280	\$0	\$4,378,948	-\$213,391	\$1,022.04	105.1%
Jun-18	4,006	\$4,186,011	\$2,584,783	\$0	\$948,297	\$316,595	\$0	\$3,849,675	\$336,336	\$881.95	92.0%
Jul-18	4,027	\$4,193,847	\$2,719,596	\$0	\$1,087,767	\$318,066	-\$29,545	\$4,095,884	\$97,964	\$938.12	97.7%
Aug-18	4,006	\$4,170,389	\$2,976,059	\$0	\$1,121,455	\$316,338	-\$64,707	\$4,349,145	-\$178,756	\$1,006.69	104.3%
Sep-18	3,999	\$4,165,585	\$2,367,426	\$0	\$948,073	\$315,919	-\$277,620	\$3,353,798	\$811,787	\$759.66	80.5%
Oct-18	4,009	\$4,165,691	\$2,602,109	\$0	\$1,021,112	\$316,542	-\$8,976	\$3,930,786	\$234,905	\$901.53	94.4%
Nov-18	3,981	\$4,130,176	\$2,664,886	\$0	\$996,076	\$314,225	-\$754	\$3,974,433	\$155,744	\$919.42	96.2%
Dec-18	3,950	\$4,301,726	\$2,717,105	\$0	\$897,987	\$312,473	\$224	\$3,927,789	\$373,938	\$915.27	91.3%
Jan-19	3,957	\$4,308,878	\$2,814,712	\$0	\$970,474	\$365,879	\$0	\$4,151,065	\$157,813	\$956.58	96.3%
Feb-19	3,958	\$4,308,818	\$2,842,550	\$0	\$879,636	\$365,960	\$0	\$4,088,147	\$220,671	\$940.42	94.9%
Mar-19	3,939	\$4,286,097	\$3,538,700	\$0	\$947,995	\$364,259	\$0	\$4,850,954	-\$564,857	\$1,139.04	113.2%
Apr-19	3,929	\$4,268,294	\$2,949,169	\$0	\$1,012,854	\$363,257	\$0	\$4,325,281	-\$56,986	\$1,008.41	101.3%
May-19	3,937	\$4,275,658	\$2,488,352	\$0	\$929,847	\$364,052	\$0	\$3,782,252	\$493,406	\$868.22	88.5%
Jun-19	3,946	\$4,282,374	\$2,816,979	\$0	\$892,778	\$364,796	\$0	\$4,074,554	\$207,820	\$940.13	95.1%
Jul-19	3,929	\$4,265,355	\$3,879,523	\$0	\$950,531	\$363,331	\$0	\$5,193,385	-\$928,030	\$1,229.33	121.8%
Aug-19	3,911	\$4,250,316	\$2,986,201	\$0	\$914,827	\$361,798	\$0	\$4,262,825	-\$12,510	\$997.45	100.3%
Sep-19	3,905	\$3,928,958	\$3,054,615	\$0	\$821,510	\$361,268	\$0	\$4,237,393	-\$308,435	\$992.61	107.9%
2015	4,960	\$49,524,371	\$26,241,999	\$13,681,568	\$11,812,227	\$5,199,036	-\$65,205	\$56,869,626	-\$7,345,255	\$868.06	114.8%
2016	4,472	\$49,649,165	\$25,583,459	\$12,289,322	\$11,563,318	\$4,386,355	-\$848,093	\$52,974,360	-\$3,325,196	\$905.46	106.7%
2017	4,132	\$51,548,146	\$22,575,148	\$11,171,550	\$12,365,655	\$4,392,626	-\$77,202	\$50,427,777	\$1,120,369	\$928.50	97.8%
2018	3,998	\$50,293,893	\$31,717,719	\$1,695	\$11,965,340	\$3,791,051	-\$381,378	\$47,094,428	\$3,199,465	\$902.68	93.6%
2019 YTD	3,935	\$38,174,748	\$27,370,803	\$0	\$8,320,453	\$3,274,600	\$0	\$38,965,856	-\$791,108	\$1,007.91	102.1%
Current 12 Months	3,946	\$50,772,342	\$35,354,902	\$0	\$11,235,628	\$4,217,839	-\$9,506	\$50,798,863	-\$26,522	\$983.74	100.1%

Data Sources:

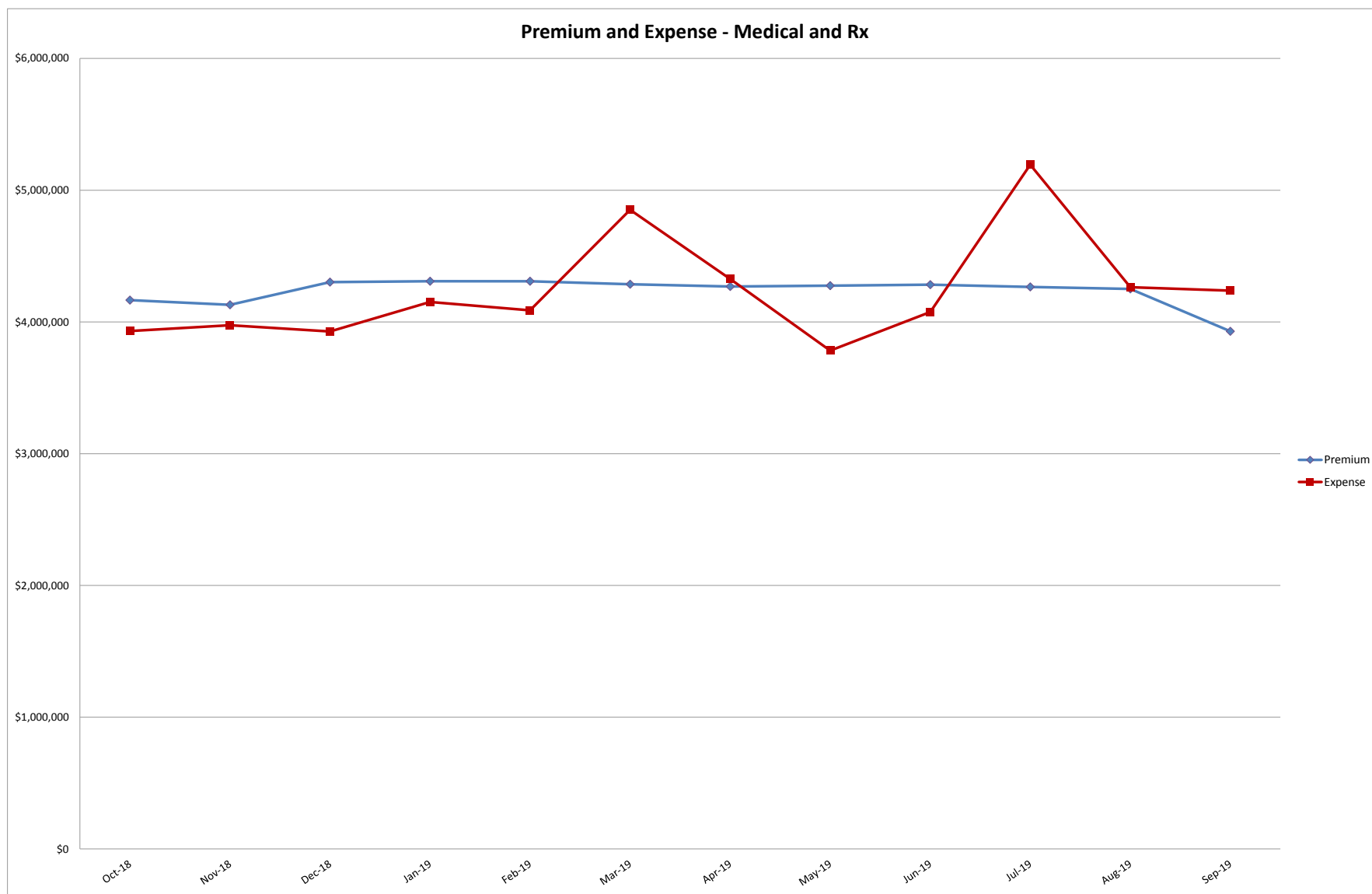
Enrollment & Premium: Hourglass; **Medical Claims & Capitation:** Anthem CIL, Anthem CLR, Anthem MDP; **Rx Claims:** Envelope, EmpiRx, Anthem MDP; **Fixed Cost Schedule:** Appendix

Notes:

1. Fixed Cost Schedule: Appendix
2. Pooling Points: HMO = \$400,000 and EPO/PPO/HDHP = \$450,000.
3. EmpiRx PBM replaced Envelope PBM effective 1/1/2018
4. Fresno converted HMO to EPO plan effective 12/18/2017



San Joaquin Valley Insurance Authority (SJVIA)
Anthem Blue Cross Premium and Claims Report as of September 2019
County of Fresno - All Medical





San Joaquin Valley Insurance Authority (SJVIA)
Anthem Blue Cross Premium and Claims Report as of September 2019
County of Fresno - HMO

MONTH-YEAR	ENROLLED	FUNDING / PREMIUM	CLAIMS EXPENSE						SURPLUS / (DEFICIT)	AVERAGE CLAIM COST PEPM	TOTAL EXPENSE LOSS RATIO
			MEDICAL	CAPITATION	RX	FIXED	POOLED CLAIMS	TOTAL EXPENSE			
Jan-17	3,261	\$3,662,440	\$953,124	\$943,781	\$852,019	\$284,816	\$0	\$3,033,740	\$628,700	\$842.97	82.8%
Feb-17	3,242	\$3,634,968	\$1,495,166	\$939,983	\$752,976	\$283,156	\$0	\$3,471,281	\$163,687	\$983.38	95.5%
Mar-17	3,220	\$3,611,288	\$1,793,588	\$935,255	\$920,529	\$281,235	\$0	\$3,930,607	-\$319,318	\$1,133.35	108.8%
Apr-17	3,107	\$3,489,598	\$1,152,900	\$926,167	\$811,501	\$271,365	\$0	\$3,161,933	\$327,664	\$930.34	90.6%
May-17	3,111	\$3,491,293	\$1,670,467	\$925,137	\$899,619	\$271,715	\$0	\$3,766,937	-\$275,644	\$1,123.50	107.9%
Jun-17	3,189	\$3,571,890	\$1,276,006	\$920,448	\$965,026	\$278,527	\$0	\$3,440,007	\$131,884	\$991.37	96.3%
Jul-17	3,167	\$3,539,921	\$1,188,689	\$939,122	\$793,647	\$276,606	\$0	\$3,198,064	\$341,857	\$922.47	90.3%
Aug-17	3,161	\$3,525,402	\$1,659,111	\$936,084	\$902,562	\$276,082	\$0	\$3,773,839	-\$248,437	\$1,106.54	107.0%
Sep-17	3,154	\$3,516,103	\$1,359,765	\$932,821	\$828,090	\$275,470	\$0	\$3,396,146	\$119,957	\$989.43	96.6%
Oct-17	3,125	\$3,485,050	\$2,043,211	\$927,014	\$882,280	\$272,938	-\$75,682	\$4,049,761	-\$564,710	\$1,208.58	116.2%
Nov-17	3,134	\$3,487,125	\$1,426,707	\$922,220	\$867,911	\$273,724	-\$1,520	\$3,489,042	-\$1,917	\$1,025.95	100.1%
Dec-17	3,148	\$1,997,542	\$1,087,503	\$923,518	\$440,918	\$274,946	\$0	\$2,726,885	-\$729,343	\$778.89	136.5%
Jan-18	0	\$0	\$439,750	\$1,303	\$804	\$0	\$0	\$441,857	-\$441,857	\$0.00	0.0%
Feb-18	0	\$0	\$247,831	\$392	\$0	\$0	\$0	\$248,223	-\$248,223	\$0.00	0.0%
Mar-18	0	\$0	-\$3,860	\$0	\$0	\$0	\$0	-\$3,860	\$3,860	\$0.00	0.0%
Apr-18	0	\$0	-\$145,069	\$0	\$0	\$0	\$0	-\$145,069	\$145,069	\$0.00	0.0%
May-18	0	\$0	-\$10,273	\$0	\$0	\$0	\$0	-\$10,273	\$10,273	\$0.00	0.0%
Jun-18	0	\$0	\$4,325	\$0	\$0	\$0	\$0	\$4,325	-\$4,325	\$0.00	0.0%
Jul-18	0	\$0	-\$21,403	\$0	\$0	\$0	\$0	-\$21,403	\$21,403	\$0.00	0.0%
Aug-18	0	\$0	-\$60,627	\$0	\$0	\$0	\$0	-\$60,627	\$60,627	\$0.00	0.0%
Sep-18	0	\$0	\$17,877	\$0	\$0	\$0	\$0	\$17,877	-\$17,877	\$0.00	0.0%
Oct-18	0	\$0	\$47,414	\$0	\$0	\$0	\$0	\$47,414	-\$47,414	\$0.00	0.0%
Nov-18	0	\$0	\$78,484	\$0	\$0	\$0	\$0	\$78,484	-\$78,484	\$0.00	0.0%
Dec-18	0	\$0	\$23,792	\$0	\$0	\$0	\$0	\$23,792	-\$23,792	\$0.00	0.0%
Jan-19	0	\$0	\$2,722	\$0	\$0	\$0	\$0	\$2,722	-\$2,722	\$0.00	0.0%
Feb-19	0	\$0	\$290	\$0	\$0	\$0	\$0	\$290	-\$290	\$0.00	0.0%
Mar-19	0	\$0	\$858	\$0	\$0	\$0	\$0	\$858	-\$858	\$0.00	0.0%
Apr-19	0	\$0	\$8,212	\$0	\$0	\$0	\$0	\$8,212	-\$8,212	\$0.00	0.0%
May-19	0	\$0	\$119	\$0	\$0	\$0	\$0	\$119	-\$119	\$0.00	0.0%
Jun-19	0	\$0	\$9,988	\$0	\$0	\$0	\$0	\$9,988	-\$9,988	\$0.00	0.0%
Jul-19	0	\$0	\$51,413	\$0	\$0	\$0	\$0	\$51,413	-\$51,413	\$0.00	0.0%
Aug-19	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0.00	0.0%
Sep-19	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0.00	0.0%
2015	4,187	\$42,875,569	\$22,258,882	\$13,681,568	\$10,102,432	\$4,546,489	-\$65,205	\$50,524,166	-\$7,648,597	\$915.11	117.8%
2016	3,630	\$42,279,343	\$20,642,331	\$12,289,322	\$9,665,156	\$3,734,142	-\$848,093	\$45,482,858	-\$3,203,514	\$958.48	107.6%
2017	3,168	\$41,012,620	\$17,106,236	\$11,171,550	\$9,917,078	\$3,320,579	-\$77,202	\$41,438,241	-\$425,621	\$1,002.60	101.0%
2018	0	\$0	\$618,241	\$1,695	\$804	\$0	\$0	\$620,740	-\$620,740	\$0.00	0.0%
2019 YTD	0	\$0	\$73,602	\$0	\$0	\$0	\$0	\$73,602	-\$73,602	\$0.00	0.0%
Current 12 Months	0	\$0	\$223,292	\$0	\$0	\$0	\$0	\$223,292	-\$223,292	#DIV/0!	100.0%

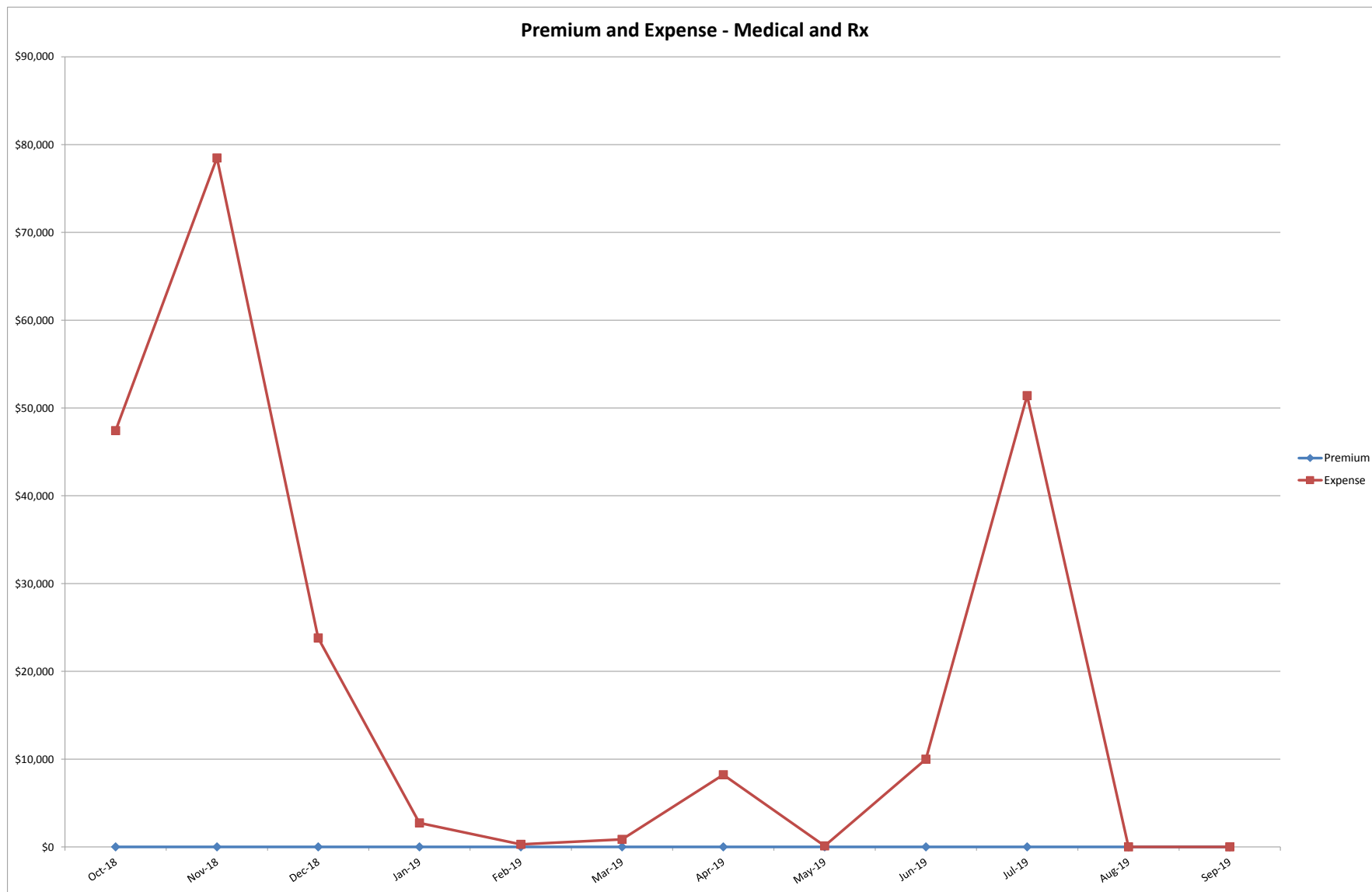
Data Sources:

Enrollment & Premium: Hourglass; Medical Claims & Capitation: Anthem CIL, Anthem CLR, Anthem MDP; Rx Claims: Envelope, EmpiRx, Anthem MDP; Fixed Cost Schedule: Appendix

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San Joaquin Valley Insurance Authority (SJVIA)
Anthem Blue Cross Premium and Claims Report as of September 2019
County of Fresno - HMO





San Joaquin Valley Insurance Authority (SJVIA)
Anthem Blue Cross Premium and Claims Report as of September 2019
County of Fresno - EPO

MONTH-YEAR	ENROLLED	FUNDING / PREMIUM	CLAIMS EXPENSE					SURPLUS / (DEFICIT)	AVERAGE CLAIM COST PEPM	TOTAL EXPENSE LOSS RATIO
			MEDICAL	RX	FIXED	POOLED CLAIMS	TOTAL EXPENSE			
Jan-17	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0.00	0.0%
Feb-17	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0.00	0.0%
Mar-17	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0.00	0.0%
Apr-17	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0.00	0.0%
May-17	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0.00	0.0%
Jun-17	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0.00	0.0%
Jul-17	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0.00	0.0%
Aug-17	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0.00	0.0%
Sep-17	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0.00	0.0%
Oct-17	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0.00	0.0%
Nov-17	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0.00	0.0%
Dec-17	3,048	\$1,471,887	\$68,189	\$251,226	\$307,056	\$0	\$626,470	\$845,417	\$104.79	42.6%
Jan-18	3,121	\$3,460,514	\$743,187	\$867,858	\$256,733	\$0	\$1,867,779	\$1,592,735	\$516.20	54.0%
Feb-18	3,122	\$3,463,479	\$1,542,101	\$789,699	\$256,816	\$0	\$2,588,616	\$874,863	\$746.89	74.7%
Mar-18	3,112	\$3,451,850	\$3,301,710	\$924,970	\$255,993	\$0	\$4,482,673	-\$1,030,823	\$1,358.19	129.9%
Apr-18	3,087	\$3,423,792	\$2,596,335	\$801,696	\$253,937	\$0	\$3,651,967	-\$228,175	\$1,100.76	106.7%
May-18	3,074	\$3,408,456	\$2,670,046	\$883,943	\$252,867	\$0	\$3,806,856	-\$398,400	\$1,156.14	111.7%
Jun-18	3,098	\$3,429,672	\$2,361,578	\$767,589	\$254,841	\$0	\$3,384,008	\$45,664	\$1,010.06	98.7%
Jul-18	3,101	\$3,429,177	\$2,413,373	\$911,839	\$255,088	-\$29,545	\$3,550,755	-\$121,578	\$1,062.78	103.5%
Aug-18	3,080	\$3,407,283	\$2,623,941	\$946,096	\$253,361	-\$64,707	\$3,758,691	-\$351,408	\$1,138.09	110.3%
Sep-18	3,084	\$3,412,914	\$2,122,966	\$813,696	\$253,690	-\$277,620	\$2,912,732	\$500,182	\$862.21	85.3%
Oct-18	3,080	\$3,405,753	\$2,177,898	\$850,790	\$253,361	-\$8,976	\$3,273,073	\$132,681	\$980.43	96.1%
Nov-18	3,051	\$3,370,639	\$2,299,743	\$823,630	\$250,975	-\$754	\$3,373,595	-\$2,956	\$1,023.47	100.1%
Dec-18	3,076	\$3,562,357	\$2,256,483	\$730,643	\$253,032	\$224	\$3,240,382	\$321,975	\$971.18	91.0%
Jan-19	3,073	\$3,559,246	\$2,604,617	\$879,905	\$294,240	\$0	\$3,778,762	-\$219,516	\$1,133.92	106.2%
Feb-19	3,073	\$3,560,485	\$2,724,566	\$785,480	\$294,240	\$0	\$3,804,286	-\$243,801	\$1,142.22	106.8%
Mar-19	3,062	\$3,544,198	\$3,384,517	\$821,110	\$293,187	\$0	\$4,498,813	-\$954,615	\$1,373.49	126.9%
Apr-19	3,049	\$3,530,743	\$2,630,414	\$901,971	\$291,942	\$0	\$3,824,327	-\$293,583	\$1,158.54	108.3%
May-19	3,059	\$3,541,346	\$2,295,464	\$788,293	\$292,899	\$0	\$3,376,656	\$164,690	\$1,008.09	95.3%
Jun-19	3,060	\$3,545,756	\$2,650,766	\$789,556	\$292,995	\$0	\$3,733,317	-\$187,561	\$1,124.29	105.3%
Jul-19	3,054	\$3,534,380	\$3,391,960	\$823,278	\$292,421	\$0	\$4,507,658	-\$973,278	\$1,380.24	127.5%
Aug-19	3,049	\$3,530,743	\$2,755,785	\$799,532	\$291,942	\$0	\$3,847,258	-\$316,515	\$1,166.06	109.0%
Sep-19	3,046	\$3,255,421	\$2,908,388	\$731,856	\$291,655	\$0	\$3,931,898	-\$676,478	\$1,195.09	120.8%
2015	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0.00	0.0%
2017	3,048	\$1,471,887	\$68,189	\$251,226	\$307,056	\$0	\$626,470	\$845,417	\$104.79	42.6%
2018	3,091	\$41,225,886	\$27,109,361	\$10,112,448	\$3,050,694	-\$381,378	\$39,891,126	\$1,334,760	\$993.38	96.8%
2019 YTD	3,058	\$31,602,319	\$25,346,477	\$7,320,981	\$2,635,519	\$0	\$35,302,977	-\$3,700,657	\$1,186.83	111.7%
Current 12 Months	3,061	\$41,941,069	\$32,080,601	\$9,726,045	\$3,392,887	-\$9,506	\$45,190,026	-\$3,248,957	\$1,137.89	107.7%

Data Sources:

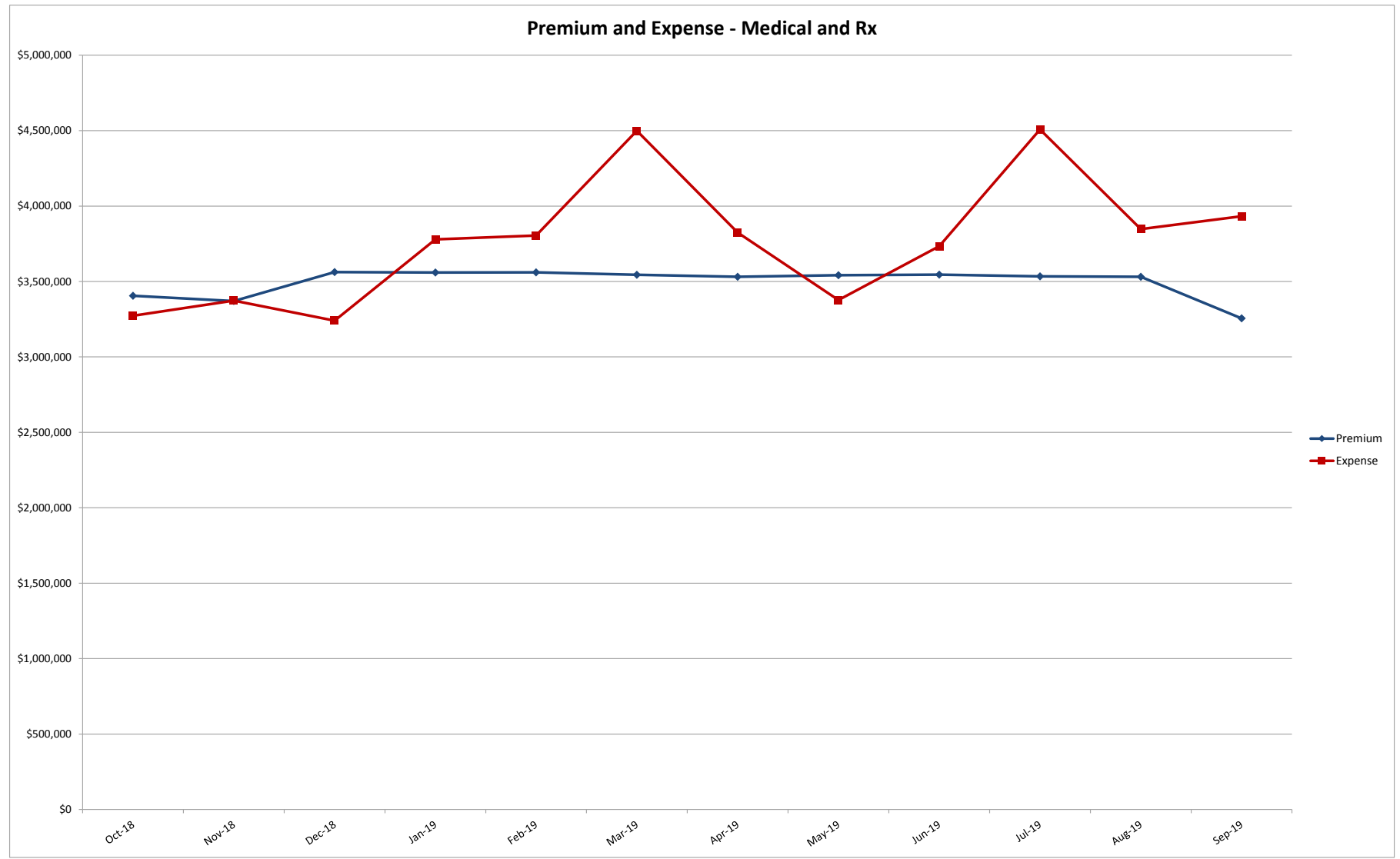
Enrollment & Premium: Hourglass; Medical Claims & Capitation: Anthem CII, Anthem CLR, Anthem MDP; Rx Claims: Enroll, EmpiRx, Anthem MDP; Fixed Cost Schedule: Appendix

Notes:

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2. Pooling Points: HMO = \$400,000 and EPO/PPO/HDHP = \$450,000.
3. EmpiRx PBM replaced Enroll PBM effective 1/1/2018
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San Joaquin Valley Insurance Authority (SJVIA)
Anthem Blue Cross Premium and Claims Report as of September 2019
County of Fresno - EPO





San Joaquin Valley Insurance Authority (SJVIA)
Anthem Blue Cross Premium and Claims Report as of September 2019
County of Fresno - PPO

MONTH-YEAR	ENROLLED	FUNDING / PREMIUM	CLAIMS EXPENSE					SURPLUS / (DEFICIT)	AVERAGE CLAIM COST PEPM	TOTAL EXPENSE LOSS RATIO
			MEDICAL	RX	FIXED	POOLED CLAIMS	TOTAL EXPENSE			
Jan-17	214	\$235,804	\$69,640	\$49,735	\$14,160	\$0	\$133,535	\$102,268	\$557.83	56.6%
Feb-17	216	\$237,336	\$90,222	\$65,802	\$14,293	\$0	\$170,316	\$67,019	\$722.33	71.8%
Mar-17	220	\$238,848	\$181,844	\$68,720	\$14,557	\$0	\$265,121	-\$26,274	\$1,138.93	111.0%
Apr-17	201	\$216,533	\$368,860	\$44,582	\$13,300	\$0	\$426,742	-\$210,210	\$2,056.93	197.1%
May-17	174	\$195,554	\$280,427	\$71,203	\$11,514	\$0	\$363,144	-\$167,590	\$2,020.86	185.7%
Jun-17	185	\$209,687	\$228,069	\$56,514	\$12,241	\$0	\$296,825	-\$87,138	\$1,538.29	141.6%
Jul-17	184	\$207,686	\$128,962	\$48,594	\$12,175	\$0	\$189,731	\$17,955	\$964.98	91.4%
Aug-17	219	\$232,775	\$137,094	\$76,042	\$14,491	\$0	\$227,627	\$5,148	\$973.22	97.8%
Sep-17	219	\$235,182	\$65,554	\$50,263	\$14,491	\$0	\$130,309	\$104,873	\$528.85	55.4%
Oct-17	219	\$236,370	\$118,638	\$71,444	\$14,491	\$0	\$204,573	\$31,796	\$867.95	86.5%
Nov-17	219	\$238,773	\$70,677	\$70,234	\$14,491	\$0	\$155,402	\$83,371	\$643.43	65.1%
Dec-17	168	\$210,141	\$48,983	\$64,385	\$11,117	\$0	\$124,485	\$85,656	\$674.81	59.2%
Jan-18	150	\$195,387	\$45,533	\$41,798	\$10,202	\$0	\$97,532	\$97,854	\$582.20	49.9%
Feb-18	144	\$186,014	\$47,407	\$28,716	\$9,793	\$0	\$85,917	\$100,097	\$528.63	46.2%
Mar-18	145	\$186,862	\$152,687	\$43,074	\$9,861	\$0	\$205,622	-\$18,760	\$1,350.07	110.0%
Apr-18	141	\$182,600	\$64,231	\$49,226	\$9,589	\$0	\$123,047	\$59,553	\$804.66	67.4%
May-18	142	\$183,448	\$57,573	\$48,168	\$9,657	\$0	\$115,399	\$68,049	\$744.66	62.9%
Jun-18	140	\$179,930	\$69,671	\$37,164	\$9,521	\$0	\$116,356	\$63,574	\$763.10	64.7%
Jul-18	137	\$176,227	\$44,881	\$54,967	\$9,317	\$0	\$109,165	\$67,062	\$728.81	61.9%
Aug-18	138	\$177,364	\$201,540	\$43,465	\$9,385	\$0	\$254,391	-\$77,026	\$1,775.40	143.4%
Sep-18	136	\$175,089	\$41,726	\$26,754	\$9,249	\$0	\$77,729	\$97,360	\$503.53	44.4%
Oct-18	137	\$173,951	\$51,742	\$49,194	\$9,317	\$0	\$110,253	\$63,697	\$736.76	63.4%
Nov-18	133	\$171,207	\$40,985	\$42,717	\$9,045	\$0	\$92,747	\$78,459	\$629.34	54.2%
Dec-18	118	\$157,800	\$38,146	\$32,683	\$8,025	\$0	\$78,854	\$78,946	\$600.25	50.0%
Jan-19	117	\$157,417	\$66,705	\$37,320	\$9,482	\$0	\$113,506	\$43,911	\$889.10	72.1%
Feb-19	119	\$160,304	\$42,263	\$25,965	\$9,644	\$0	\$77,872	\$82,432	\$573.34	48.6%
Mar-19	117	\$157,910	\$31,442	\$33,770	\$9,482	\$0	\$74,694	\$83,215	\$557.37	47.3%
Apr-19	115	\$153,009	\$70,633	\$30,418	\$9,320	\$0	\$110,371	\$42,638	\$878.71	72.1%
May-19	115	\$153,900	-\$7,775	\$36,459	\$9,320	\$0	\$38,003	\$115,897	\$249.42	24.7%
Jun-19	115	\$153,102	\$55,699	\$25,717	\$9,320	\$0	\$90,736	\$62,366	\$707.97	59.3%
Jul-19	115	\$153,102	\$63,868	\$29,255	\$9,320	\$0	\$102,442	\$50,660	\$809.76	66.9%
Aug-19	115	\$153,102	\$57,549	\$23,960	\$9,320	\$0	\$90,829	\$62,273	\$708.77	59.3%
Sep-19	115	\$142,210	\$47,280	\$22,624	\$9,320	\$0	\$79,223	\$62,987	\$607.86	55.7%
2015	190	\$2,293,437	\$1,703,479	\$775,586	\$160,307	\$0	\$2,639,372	-\$345,935	\$1,087.31	115.1%
2016	189	\$2,405,918	\$1,528,953	\$719,323	\$146,141	\$0	\$2,394,417	\$11,501	\$993.05	99.5%
2017	203	\$2,694,687	\$1,788,970	\$737,518	\$161,322	\$0	\$2,687,811	\$6,876	\$1,036.30	99.7%
2018	138	\$2,145,877	\$856,122	\$497,925	\$112,965	\$0	\$1,467,011	\$678,866	\$815.20	68.4%
2019 YTD	116	\$1,384,056	\$427,665	\$265,487	\$84,525	\$0	\$777,676	\$606,380	\$664.58	56.2%
Current 12 Months	119	\$1,887,013	\$558,538	\$390,081	\$110,913	\$0	\$1,059,531	\$827,482	\$662.91	56.1%

Data Sources:

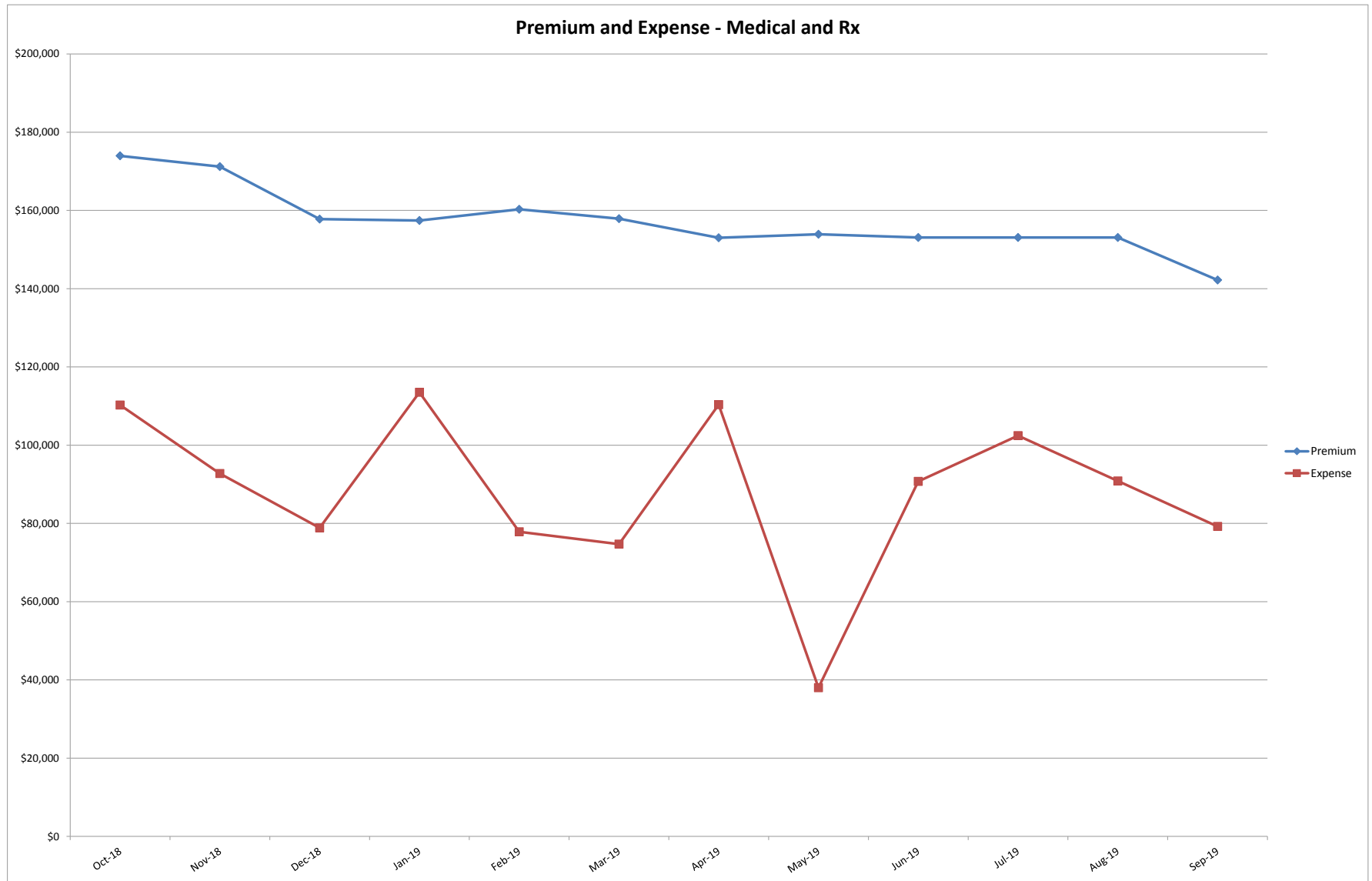
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3. EmpiRx PBM replaced Envelope PBM effective 1/1/2018
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San Joaquin Valley Insurance Authority (SJVIA)
Anthem Blue Cross Premium and Claims Report as of September 2019
County of Fresno - PPO





San Joaquin Valley Insurance Authority (SJVIA)
Anthem Blue Cross Premium and Claims Report as of September 2019
County of Fresno - HDHP

MONTH-YEAR	ENROLLED	FUNDING / PREMIUM	CLAIMS EXPENSE					SURPLUS / (DEFICIT)	AVERAGE CLAIM COST PEPM	TOTAL EXPENSE LOSS RATIO
			MEDICAL	RX	FIXED	POOLED CLAIMS	TOTAL EXPENSE			
Jan-17	742	\$519,928	\$300,978	\$45,990	\$49,098	\$0	\$396,066	\$123,862	\$467.61	76.2%
Feb-17	746	\$523,429	\$389,747	\$50,969	\$49,363	\$0	\$490,079	\$33,351	\$590.77	93.6%
Mar-17	736	\$516,317	\$291,413	\$120,319	\$48,701	\$0	\$460,433	\$55,884	\$559.42	89.2%
Apr-17	714	\$500,909	\$416,805	\$83,704	\$47,245	\$0	\$547,754	-\$46,846	\$700.99	109.4%
May-17	761	\$531,698	\$183,809	\$116,820	\$50,355	\$0	\$350,984	\$180,714	\$395.04	66.0%
Jun-17	795	\$554,691	\$337,083	\$140,573	\$52,605	\$0	\$530,261	\$24,430	\$600.83	95.6%
Jul-17	810	\$561,522	\$339,393	\$128,974	\$53,598	\$0	\$521,965	\$39,558	\$578.23	93.0%
Aug-17	771	\$533,044	\$308,915	\$143,600	\$51,017	\$0	\$503,532	\$29,512	\$586.92	94.5%
Sep-17	775	\$534,906	\$277,334	\$180,282	\$51,282	\$0	\$508,898	\$26,008	\$590.47	95.1%
Oct-17	771	\$531,342	\$288,740	\$152,604	\$51,017	\$0	\$492,361	\$38,981	\$572.43	92.7%
Nov-17	781	\$534,747	\$163,273	\$141,858	\$51,679	\$0	\$356,810	\$177,937	\$390.69	66.7%
Dec-17	721	\$526,419	\$314,263	\$154,140	\$47,709	\$0	\$516,112	\$10,307	\$649.66	98.0%
Jan-18	743	\$560,552	\$115,112	\$70,628	\$50,531	\$0	\$236,271	\$324,281	\$249.99	42.1%
Feb-18	747	\$565,458	\$230,485	\$67,174	\$50,803	\$0	\$348,462	\$216,995	\$398.47	61.6%
Mar-18	751	\$567,983	\$466,698	\$113,171	\$51,076	\$0	\$630,945	-\$62,962	\$772.13	111.1%
Apr-18	754	\$570,419	\$226,826	\$95,884	\$51,280	\$0	\$373,990	\$196,430	\$428.00	65.6%
May-18	761	\$573,653	\$297,446	\$117,765	\$51,756	\$0	\$466,967	\$106,686	\$545.61	81.4%
Jun-18	768	\$576,408	\$149,209	\$143,545	\$52,232	\$0	\$344,986	\$231,423	\$381.19	59.9%
Jul-18	789	\$588,444	\$282,745	\$120,962	\$53,660	\$0	\$457,367	\$131,077	\$511.67	77.7%
Aug-18	788	\$585,742	\$211,205	\$131,894	\$53,592	\$0	\$396,691	\$189,051	\$435.40	67.7%
Sep-18	779	\$577,583	\$184,857	\$107,623	\$52,980	\$0	\$345,460	\$232,123	\$375.46	59.8%
Oct-18	792	\$585,988	\$325,055	\$121,128	\$53,864	\$0	\$500,046	\$85,941	\$563.36	85.3%
Nov-18	797	\$588,330	\$245,674	\$129,729	\$54,204	\$0	\$429,607	\$158,724	\$471.02	73.0%
Dec-18	756	\$581,569	\$398,684	\$134,661	\$51,416	\$0	\$584,760	-\$3,191	\$705.48	100.5%
Jan-19	767	\$592,215	\$140,668	\$53,249	\$62,158	\$0	\$256,075	\$336,140	\$252.83	43.2%
Feb-19	766	\$588,029	\$75,431	\$68,192	\$62,077	\$0	\$205,699	\$382,330	\$187.50	35.0%
Mar-19	760	\$583,989	\$121,883	\$93,115	\$61,590	\$0	\$276,589	\$307,401	\$282.89	47.4%
Apr-19	765	\$584,542	\$239,910	\$80,465	\$61,996	\$0	\$382,371	\$202,171	\$418.79	65.4%
May-19	763	\$580,411	\$200,544	\$105,095	\$61,834	\$0	\$367,473	\$212,938	\$400.58	63.3%
Jun-19	771	\$583,516	\$100,526	\$77,505	\$62,482	\$0	\$240,513	\$343,003	\$230.91	41.2%
Jul-19	760	\$577,873	\$372,282	\$97,999	\$61,590	\$0	\$531,871	\$46,002	\$618.79	92.0%
Aug-19	747	\$566,470	\$172,867	\$91,334	\$60,537	\$0	\$324,738	\$241,732	\$353.68	57.3%
Sep-19	744	\$531,327	\$98,947	\$67,031	\$60,294	\$0	\$226,271	\$305,056	\$223.09	42.6%
2015	583	\$4,355,365	\$2,279,638	\$934,209	\$492,240	\$0	\$3,706,087	\$649,277	\$459.06	85.1%
2016	653	\$4,963,904	\$3,412,175	\$1,178,839	\$513,858	\$0	\$5,104,872	-\$133,182	\$585.59	102.8%
2017	760	\$6,368,952	\$3,611,753	\$1,459,833	\$603,669	\$0	\$5,675,255	\$693,697	\$555.91	89.1%
2018	769	\$6,922,130	\$3,133,995	\$1,354,164	\$627,392	\$0	\$5,115,551	\$1,806,579	\$486.52	73.9%
2019 YTD	760	\$5,188,373	\$1,523,060	\$733,985	\$554,557	\$0	\$2,811,601	\$2,376,772	\$329.83	54.2%
Current 12 Months	766	\$6,944,260	\$2,492,472	\$1,119,502	\$714,040	\$0	\$4,326,014	\$2,618,246	\$393.12	62.3%

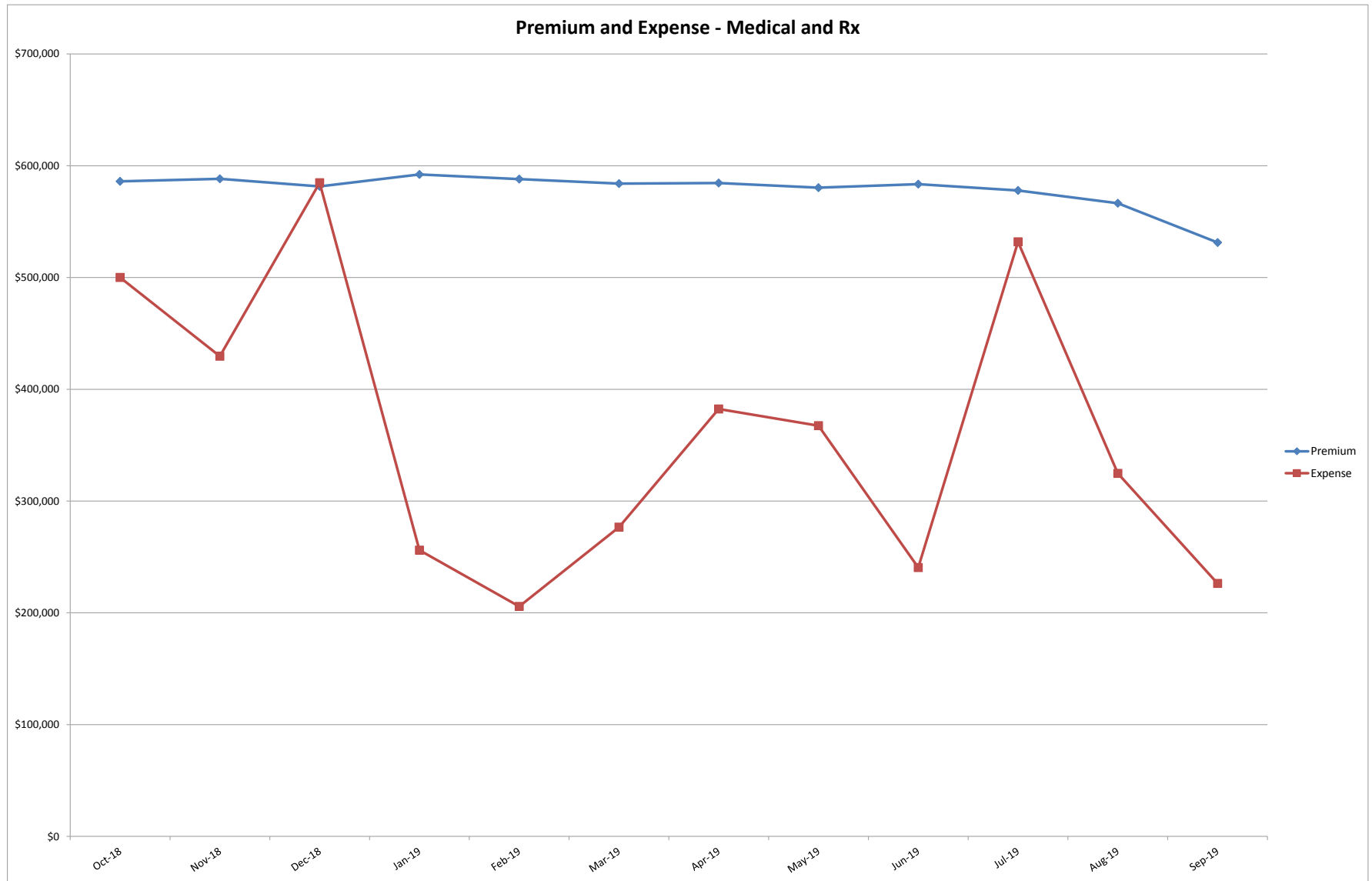
Data Sources:

Enrollment & Premium: Hourglass; Medical Claims & Capitation: Anthem CIL, Anthem CLR, Anthem MDP; Rx Claims: Envelope, EmpiRx, Anthem MDP; Fixed Cost Schedule: Appendix

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San Joaquin Valley Insurance Authority (SJVIA)
Anthem Blue Cross Premium and Claims Report as of September 2019
County of Fresno - HDHP





San Joaquin Valley Insurance Authority (SJVIA)
Anthem Blue Cross Premium and Claims Report as of September 2019
County of Tulare - All Medical

MONTH-YEAR	ENROLLED	FUNDING / PREMIUM	CLAIMS EXPENSE						SURPLUS / (DEFICIT)	AVERAGE CLAIM COST PEPM	TOTAL EXPENSE LOSS RATIO
			MEDICAL	CAPITATION	RX	FIXED	POOLED CLAIMS	TOTAL EXPENSE			
Jan-17	2,824	\$2,110,561	\$1,261,565	\$0	\$595,840	\$186,885	\$0	\$2,044,291	\$66,271	\$657.72	96.9%
Feb-17	2,814	\$2,107,318	\$1,097,844	\$0	\$536,533	\$186,224	\$0	\$1,820,600	\$286,718	\$580.80	86.4%
Mar-17	2,825	\$2,117,411	\$924,126	\$0	\$571,707	\$186,951	\$0	\$1,682,784	\$434,626	\$529.50	79.5%
Apr-17	2,816	\$2,110,125	\$1,032,065	\$0	\$530,547	\$186,356	\$0	\$1,748,968	\$361,157	\$554.90	82.9%
May-17	2,829	\$2,117,202	\$1,311,089	\$0	\$522,523	\$187,216	\$0	\$2,020,829	\$96,374	\$648.15	95.4%
Jun-17	2,822	\$2,109,284	\$1,799,781	\$0	\$635,657	\$186,753	\$0	\$2,622,191	-\$512,907	\$863.02	124.3%
Jul-17	2,851	\$2,128,126	\$1,001,046	\$0	\$566,630	\$188,672	\$0	\$1,756,347	\$371,779	\$549.87	82.5%
Aug-17	2,853	\$2,132,516	\$1,440,700	\$0	\$703,354	\$188,804	\$0	\$2,332,858	-\$200,342	\$751.51	109.4%
Sep-17	2,866	\$2,135,392	\$967,631	\$0	\$718,838	\$189,664	\$0	\$1,876,134	\$259,259	\$588.44	87.9%
Oct-17	2,861	\$2,133,836	\$1,558,013	\$0	\$666,865	\$189,334	\$0	\$2,414,211	-\$280,375	\$777.66	113.1%
Nov-17	2,874	\$2,142,485	\$1,378,838	\$0	\$573,506	\$190,194	\$0	\$2,142,538	-\$53	\$679.31	100.0%
Dec-17	2,890	\$2,151,414	\$1,175,436	\$0	\$691,203	\$191,252	\$0	\$2,057,892	\$93,522	\$645.90	95.7%
Jan-18	2,906	\$2,233,054	\$1,310,194	\$0	\$606,636	\$191,839	\$0	\$2,108,670	\$124,385	\$659.61	94.4%
Feb-18	2,902	\$2,231,530	\$819,668	\$0	\$626,710	\$191,575	\$0	\$1,637,953	\$593,577	\$498.41	73.4%
Mar-18	2,905	\$2,232,260	\$1,146,872	\$0	\$645,723	\$191,773	\$0	\$1,984,368	\$247,891	\$617.07	88.9%
Apr-18	2,914	\$2,235,436	\$1,016,951	\$0	\$635,692	\$192,367	\$0	\$1,845,010	\$390,426	\$567.14	82.5%
May-18	2,949	\$2,253,600	\$1,079,799	\$0	\$656,547	\$194,678	\$0	\$1,931,024	\$322,576	\$588.79	85.7%
Jun-18	2,949	\$2,250,990	\$992,192	\$0	\$648,064	\$194,678	\$0	\$1,834,933	\$416,056	\$556.21	81.5%
Jul-18	2,938	\$2,241,803	\$1,160,748	\$0	\$672,851	\$193,937	\$0	\$2,027,537	\$214,266	\$624.10	90.4%
Aug-18	2,951	\$2,251,754	\$1,124,526	\$0	\$693,695	\$194,796	\$0	\$2,013,017	\$238,738	\$616.14	89.4%
Sep-18	2,936	\$2,239,926	\$959,752	\$0	\$681,913	\$193,805	\$0	\$1,835,470	\$404,456	\$559.15	81.9%
Oct-18	2,957	\$2,253,323	\$1,585,019	\$0	\$626,084	\$195,192	\$0	\$2,406,295	-\$152,972	\$747.75	106.8%
Nov-18	2,980	\$2,264,462	\$1,540,176	\$0	\$571,677	\$196,710	-\$161,954	\$2,146,609	\$117,853	\$654.33	94.8%
Dec-18	2,985	\$2,264,868	\$1,094,397	\$0	\$596,673	\$197,040	-\$7,972	\$1,880,138	\$384,730	\$563.85	83.0%
Jan-19	3,003	\$2,333,355	\$1,415,408	\$0	\$629,123	\$221,802	\$0	\$2,266,333	\$67,022	\$680.83	97.1%
Feb-19	2,994	\$2,326,510	\$1,152,990	\$0	\$640,750	\$221,137	\$0	\$2,014,876	\$311,634	\$599.11	86.6%
Mar-19	3,016	\$2,342,718	\$1,454,749	\$0	\$653,340	\$222,762	\$0	\$2,330,850	\$11,868	\$698.97	99.5%
Apr-19	3,023	\$2,350,999	\$1,504,938	\$0	\$714,212	\$223,279	\$0	\$2,442,429	-\$91,430	\$734.09	103.9%
May-19	3,030	\$2,356,830	\$1,415,816	\$0	\$673,608	\$223,796	\$0	\$2,313,220	\$43,610	\$689.58	98.1%
Jun-19	3,009	\$2,341,334	\$1,197,137	\$0	\$579,623	\$222,245	\$0	\$1,999,004	\$342,330	\$590.48	85.4%
Jul-19	3,013	\$2,339,129	\$1,236,970	\$0	\$778,789	\$222,540	\$0	\$2,238,299	\$100,830	\$669.02	95.7%
Aug-19	3,027	\$2,349,930	\$1,478,411	\$0	\$637,468	\$223,574	\$0	\$2,339,453	\$10,477	\$699.00	99.6%
Sep-19	3,004	\$2,328,412	\$1,326,398	\$0	\$589,285	\$221,875	\$0	\$2,137,559	\$190,852	\$637.71	91.8%
2015	2,774	\$21,998,530	\$14,444,032	\$947,923	\$5,874,825	\$2,418,678	-\$219,668	\$23,465,790	-\$1,467,260	\$632.35	106.7%
2016	2,805	\$23,218,029	\$13,512,978	\$873,682	\$6,565,449	\$2,246,924	\$0	\$23,199,033	\$18,996	\$622.48	99.9%
2017	2,844	\$25,495,670	\$14,948,135	\$0	\$7,313,202	\$2,258,305	\$0	\$24,519,642	\$976,028	\$652.35	96.2%
2018	2,939	\$26,953,007	\$13,830,294	\$0	\$7,662,266	\$2,328,390	-\$169,926	\$23,651,024	\$3,301,982	\$604.52	87.7%
2019 YTD	3,013	\$21,069,216	\$12,182,818	\$0	\$5,896,197	\$2,003,009	\$0	\$20,082,024	\$987,192	\$666.65	95.3%
Current 12 Months	3,003	\$27,851,869	\$16,402,410	\$0	\$7,690,632	\$2,591,951	-\$169,926	\$26,515,066	\$1,336,803	\$663.78	95.2%

Data Sources:

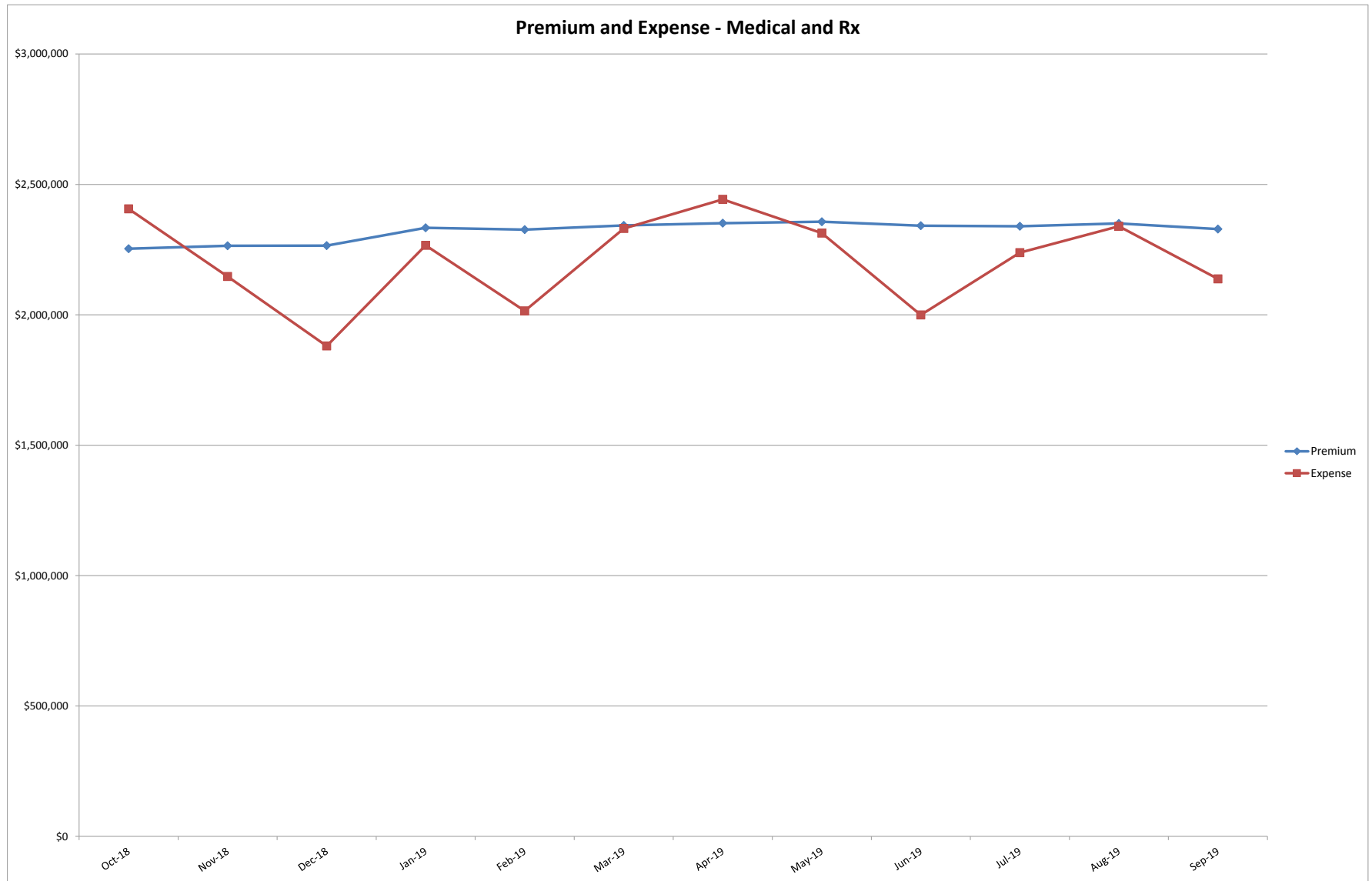
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San Joaquin Valley Insurance Authority (SJVIA)
Anthem Blue Cross Premium and Claims Report as of September 2019
County of Tulare - All Medical





San Joaquin Valley Insurance Authority (SJVIA)
Anthem Blue Cross Premium and Claims Report as of September 2019
County of Tulare - HMO

MONTH-YEAR	ENROLLED	FUNDING / PREMIUM	CLAIMS EXPENSE						SURPLUS / (DEFICIT)	AVERAGE CLAIM COST PEPM	TOTAL EXPENSE LOSS RATIO
			MEDICAL	CAPITATION	RX	FIXED	POOLED CLAIMS	TOTAL EXPENSE			
Jan-17	1	\$1,593	\$197,867	\$0	\$19	\$87	\$0	\$197,973	-\$196,381	\$197,885.93	12429.6%
Feb-17	1	\$1,593	\$60,175	\$0	\$0	\$87	\$0	\$60,262	-\$58,669	\$60,174.67	3783.5%
Mar-17	1	\$1,593	\$20,631	\$0	\$0	\$87	\$0	\$20,719	-\$19,126	\$20,631.20	1300.8%
Apr-17	1	\$1,593	\$5,165	\$0	\$0	\$87	\$0	\$5,252	-\$3,660	\$5,165.00	329.8%
May-17	1	\$1,593	-\$8,486	\$0	\$0	\$87	\$0	-\$8,398	\$9,991	-\$8,485.61	-527.3%
Jun-17	1	\$1,593	\$5,438	\$0	\$0	\$87	\$0	\$5,526	-\$3,933	\$5,438.37	346.9%
Jul-17	1	\$1,593	-\$2,965	\$0	\$0	\$87	\$0	-\$2,878	\$4,471	-\$2,965.34	-180.7%
Aug-17	1	\$1,593	\$0	\$0	\$0	\$87	\$0	\$87	\$1,505	\$0.00	5.5%
Sep-17	1	\$1,593	\$696	\$0	\$0	\$87	\$0	\$783	\$809	\$696.00	49.2%
Oct-17	1	\$1,593	-\$5,875	\$0	\$0	\$87	\$0	-\$5,788	\$7,380	-\$5,875.00	-363.4%
Nov-17	1	\$1,593	\$39	\$0	\$0	\$87	\$0	\$126	\$1,466	\$39.00	7.9%
Dec-17	1	\$1,593	-\$754	\$0	\$0	\$87	\$0	-\$667	\$2,259	-\$754.00	-41.9%
Jan-18	1	\$1,593	\$0	\$0	\$0	\$80	\$0	\$80	\$1,513	\$0.00	5.0%
Feb-18	1	\$1,593	\$0	\$0	\$0	\$80	\$0	\$80	\$1,513	\$0.00	5.0%
Mar-18	1	\$1,593	\$0	\$0	\$0	\$80	\$0	\$80	\$1,513	\$0.00	5.0%
Apr-18	1	\$1,593	\$2,160	\$0	\$0	\$80	\$0	\$2,240	-\$648	\$2,160.00	140.7%
May-18	1	\$1,593	-\$1,326	\$0	\$0	\$80	\$0	-\$1,246	\$2,839	-\$1,326.00	-78.2%
Jun-18	1	\$1,593	\$0	\$0	\$0	\$80	\$0	\$80	\$1,513	\$0.00	5.0%
Jul-18	0	\$0	-\$20	\$0	\$0	\$0	\$0	-\$20	\$20	\$0.00	0.0%
Aug-18	0	\$0	\$5,911	\$0	\$0	\$0	\$0	\$5,911	-\$5,911	\$0.00	0.0%
Sep-18	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0.00	0.0%
Oct-18	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0.00	0.0%
Nov-18	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0.00	0.0%
Dec-18	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0.00	0.0%
Jan-19	0	\$0	-\$393	\$0	\$0	\$0	\$0	-\$393	\$393	\$0.00	0.0%
Feb-19	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0.00	0.0%
Mar-19	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0.00	0.0%
Apr-19	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0.00	0.0%
May-19	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0.00	0.0%
Jun-19	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0.00	0.0%
Jul-19	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0.00	0.0%
Aug-19	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0.00	0.0%
Sep-19	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0.00	0.0%
2015	324	\$3,113,449	\$2,576,592	\$947,923	\$596,111	\$351,916	-\$219,668	\$4,252,873	-\$1,139,424	\$1,003.07	136.6%
2016	292	\$3,189,435	\$1,369,824	\$873,682	\$894,540	\$300,484	\$0	\$3,438,530	-\$249,094	\$895.31	107.8%
2017	1	\$19,113	\$271,932	\$0	\$19	\$1,048	\$0	\$272,998	-\$253,885	\$22,662.52	1428.3%
2018	1	\$9,557	\$6,725	\$0	\$0	\$482	\$0	\$7,207	\$2,350	\$1,120.83	75.4%
2019 YTD	0	\$0	-\$393	\$0	\$0	\$0	\$0	-\$393	\$393	\$0.00	0.0%
Current 12 Months	0	\$0	-\$393	\$0	\$0	\$0	\$0	-\$393	\$393	#DIV/0!	100.0%

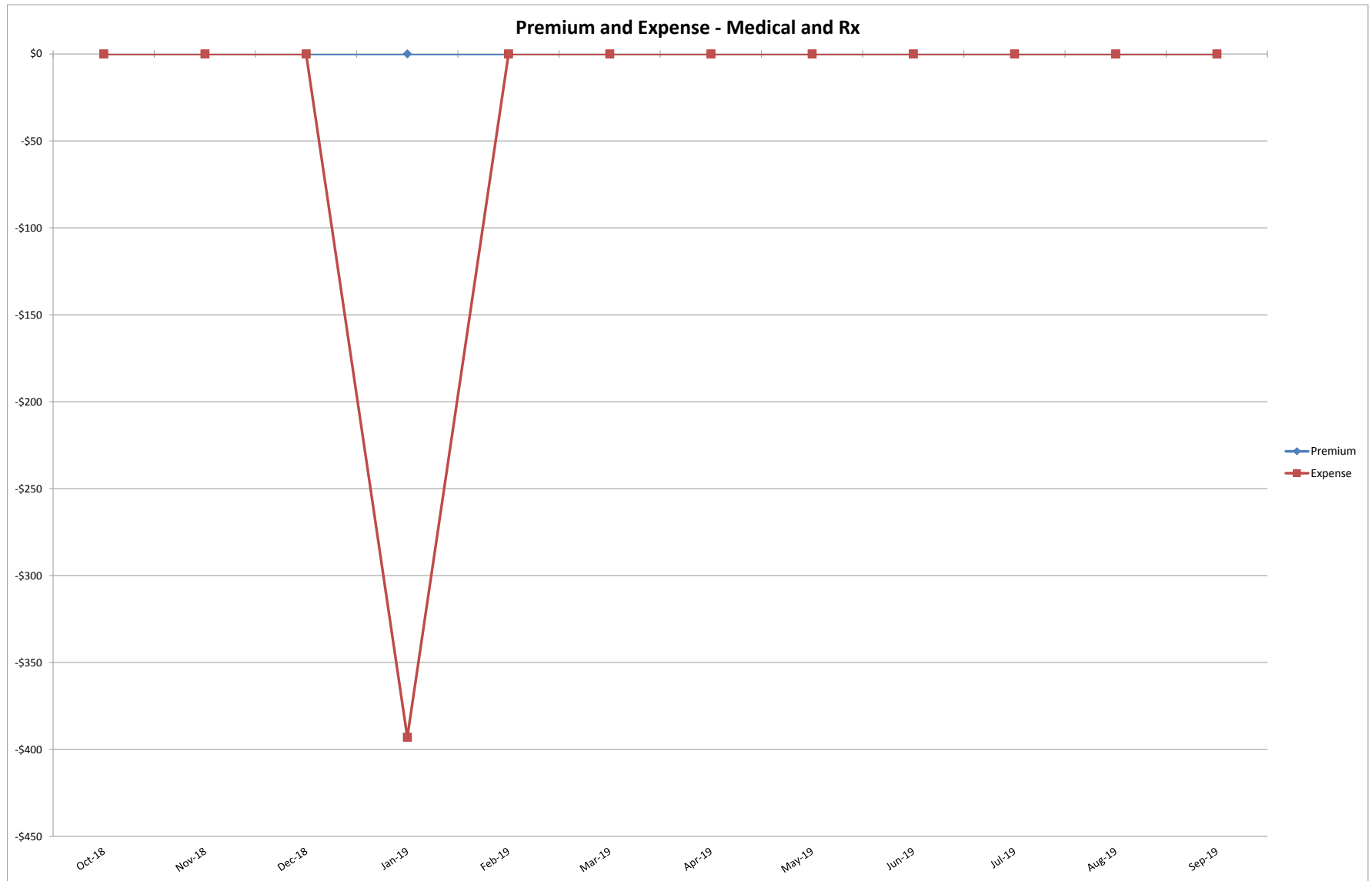
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Anthem Blue Cross Premium and Claims Report as of September 2019
County of Tulare - HMO





San Joaquin Valley Insurance Authority (SJVIA)
Anthem Blue Cross Premium and Claims Report as of September 2019
County of Tulare - PPO

MONTH-YEAR	ENROLLED	FUNDING / PREMIUM	CLAIMS EXPENSE					SURPLUS / (DEFICIT)	AVERAGE CLAIM COST PEPM	TOTAL EXPENSE LOSS RATIO
			MEDICAL	RX	FIXED	POOLED CLAIMS	TOTAL EXPENSE			
Jan-17	2,785	\$2,083,764	\$1,063,327	\$595,773	\$184,283	\$0	\$1,843,383	\$240,381	\$595.73	88.5%
Feb-17	2,774	\$2,079,970	\$1,037,311	\$536,528	\$183,556	\$0	\$1,757,394	\$322,576	\$567.35	84.5%
Mar-17	2,785	\$2,090,062	\$903,425	\$571,682	\$184,283	\$0	\$1,659,390	\$430,672	\$529.66	79.4%
Apr-17	2,777	\$2,083,327	\$1,025,542	\$529,915	\$183,754	\$0	\$1,739,211	\$344,117	\$560.12	83.5%
May-17	2,790	\$2,090,405	\$1,317,845	\$522,476	\$184,614	\$0	\$2,024,935	\$65,470	\$659.61	96.9%
Jun-17	2,783	\$2,082,487	\$1,790,162	\$635,565	\$184,151	\$0	\$2,609,878	-\$527,391	\$871.62	125.3%
Jul-17	2,812	\$2,101,329	\$1,002,601	\$566,607	\$186,070	\$0	\$1,755,278	\$346,051	\$558.04	83.5%
Aug-17	2,814	\$2,105,719	\$1,432,300	\$702,997	\$186,202	\$0	\$2,321,499	-\$215,780	\$758.81	110.2%
Sep-17	2,829	\$2,111,374	\$953,510	\$718,810	\$187,195	\$0	\$1,859,515	\$251,859	\$591.13	88.1%
Oct-17	2,824	\$2,109,268	\$1,558,844	\$666,488	\$186,864	\$0	\$2,412,196	-\$302,928	\$788.01	114.4%
Nov-17	2,837	\$2,117,916	\$1,366,694	\$572,930	\$187,724	\$0	\$2,127,348	-\$9,432	\$683.69	100.4%
Dec-17	2,854	\$2,127,396	\$1,154,716	\$690,647	\$188,849	\$0	\$2,034,212	\$93,184	\$646.59	95.6%
Jan-18	2,868	\$2,207,849	\$1,301,870	\$606,579	\$189,317	\$0	\$2,097,766	\$110,083	\$665.43	95.0%
Feb-18	2,866	\$2,207,463	\$817,799	\$626,710	\$189,185	\$0	\$1,633,694	\$573,769	\$504.02	74.0%
Mar-18	2,869	\$2,208,192	\$1,146,243	\$645,723	\$189,383	\$0	\$1,981,349	\$226,843	\$624.60	89.7%
Apr-18	2,878	\$2,211,369	\$1,009,661	\$635,692	\$189,977	\$0	\$1,835,330	\$376,039	\$571.70	83.0%
May-18	2,913	\$2,229,533	\$1,079,344	\$656,429	\$192,287	\$0	\$1,928,060	\$301,473	\$595.87	86.5%
Jun-18	2,913	\$2,226,922	\$990,129	\$646,900	\$192,287	\$0	\$1,829,316	\$397,606	\$561.97	82.1%
Jul-18	2,902	\$2,218,191	\$1,155,655	\$672,061	\$191,561	\$0	\$2,019,277	\$198,913	\$629.81	91.0%
Aug-18	2,916	\$2,228,711	\$1,112,829	\$692,510	\$192,485	\$0	\$1,997,824	\$230,887	\$619.11	89.6%
Sep-18	2,902	\$2,217,452	\$953,264	\$680,174	\$191,561	\$0	\$1,824,999	\$392,453	\$562.87	82.3%
Oct-18	2,922	\$2,230,849	\$1,567,419	\$625,792	\$192,881	\$0	\$2,386,093	-\$155,244	\$750.59	107.0%
Nov-18	2,944	\$2,241,418	\$1,535,164	\$569,947	\$194,333	-\$161,954	\$2,137,491	\$103,927	\$660.04	95.4%
Dec-18	2,949	\$2,241,427	\$1,087,909	\$596,432	\$194,663	-\$7,972	\$1,871,033	\$370,395	\$568.45	83.5%
Jan-19	2,967	\$2,307,702	\$1,404,320	\$621,137	\$219,143	\$0	\$2,244,600	\$63,103	\$682.66	97.3%
Feb-19	2,959	\$2,301,440	\$1,151,266	\$633,945	\$218,552	\$0	\$2,003,762	\$297,678	\$603.32	87.1%
Mar-19	2,981	\$2,317,648	\$1,449,959	\$644,508	\$220,177	\$0	\$2,314,643	\$3,005	\$702.61	99.9%
Apr-19	2,987	\$2,324,861	\$1,491,916	\$705,323	\$220,620	\$0	\$2,417,859	-\$92,998	\$735.60	104.0%
May-19	2,994	\$2,330,692	\$1,395,867	\$664,765	\$221,137	\$0	\$2,281,769	\$48,922	\$688.25	97.9%
Jun-19	2,975	\$2,316,847	\$1,189,326	\$570,785	\$219,734	\$0	\$1,979,844	\$337,002	\$591.63	85.5%
Jul-19	2,979	\$2,314,641	\$1,213,450	\$770,596	\$220,029	\$0	\$2,204,075	\$110,566	\$666.01	95.2%
Aug-19	2,993	\$2,325,443	\$1,431,542	\$629,281	\$221,063	\$0	\$2,281,886	\$43,557	\$688.55	98.1%
Sep-19	2,971	\$2,304,506	\$1,323,455	\$588,644	\$219,438	\$0	\$2,131,537	\$172,969	\$643.59	92.5%
2015	2,418	\$18,669,716	\$11,692,885	\$5,270,004	\$2,040,045	\$0	\$19,002,934	-\$333,218	\$584.62	101.8%
2016	2,481	\$19,812,211	\$12,016,280	\$5,664,640	\$1,921,524	\$0	\$19,602,444	\$209,767	\$593.96	98.9%
2017	2,805	\$25,183,018	\$14,606,277	\$7,310,416	\$2,227,547	\$0	\$24,144,240	\$1,038,777	\$651.04	95.9%
2018	2,904	\$26,669,376	\$13,757,286	\$7,654,950	\$2,299,920	-\$169,926	\$23,542,231	\$3,127,146	\$609.68	88.3%
2019 YTD	2,978	\$20,843,779	\$12,051,100	\$5,828,983	\$1,979,891	\$0	\$19,859,975	\$983,805	\$667.02	95.3%
Current 12 Months	2,968	\$27,557,473	\$16,241,592	\$7,621,155	\$2,561,769	-\$169,926	\$26,254,590	\$1,302,883	\$665.14	95.3%

Data Sources:

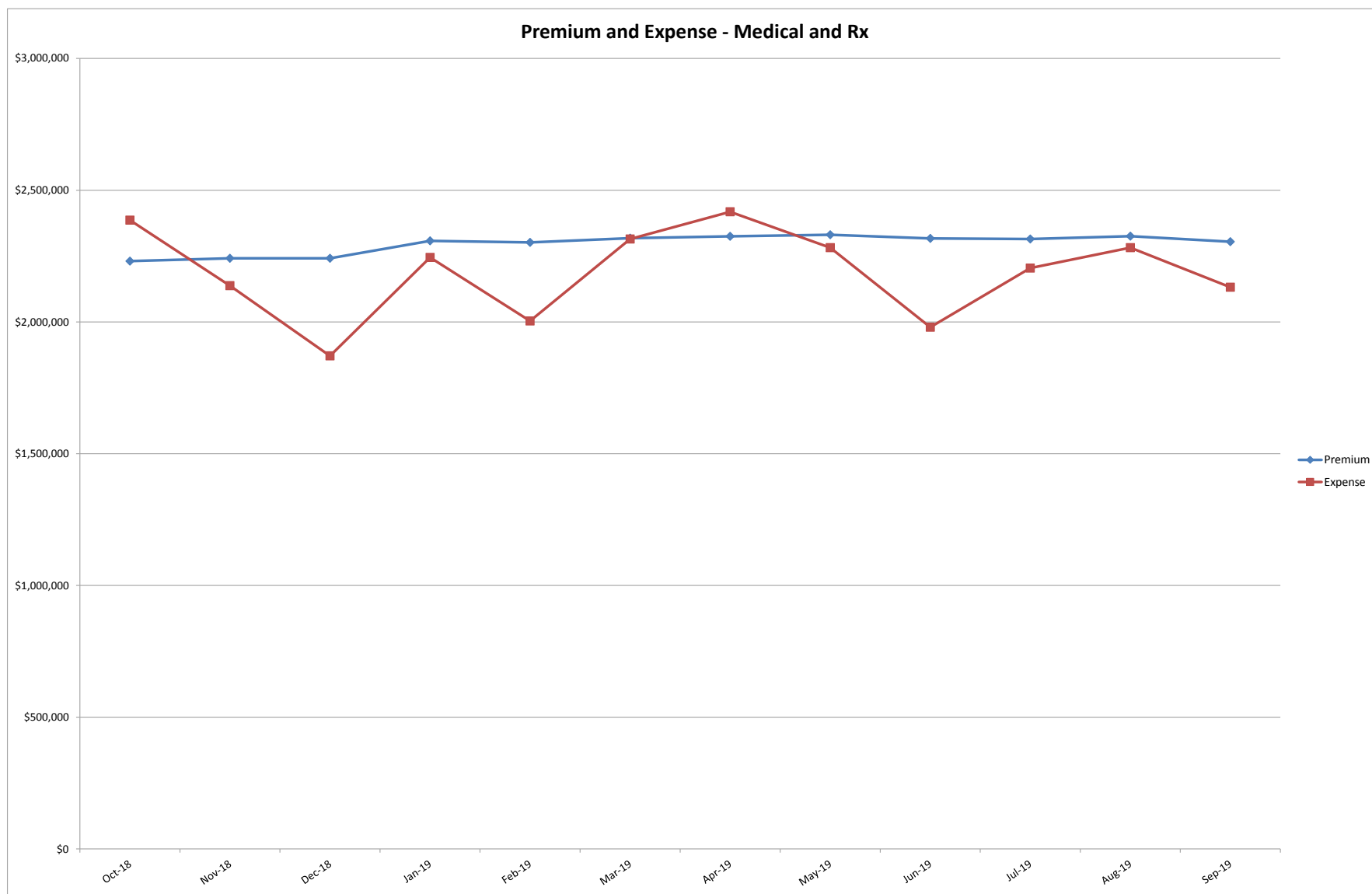
Enrollment & Premium: Hourglass; Medical Claims & Capitation: Anthem CIL, Anthem CLR, Anthem MDP; Rx Claims: Envolve, EmpiRx, Anthem MDP; Fixed Cost Schedule: Appendix

Notes:

1. Fixed Cost Schedule: Appendix
2. Pooling Points: HMO = \$400,000 and EPO/PPO/HDHP = \$450,000.
3. EmpiRx PBM replaced Envolve PBM effective 1/1/2018



San Joaquin Valley Insurance Authority (SJVIA)
Anthem Blue Cross Premium and Claims Report as of September 2019
County of Tulare - PPO





San Joaquin Valley Insurance Authority (SJVIA)
Anthem Blue Cross Premium and Claims Report as of September 2019
County of Tulare - HDHP

MONTH-YEAR	ENROLLED	FUNDING / PREMIUM	CLAIMS EXPENSE					SURPLUS / (DEFICIT)	AVERAGE CLAIM COST PEPM	TOTAL EXPENSE LOSS RATIO
			MEDICAL	RX	FIXED	POOLED CLAIMS	TOTAL EXPENSE			
Jan-17	38	\$25,205	\$371	\$49	\$2,514	\$0	\$2,934	\$22,270	\$11.05	11.6%
Feb-17	39	\$25,755	\$358	\$5	\$2,581	\$0	\$2,944	\$22,812	\$9.31	11.4%
Mar-17	39	\$25,755	\$70	\$25	\$2,581	\$0	\$2,676	\$23,080	\$2.44	10.4%
Apr-17	38	\$25,205	\$1,358	\$632	\$2,514	\$0	\$4,504	\$20,700	\$52.37	17.9%
May-17	38	\$25,205	\$1,730	\$47	\$2,514	\$0	\$4,291	\$20,913	\$46.76	17.0%
Jun-17	38	\$25,205	\$4,181	\$92	\$2,514	\$0	\$6,787	\$18,417	\$112.45	26.9%
Jul-17	38	\$25,205	\$1,410	\$23	\$2,514	\$0	\$3,947	\$21,257	\$37.71	15.7%
Aug-17	38	\$25,205	\$8,400	\$357	\$2,514	\$0	\$11,271	\$13,933	\$230.45	44.7%
Sep-17	36	\$22,426	\$13,425	\$28	\$2,382	\$0	\$15,835	\$6,590	\$373.69	70.6%
Oct-17	36	\$22,976	\$5,044	\$377	\$2,382	\$0	\$7,803	\$15,172	\$150.58	34.0%
Nov-17	36	\$22,976	\$12,105	\$576	\$2,382	\$0	\$15,063	\$7,912	\$352.25	65.6%
Dec-17	35	\$22,425	\$21,474	\$556	\$2,316	\$0	\$24,346	-\$1,921	\$629.43	108.6%
Jan-18	37	\$23,613	\$8,324	\$57	\$2,442	\$0	\$10,823	\$12,789	\$226.51	45.8%
Feb-18	35	\$22,475	\$1,869	\$0	\$2,310	\$0	\$4,179	\$18,295	\$53.40	18.6%
Mar-18	35	\$22,475	\$629	\$0	\$2,310	\$0	\$2,939	\$19,535	\$17.97	13.1%
Apr-18	35	\$22,475	\$5,130	\$0	\$2,310	\$0	\$7,440	\$15,034	\$146.57	33.1%
May-18	35	\$22,475	\$1,781	\$118	\$2,310	\$0	\$4,209	\$18,265	\$54.26	18.7%
Jun-18	35	\$22,475	\$2,063	\$1,164	\$2,310	\$0	\$5,537	\$16,937	\$92.20	24.6%
Jul-18	36	\$23,612	\$5,113	\$790	\$2,376	\$0	\$8,279	\$15,332	\$163.97	35.1%
Aug-18	35	\$23,043	\$5,786	\$1,185	\$2,310	\$0	\$9,281	\$13,761	\$199.17	40.3%
Sep-18	34	\$22,474	\$6,488	\$1,739	\$2,244	\$0	\$10,471	\$12,002	\$241.97	46.6%
Oct-18	35	\$22,475	\$17,600	\$292	\$2,310	\$0	\$20,202	\$2,272	\$511.20	89.9%
Nov-18	36	\$23,044	\$5,012	\$1,730	\$2,376	\$0	\$9,118	\$13,925	\$187.28	39.6%
Dec-18	36	\$23,441	\$6,488	\$241	\$2,376	\$0	\$9,105	\$14,335	\$186.92	38.8%
Jan-19	36	\$25,652	\$11,481	\$7,986	\$2,659	\$0	\$22,126	\$3,526	\$540.76	86.3%
Feb-19	35	\$25,070	\$1,724	\$6,805	\$2,585	\$0	\$11,115	\$13,956	\$243.70	44.3%
Mar-19	35	\$25,070	\$4,790	\$8,832	\$2,585	\$0	\$16,207	\$8,863	\$389.21	64.6%
Apr-19	36	\$26,138	\$13,022	\$8,889	\$2,659	\$0	\$24,571	\$1,567	\$608.66	94.0%
May-19	36	\$26,138	\$19,949	\$8,843	\$2,659	\$0	\$31,451	-\$5,313	\$799.77	120.3%
Jun-19	34	\$24,488	\$7,811	\$8,838	\$2,511	\$0	\$19,160	\$5,328	\$489.67	78.2%
Jul-19	34	\$24,488	\$23,520	\$8,193	\$2,511	\$0	\$34,224	-\$9,736	\$932.73	139.8%
Aug-19	34	\$24,488	\$46,869	\$8,187	\$2,511	\$0	\$57,567	-\$33,079	\$1,619.29	235.1%
Sep-19	33	\$23,905	\$2,944	\$641	\$2,437	\$0	\$6,022	\$17,883	\$108.64	25.2%
2015	32	\$215,364	\$174,555	\$8,710	\$26,718	\$0	\$209,983	\$5,381	\$482.28	97.5%
2016	32	\$216,382	\$126,874	\$6,269	\$24,916	\$0	\$158,059	\$58,323	\$344.93	73.0%
2017	37	\$293,539	\$69,926	\$2,767	\$29,710	\$0	\$102,403	\$191,136	\$161.90	34.9%
2018	35	\$274,074	\$66,283	\$7,316	\$27,988	\$0	\$101,587	\$172,487	\$173.58	37.1%
2019 YTD	35	\$225,437	\$132,110	\$67,214	\$23,118	\$0	\$222,442	\$2,995	\$636.82	98.7%
Current 12 Months	35	\$294,396	\$161,210	\$69,477	\$30,181	\$0	\$260,869	\$33,528	\$549.26	88.6%

Data Sources:

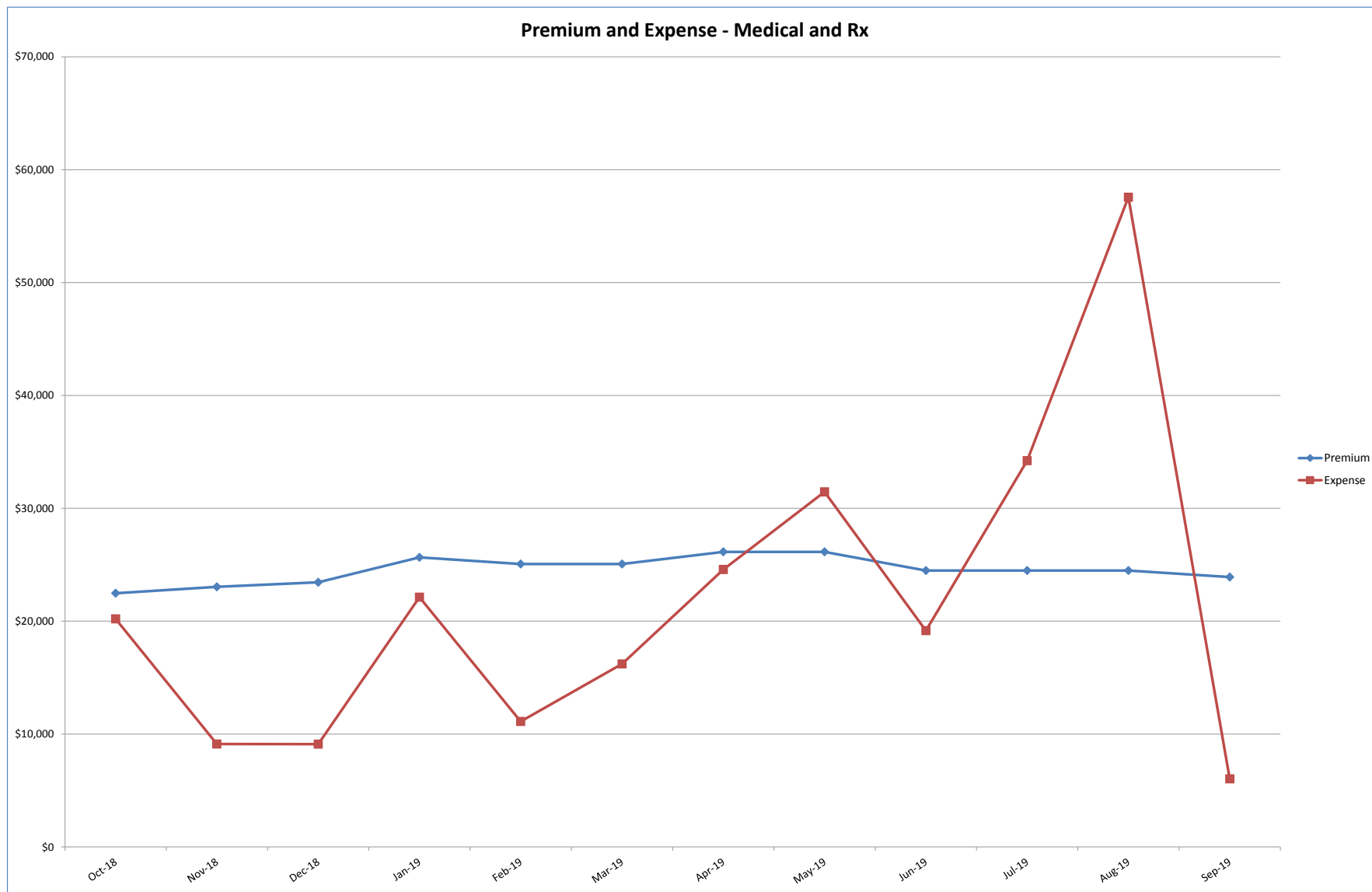
Enrollment & Premium: Hourglass; **Medical Claims & Capitation:** Anthem CIL, Anthem CLR, Anthem MDP; **Rx Claims:** Envolve, EmpiRx, Anthem MDP; **Fixed Cost Schedule:** Appendix

Notes:

1. Fixed Cost Schedule: Appendix
2. Pooling Points: HMO = \$400,000 and EPO/PPO/HDHP = \$450,000.
3. EmpiRx PBM replaced Envolve PBM effective 1/1/2018



San Joaquin Valley Insurance Authority (SJVIA)
Anthem Blue Cross Premium and Claims Report as of September 2019
County of Tulare - HDHP





San Joaquin Valley Insurance Authority (SJVIA)
Anthem Blue Cross Premium and Claims Report as of September 2019
All Others - All Medical

MONTH-YEAR	ENROLLED	FUNDING / PREMIUM	CLAIMS EXPENSE						SURPLUS / (DEFICIT)	AVERAGE CLAIM COST PEPM	TOTAL EXPENSE LOSS RATIO
			MEDICAL	CAPITATION	RX	FIXED	POOLED CLAIMS	TOTAL EXPENSE			
Jan-17	183	\$286,401	\$115,526	\$52,154	\$28,813	\$15,206	\$0	\$211,699	\$74,701	\$1,073.73	73.9%
Feb-17	182	\$284,629	\$185,571	\$51,965	\$34,881	\$15,117	\$0	\$287,534	-\$2,905	\$1,496.80	101.0%
Mar-17	178	\$277,523	\$131,952	\$52,088	\$34,651	\$14,823	\$0	\$233,514	\$44,009	\$1,228.60	84.1%
Apr-17	175	\$275,490	\$93,321	\$50,866	\$33,243	\$14,555	\$0	\$191,985	\$83,505	\$1,013.89	69.7%
May-17	178	\$279,753	\$485,586	\$51,944	\$40,593	\$14,802	\$0	\$592,925	-\$313,172	\$3,247.88	211.9%
Jun-17	181	\$282,736	\$272,269	\$52,026	\$34,035	\$15,049	\$0	\$373,378	-\$90,642	\$1,979.72	132.1%
Jul-17	182	\$285,099	\$170,028	\$52,051	\$37,524	\$15,096	\$0	\$274,698	\$10,401	\$1,426.39	96.4%
Aug-17	184	\$289,453	\$133,904	\$52,825	\$38,615	\$15,274	\$0	\$240,619	\$48,835	\$1,224.70	83.1%
Sep-17	184	\$288,851	\$162,496	\$52,763	\$40,000	\$15,253	\$0	\$270,512	\$18,339	\$1,387.28	93.7%
Oct-17	184	\$286,225	\$129,356	\$52,396	\$37,398	\$15,274	\$0	\$234,424	\$51,801	\$1,191.03	81.9%
Nov-17	185	\$286,335	\$263,222	\$52,701	\$39,078	\$15,364	\$0	\$370,365	-\$84,030	\$1,918.92	129.3%
Dec-17	185	\$288,923	\$162,065	\$53,304	\$40,948	\$15,385	\$0	\$271,702	\$17,221	\$1,385.50	94.0%
Jan-18	38	\$71,512	\$113,536	\$0	\$5,036	\$2,622	\$0	\$121,194	-\$49,683	\$3,120.32	169.5%
Feb-18	40	\$73,337	\$86,671	\$0	\$7,680	\$2,760	\$0	\$97,111	-\$23,774	\$2,358.76	132.4%
Mar-18	40	\$73,337	\$77,603	\$0	\$9,021	\$2,760	\$0	\$89,384	-\$16,047	\$2,165.59	121.9%
Apr-18	39	\$71,690	\$33,297	\$0	\$6,186	\$2,691	\$0	\$42,175	\$29,516	\$1,012.39	58.8%
May-18	37	\$68,404	\$47,159	\$0	\$7,047	\$2,553	\$0	\$56,759	\$11,645	\$1,465.03	83.0%
Jun-18	37	\$68,412	\$118,930	\$0	\$7,983	\$2,553	\$0	\$129,467	-\$61,054	\$3,430.09	189.2%
Jul-18	37	\$66,952	\$1,487	\$0	\$6,422	\$2,553	\$0	\$10,463	\$56,489	\$213.76	15.6%
Aug-18	38	\$68,960	\$56,140	\$0	\$37,091	\$2,622	\$0	\$95,854	-\$26,894	\$2,453.46	139.0%
Sep-18	36	\$64,940	\$58,032	\$0	\$38,273	\$2,484	\$0	\$98,790	-\$33,849	\$2,675.14	152.1%
Oct-18	37	\$67,313	\$33,790	\$0	\$6,439	\$2,553	\$0	\$42,782	\$24,531	\$1,087.26	63.6%
Nov-18	38	\$68,226	\$53,569	\$0	\$7,576	\$2,622	\$0	\$63,767	\$4,459	\$1,609.08	93.5%
Dec-18	37	\$65,853	\$26,457	\$0	\$8,265	\$2,553	\$0	\$37,276	\$28,577	\$938.44	56.6%
Jan-19	38	\$68,843	\$20,077	\$0	\$3,619	\$3,441	\$0	\$27,137	\$41,706	\$623.58	39.4%
Feb-19	38	\$68,843	\$20,058	\$0	\$6,204	\$3,441	\$0	\$29,704	\$39,139	\$691.12	43.1%
Mar-19	37	\$67,885	\$31,506	\$0	\$6,524	\$3,351	\$0	\$41,380	\$26,505	\$1,027.83	61.0%
Apr-19	37	\$66,596	\$26,423	\$0	\$5,317	\$3,351	\$0	\$35,091	\$31,505	\$857.85	52.7%
May-19	35	\$63,149	\$34,997	\$0	\$5,092	\$3,170	\$0	\$43,259	\$19,890	\$1,145.41	68.5%
Jun-19	35	\$63,149	\$47,845	\$0	\$6,568	\$3,170	\$0	\$57,583	\$5,566	\$1,554.67	91.2%
Jul-19	34	\$61,617	\$36,040	\$0	\$2,600	\$3,079	\$0	\$41,719	\$19,898	\$1,136.47	67.7%
Aug-19	33	\$62,192	\$44,424	\$0	\$3,324	\$2,988	\$0	\$50,736	\$11,455	\$1,446.90	81.6%
Sep-19	32	\$60,277	\$143,186	\$0	\$3,349	\$2,898	\$0	\$149,433	-\$89,156	\$4,579.21	247.9%
2015	123	\$1,660,403	\$2,594,309	\$428,402	\$355,693	\$129,738	-\$50,695	\$3,457,448	-\$1,797,044	\$2,251.49	208.2%
2016	149	\$2,173,860	\$2,132,611	\$434,864	\$387,689	\$142,746	-\$19,394	\$3,078,516	-\$904,656	\$1,644.69	141.6%
2017	182	\$3,411,417	\$2,305,296	\$627,083	\$439,781	\$181,196	\$0	\$3,553,356	-\$141,938	\$1,546.15	104.2%
2018	38	\$828,936	\$706,671	\$0	\$147,019	\$31,331	\$0	\$885,021	-\$56,085	\$1,880.38	106.8%
2019 YTD	35	\$582,551	\$404,556	\$0	\$42,598	\$28,889	\$0	\$476,042	\$106,509	\$1,401.74	81.7%
Current 12 Months	36	\$783,943	\$518,372	\$0	\$64,878	\$36,618	\$0	\$619,868	\$164,076	\$1,353.25	79.1%

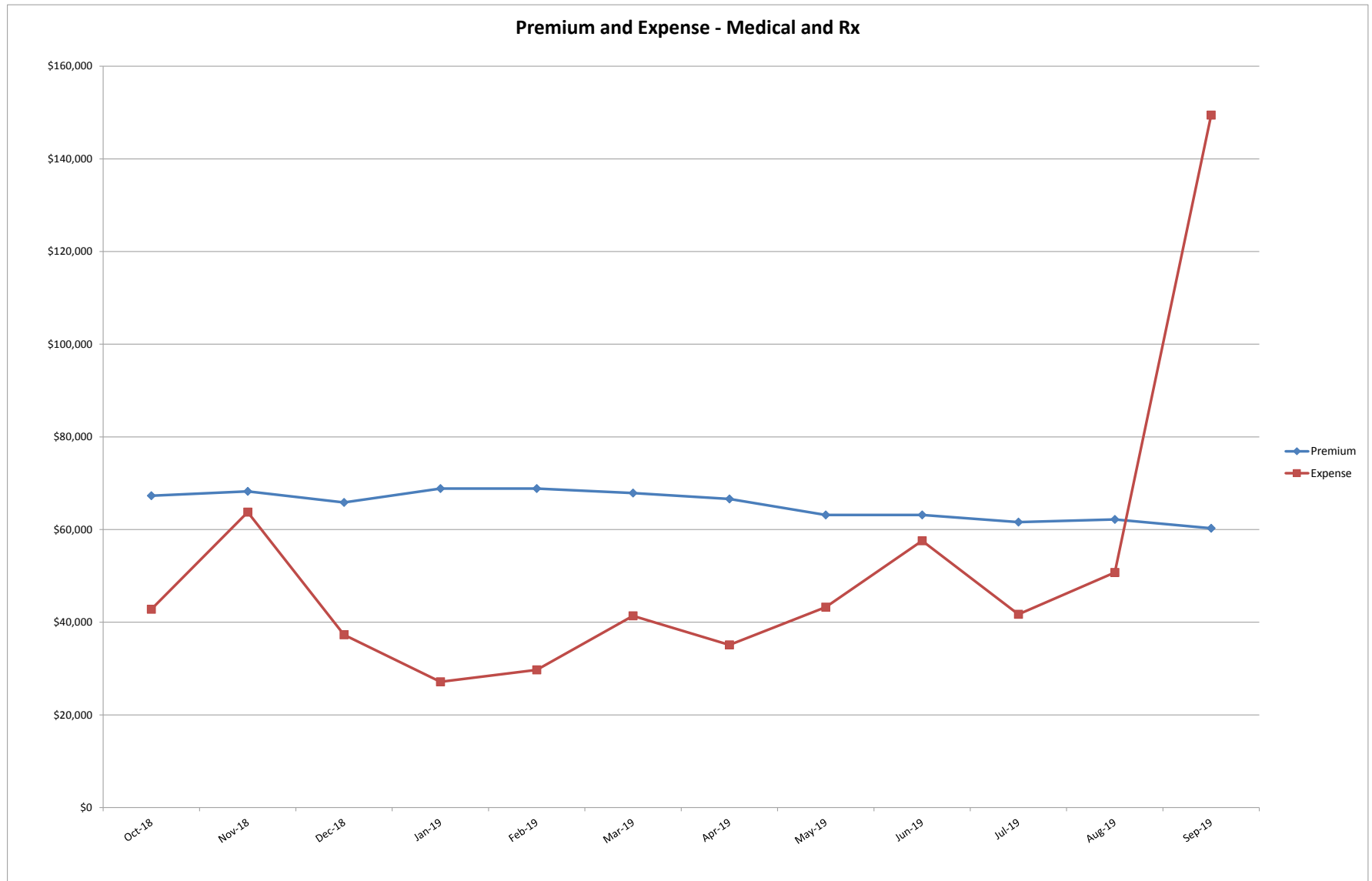
Data Sources:

Enrollment & Premium: Hourglass; **Medical Claims & Capitation:** Anthem CII, Anthem CLR, Anthem MDP; **Rx Claims:** Envolve, EmpiRx, Anthem MDP; **Fixed Cost Schedule:** Appendix

Notes:

1. Fixed Cost Schedule: Appendix
2. Pooling Points: HMO = \$400,000 and EPO/PPO/HDHP = \$450,000.
3. EmpiRx PBM replaced Envolve PBM effective 1/1/2018
4. Waterford and Ceres terminated from SJVIA effective 1/1/2018
5. All Others Claims include runout for Ceres and Waterford

San Joaquin Valley Insurance Authority (SJVIA)
Anthem Blue Cross Premium and Claims Report as of September 2019
All Others - All Medical





San Joaquin Valley Insurance Authority (SJVIA)
Anthem Blue Cross Premium and Claims Report as of September 2019
All Others - HMO

MONTH-YEAR	ENROLLED	FUNDING / PREMIUM	CLAIMS EXPENSE						SURPLUS / (DEFICIT)	AVERAGE CLAIM COST PEPM	TOTAL EXPENSE LOSS RATIO
			MEDICAL	CAPITATION	RX	FIXED	POOLED CLAIMS	TOTAL EXPENSE			
Jan-17	129	\$193,821	\$80,714	\$52,154	\$15,966	\$11,525	\$0	\$160,359	\$33,462	\$1,153.75	82.7%
Feb-17	128	\$192,923	\$140,017	\$51,965	\$25,740	\$11,436	\$0	\$229,157	-\$36,235	\$1,700.95	118.8%
Mar-17	127	\$192,288	\$77,874	\$52,088	\$23,850	\$11,346	\$0	\$165,158	\$27,130	\$1,211.12	85.9%
Apr-17	124	\$189,106	\$46,228	\$50,866	\$27,044	\$11,078	\$0	\$135,216	\$53,890	\$1,001.11	71.5%
May-17	126	\$192,496	\$455,444	\$51,944	\$22,748	\$11,257	\$0	\$541,393	-\$348,897	\$4,207.43	281.2%
Jun-17	128	\$194,605	\$251,759	\$52,026	\$22,230	\$11,436	\$0	\$337,451	-\$142,846	\$2,546.99	173.4%
Jul-17	127	\$192,426	\$71,385	\$52,051	\$23,604	\$11,346	\$0	\$158,386	\$34,040	\$1,157.79	82.3%
Aug-17	129	\$196,256	\$106,827	\$52,825	\$21,514	\$11,525	\$0	\$192,691	\$3,565	\$1,404.39	98.2%
Sep-17	128	\$194,780	\$130,241	\$52,763	\$26,042	\$11,436	\$0	\$220,481	-\$25,701	\$1,633.17	113.2%
Oct-17	129	\$194,711	\$91,277	\$52,396	\$23,000	\$11,525	\$0	\$178,198	\$16,512	\$1,292.04	91.5%
Nov-17	130	\$195,345	\$82,907	\$52,701	\$25,746	\$11,614	\$0	\$172,968	\$22,376	\$1,241.18	88.5%
Dec-17	131	\$198,678	\$116,605	\$53,304	\$27,326	\$11,704	\$0	\$208,939	-\$10,261	\$1,505.61	105.2%
Jan-18	0	\$0	\$44,390	\$0	\$0	\$0	\$0	\$44,390	-\$44,390	\$0.00	0.0%
Feb-18	0	\$0	\$19,476	\$0	\$0	\$0	\$0	\$19,476	-\$19,476	\$0.00	0.0%
Mar-18	0	\$0	\$13,943	\$0	\$0	\$0	\$0	\$13,943	-\$13,943	\$0.00	0.0%
Apr-18	0	\$0	\$224	\$0	\$0	\$0	\$0	\$224	-\$224	\$0.00	0.0%
May-18	0	\$0	\$1,885	\$0	\$0	\$0	\$0	\$1,885	-\$1,885	\$0.00	0.0%
Jun-18	0	\$0	-\$4,411	\$0	\$0	\$0	\$0	-\$4,411	\$4,411	\$0.00	0.0%
Jul-18	0	\$0	-\$8,439	\$0	\$0	\$0	\$0	-\$8,439	\$8,439	\$0.00	0.0%
Aug-18	0	\$0	\$24,961	\$0	\$0	\$0	\$0	\$24,961	-\$24,961	\$0.00	0.0%
Sep-18	0	\$0	-\$10	\$0	\$0	\$0	\$0	-\$10	\$10	\$0.00	0.0%
Oct-18	0	\$0	\$5,516	\$0	\$0	\$0	\$0	\$5,516	-\$5,516	\$0.00	0.0%
Nov-18	0	\$0	\$5,399	\$0	\$0	\$0	\$0	\$5,399	-\$5,399	\$0.00	0.0%
Dec-18	0	\$0	\$1,316	\$0	\$0	\$0	\$0	\$1,316	-\$1,316	\$0.00	0.0%
Jan-19	0	\$0	\$4,763	\$0	\$0	\$0	\$0	\$4,763	-\$4,763	\$0.00	0.0%
Feb-19	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0.00	0.0%
Mar-19	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0.00	0.0%
Apr-19	0	\$0	\$12	\$0	\$0	\$0	\$0	\$12	-\$12	\$0.00	0.0%
May-19	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0.00	0.0%
Jun-19	0	\$0	\$279	\$0	\$0	\$0	\$0	\$279	-\$279	\$0.00	0.0%
Jul-19	0	\$0	\$49	\$0	\$0	\$0	\$0	\$49	-\$49	\$0.00	0.0%
Aug-19	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0.00	0.0%
Sep-19	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0.00	0.0%
2015	94	\$1,211,794	\$2,250,892	\$428,402	\$257,607	\$104,791	-\$50,695	\$2,990,998	-\$1,779,204	\$2,547.40	246.8%
2016	94	\$1,280,238	\$1,072,716	\$434,864	\$217,831	\$99,223	\$0	\$1,824,634	-\$544,396	\$1,525.56	142.5%
2017	128	\$2,327,432	\$1,651,278	\$627,083	\$284,809	\$137,226	\$0	\$2,700,397	-\$372,964	\$1,668.73	116.0%
2018	0	\$0	\$104,250	\$0	\$0	\$0	\$0	\$104,250	-\$104,250	\$0.00	0.0%
2019 YTD	0	\$0	\$5,103	\$0	\$0	\$0	\$0	\$5,103	-\$5,103	\$0.00	0.0%
Current 12 Months	0	\$0	\$17,334	\$0	\$0	\$0	\$0	\$17,334	-\$17,334	#DIV/0!	100.0%

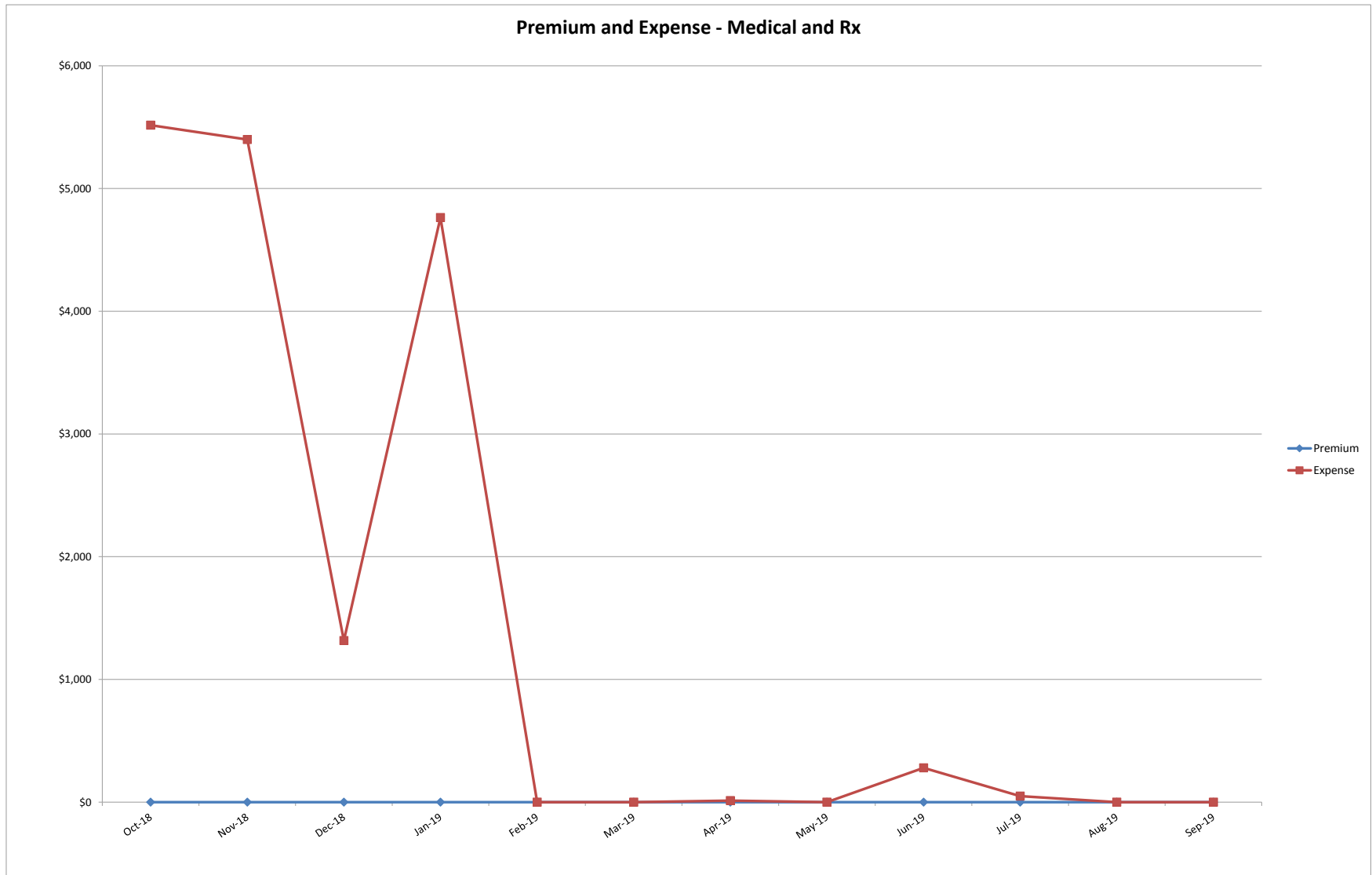
Data Sources:

Enrollment & Premium: Hourglass; Medical Claims & Capitation: Anthem CIL, Anthem CLR, Anthem MDP; Rx Claims: Enroll, EmpiRx, Anthem MDP; Fixed Cost Schedule: Appendix

Notes:

1. Fixed Cost Schedule: Appendix
2. Pooling Points: HMO = \$400,000 and EPO/PPO/HDHP = \$450,000.
3. EmpiRx PBM replaced Enroll PBM effective 1/1/2018
4. Waterford and Ceres terminated from SJVIA effective 1/1/2018
5. All Others Claims include runoff for Ceres and Waterford

San Joaquin Valley Insurance Authority (SJVIA)
Anthem Blue Cross Premium and Claims Report as of September 2019
All Others - HMO





San Joaquin Valley Insurance Authority (SJVIA)
Anthem Blue Cross Premium and Claims Report as of September 2019
All Others - PPO

MONTH-YEAR	ENROLLED	FUNDING / PREMIUM	CLAIMS EXPENSE					SURPLUS / (DEFICIT)	AVERAGE CLAIM COST PEPM	TOTAL EXPENSE LOSS RATIO
			MEDICAL	Rx	FIXED	POOLED CLAIMS	TOTAL EXPENSE			
Jan-17	50	\$88,478	\$34,812	\$12,847	\$3,409	\$0	\$51,068	\$37,410	\$953.19	57.7%
Feb-17	50	\$87,604	\$45,554	\$9,141	\$3,409	\$0	\$58,104	\$29,500	\$1,093.91	66.3%
Mar-17	46	\$80,093	\$54,078	\$10,791	\$3,136	\$0	\$68,004	\$12,089	\$1,410.19	84.9%
Apr-17	46	\$81,243	\$47,093	\$5,778	\$3,136	\$0	\$56,006	\$25,237	\$1,149.36	68.9%
May-17	47	\$82,117	\$30,046	\$16,702	\$3,204	\$0	\$49,952	\$32,165	\$994.63	60.8%
Jun-17	48	\$82,990	\$20,385	\$10,659	\$3,272	\$0	\$34,316	\$48,674	\$646.74	41.3%
Jul-17	50	\$87,532	\$98,643	\$13,428	\$3,409	\$0	\$115,479	-\$27,947	\$2,241.42	131.9%
Aug-17	50	\$88,057	\$27,003	\$15,953	\$3,409	\$0	\$46,364	\$41,692	\$859.11	52.7%
Sep-17	51	\$88,930	\$30,088	\$12,809	\$3,477	\$0	\$46,374	\$42,556	\$841.13	52.1%
Oct-17	49	\$85,134	\$37,891	\$13,246	\$3,340	\$0	\$54,477	\$30,657	\$1,043.61	64.0%
Nov-17	49	\$84,610	\$180,315	\$12,147	\$3,340	\$0	\$195,802	-\$111,193	\$3,927.80	231.4%
Dec-17	48	\$83,865	\$45,364	\$12,459	\$3,272	\$0	\$61,095	\$22,770	\$1,204.65	72.8%
Jan-18	38	\$71,512	\$69,146	\$5,036	\$2,622	\$0	\$76,804	-\$5,293	\$1,952.16	107.4%
Feb-18	40	\$73,337	\$67,195	\$7,680	\$2,760	\$0	\$77,635	-\$4,298	\$1,871.86	105.9%
Mar-18	40	\$73,337	\$63,660	\$9,021	\$2,760	\$0	\$75,441	-\$2,104	\$1,817.01	102.9%
Apr-18	39	\$71,690	\$33,073	\$6,186	\$2,691	\$0	\$41,951	\$29,740	\$1,006.65	58.5%
May-18	37	\$68,404	\$45,274	\$7,047	\$2,553	\$0	\$54,874	\$13,530	\$1,414.08	80.2%
Jun-18	37	\$68,412	\$123,341	\$7,983	\$2,553	\$0	\$133,878	-\$65,465	\$3,549.30	195.7%
Jul-18	37	\$66,952	\$9,926	\$6,422	\$2,553	\$0	\$18,902	\$48,050	\$441.84	28.2%
Aug-18	38	\$68,960	\$31,179	\$37,091	\$2,622	\$0	\$70,893	-\$1,933	\$1,796.59	102.8%
Sep-18	36	\$64,940	\$58,042	\$38,273	\$2,484	\$0	\$98,800	-\$33,859	\$2,675.42	152.1%
Oct-18	37	\$67,313	\$28,274	\$6,439	\$2,553	\$0	\$37,266	\$30,047	\$938.18	55.4%
Nov-18	38	\$68,226	\$48,170	\$7,576	\$2,622	\$0	\$58,368	\$9,858	\$1,467.00	85.6%
Dec-18	37	\$65,853	\$25,141	\$8,265	\$2,553	\$0	\$35,960	\$29,893	\$902.87	54.6%
Jan-19	38	\$68,843	\$15,314	\$3,619	\$3,441	\$0	\$22,374	\$46,469	\$498.24	32.5%
Feb-19	38	\$68,843	\$20,058	\$6,204	\$3,441	\$0	\$29,704	\$39,139	\$691.12	43.1%
Mar-19	37	\$67,885	\$31,506	\$6,524	\$3,351	\$0	\$41,380	\$26,505	\$1,027.83	61.0%
Apr-19	37	\$66,596	\$26,411	\$5,317	\$3,351	\$0	\$35,079	\$31,517	\$857.52	52.7%
May-19	35	\$63,149	\$34,997	\$5,092	\$3,170	\$0	\$43,259	\$19,890	\$1,145.41	68.5%
Jun-19	35	\$63,149	\$47,566	\$6,568	\$3,170	\$0	\$57,304	\$5,845	\$1,546.70	90.7%
Jul-19	34	\$61,617	\$35,991	\$2,600	\$3,079	\$0	\$41,670	\$19,947	\$1,135.02	67.6%
Aug-19	33	\$62,192	\$44,424	\$3,324	\$2,988	\$0	\$50,736	\$11,455	\$1,446.90	81.6%
Sep-19	32	\$60,277	\$143,186	\$3,349	\$2,898	\$0	\$149,433	-\$89,156	\$4,579.21	247.9%
2015	52	\$432,796	\$343,342	\$98,086	\$22,633	\$0	\$464,061	-\$31,265	\$1,410.31	107.2%
2016	51	\$861,303	\$1,058,213	\$161,756	\$40,396	-\$19,394	\$1,240,971	-\$379,668	\$1,977.88	144.1%
2017	49	\$1,020,653	\$651,272	\$145,959	\$39,811	\$0	\$837,042	\$183,611	\$1,365.12	82.0%
2018	38	\$828,936	\$602,421	\$147,019	\$31,331	\$0	\$780,771	\$48,165	\$1,650.75	94.2%
2019 YTD	35	\$582,551	\$399,453	\$42,598	\$28,889	\$0	\$470,939	\$111,612	\$1,385.74	80.8%
Current 12 Months	36	\$783,943	\$501,038	\$64,878	\$36,618	\$0	\$602,534	\$181,410	\$1,313.03	76.9%

Data Sources:

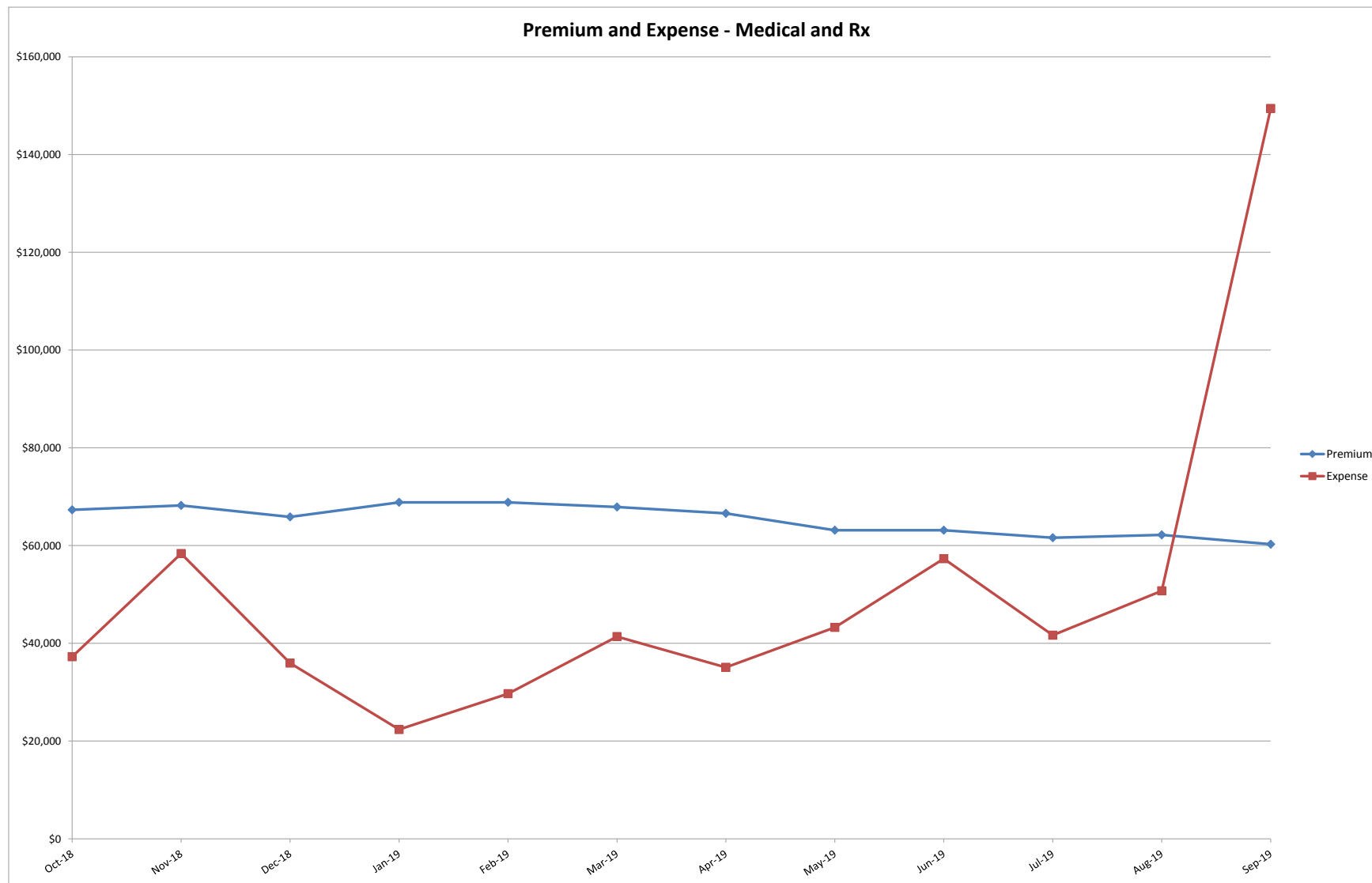
Enrollment & Premium: Hourglass; **Medical Claims & Capitation:** Anthem CIL, Anthem CLR, Anthem MDP; **Rx Claims:** Envolve, EmpiRx, Anthem MDP; **Fixed Cost Schedule:** Appendix

Notes:

1. Fixed Cost Schedule: Appendix
2. Pooling Points: HMO = \$400,000 and EPO/PPO/HDHP = \$450,000.
3. EmpiRx PBM replaced Envolve PBM effective 1/1/2018
4. Waterford and Ceres terminated from SJVIA effective 1/1/2018
5. All Others Claims include runout for Ceres and Waterford



San Joaquin Valley Insurance Authority (SJVIA)
Anthem Blue Cross Premium and Claims Report as of September 2019
All Others - PPO





San Joaquin Valley Insurance Authority (SJVIA)
Delta Dental Premium and Claims Report as of September 2019
County of Fresno and County of Tulare

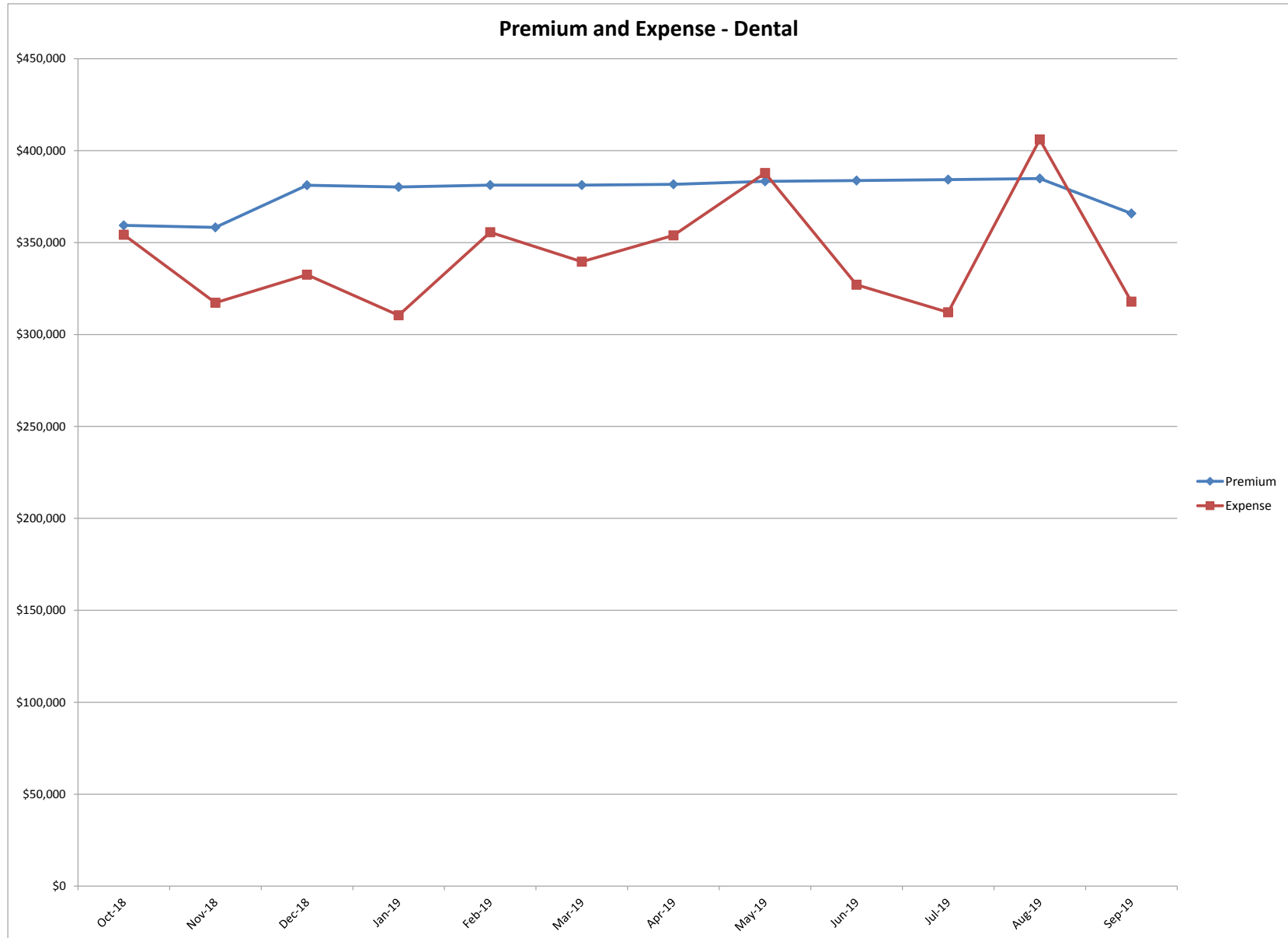
MONTH-YEAR	ENROLLED	FUNDING/ PREMIUM	PAID CLAIMS	DELTA ADMIN	TOTAL EXPENSE	SURPLUS / (DEFICIT)	TOTAL EXPENSE LOSS RATIO
Jan-17	6,685	\$367,216	\$371,915	\$33,659	\$405,573	-\$38,358	110.45%
Feb-17	6,664	\$366,591	\$304,112	\$33,602	\$337,713	\$28,878	92.12%
Mar-17	6,643	\$364,855	\$381,131	\$33,442	\$414,573	-\$49,719	113.63%
Apr-17	6,615	\$363,316	\$293,138	\$33,301	\$326,439	\$36,877	89.85%
May-17	6,628	\$363,243	\$317,709	\$33,294	\$351,004	\$12,239	96.63%
Jun-17	6,624	\$364,211	\$308,364	\$33,383	\$341,747	\$22,464	93.83%
Jul-17	6,642	\$362,305	\$275,891	\$33,209	\$309,100	\$53,205	85.31%
Aug-17	6,665	\$364,405	\$321,905	\$33,401	\$355,306	\$9,099	97.50%
Sep-17	6,652	\$364,732	\$276,901	\$33,436	\$310,337	\$54,395	85.09%
Oct-17	6,629	\$361,188	\$288,263	\$33,113	\$321,376	\$39,812	88.98%
Nov-17	6,668	\$363,185	\$311,348	\$33,025	\$344,374	\$18,811	94.82%
Dec-17	6,695	\$361,200	\$267,888	\$32,881	\$300,770	\$60,430	83.27%
Jan-18	6,772	\$362,752	\$358,669	\$33,042	\$391,712	-\$28,960	107.98%
Feb-18	6,769	\$359,841	\$319,592	\$32,861	\$352,453	\$7,388	97.95%
Mar-18	6,764	\$356,513	\$353,356	\$32,478	\$385,834	-\$29,321	108.22%
Apr-18	6,759	\$356,025	\$320,825	\$32,434	\$353,259	\$2,766	99.22%
May-18	6,766	\$352,400	\$326,445	\$32,104	\$358,548	-\$6,148	101.74%
Jun-18	6,761	\$355,588	\$279,559	\$32,394	\$311,953	\$43,635	87.73%
Jul-18	6,765	\$357,283	\$307,265	\$32,549	\$339,813	\$17,470	95.11%
Aug-18	6,776	\$359,745	\$314,402	\$32,773	\$347,174	\$12,571	96.51%
Sep-18	6,760	\$358,276	\$272,951	\$32,639	\$305,590	\$52,686	85.29%
Oct-18	6,751	\$359,337	\$321,522	\$32,736	\$354,258	\$5,080	98.59%
Nov-18	6,759	\$358,262	\$284,658	\$32,638	\$317,296	\$40,967	88.57%
Dec-18	6,776	\$381,194	\$297,758	\$34,727	\$332,484	\$48,709	87.22%
Jan-19	6,988	\$380,200	\$283,394	\$27,044	\$310,437	\$69,763	81.65%
Feb-19	7,008	\$381,256	\$328,492	\$27,121	\$355,613	\$25,643	93.27%
Mar-19	7,011	\$381,252	\$312,472	\$27,133	\$339,605	\$41,648	89.08%
Apr-19	7,019	\$381,713	\$326,743	\$27,164	\$353,906	\$27,807	92.72%
May-19	7,047	\$383,281	\$360,557	\$27,272	\$387,829	-\$4,548	101.19%
Jun-19	7,052	\$383,773	\$299,790	\$27,291	\$327,081	\$56,692	85.23%
Jul-19	7,061	\$384,202	\$284,717	\$27,326	\$312,043	\$72,159	81.22%
Aug-19	7,077	\$384,829	\$378,664	\$27,388	\$406,052	-\$21,223	105.51%
Sep-19	7,053	\$365,812	\$290,558	\$27,295	\$317,853	\$47,959	86.89%
2015	6,457	\$4,496,865	\$3,763,409	\$401,012	\$4,164,420	\$332,444	92.61%
2016	6,513	\$4,352,090	\$3,781,762	\$398,905	\$4,180,667	\$171,423	96.06%
2017	6,651	\$4,366,446	\$3,718,565	\$399,748	\$4,118,313	\$248,133	94.32%
2018	6,765	\$4,317,219	\$3,757,002	\$393,374	\$4,150,375	\$166,843	96.14%
2019 YTD	7,035	\$3,426,319	\$2,865,387	\$245,033	\$3,110,420	\$315,899	90.78%
Current 12 Months	6,967	\$4,525,112	\$3,769,325	\$345,133	\$4,114,458	\$410,655	90.92%

Data Sources: Delta Dental Financial Report Package, Hourglass

Note:

1. The above figures include all the divisions under the County of Fresno and County of Tulare.
2. The number of primary enrollees may change to include retroactive additions and/or deletions in eligibility.
3. Delta Admin Fee: \$3.87 PEPM (2019); in Mar-Dec 2018, it was estimated at 9.11% of the monthly premium due to the change in Delta's reporting.
4. Effective 12/17/18, DPPO contracts changed to self-funded; DHMO remained fully insured (not included in this report).
5. Fully insured runout claims thru Sep-2019: \$128,035.

San Joaquin Valley Insurance Authority (SJVIA)
Delta Dental Premium and Claims Report as of September 2019
County of Fresno and County of Tulare





San Joaquin Valley Insurance Authority (SJVIA)
Delta Dental Premium and Claims Report as of September 2019
County of Fresno

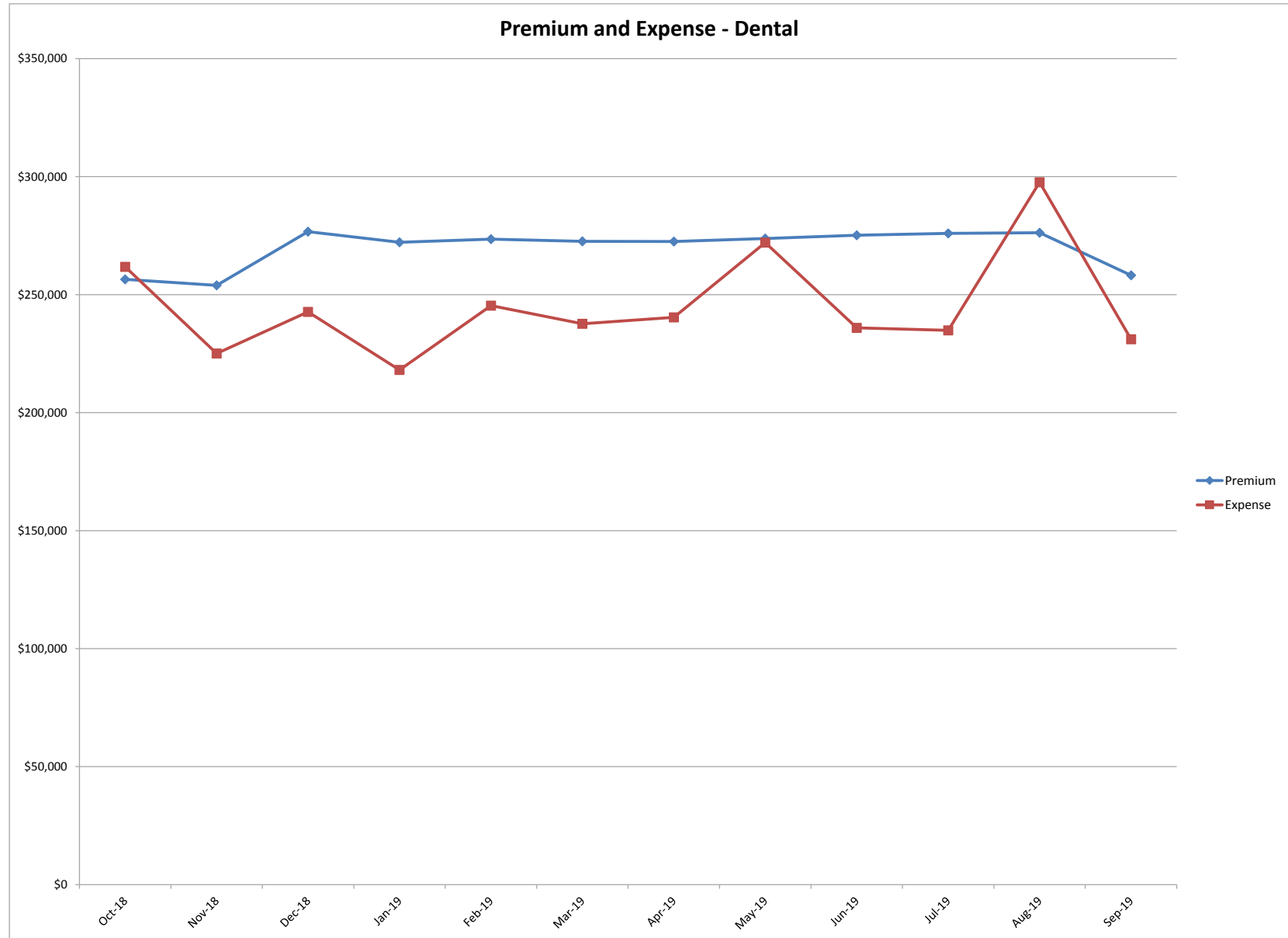
MONTH-YEAR	ENROLLED	FUNDING/ PREMIUM	PAID CLAIMS	DELTA ADMIN	TOTAL EXPENSE	SURPLUS / (DEFICIT)	TOTAL EXPENSE LOSS RATIO
Jan-17	4,180	\$261,977	\$244,267	\$24,008	\$268,275	-\$6,298	102.40%
Feb-17	4,173	\$261,255	\$204,523	\$23,942	\$228,465	\$32,790	87.45%
Mar-17	4,150	\$260,156	\$265,391	\$23,841	\$289,232	-\$29,076	111.18%
Apr-17	4,137	\$258,358	\$195,802	\$23,677	\$219,479	\$38,879	84.95%
May-17	4,153	\$259,545	\$218,926	\$23,785	\$242,711	\$16,833	93.51%
Jun-17	4,160	\$260,044	\$229,471	\$23,831	\$253,302	\$6,741	97.41%
Jul-17	4,157	\$259,656	\$207,181	\$23,796	\$230,977	\$28,679	88.95%
Aug-17	4,165	\$259,437	\$237,435	\$23,776	\$261,211	-\$1,774	100.68%
Sep-17	4,160	\$259,062	\$200,344	\$23,746	\$224,091	\$34,971	86.50%
Oct-17	4,140	\$257,743	\$201,996	\$23,627	\$225,622	\$32,121	87.54%
Nov-17	4,160	\$258,583	\$215,530	\$23,433	\$238,963	\$19,620	92.41%
Dec-17	4,187	\$257,345	\$193,557	\$23,358	\$216,915	\$40,431	84.29%
Jan-18	4,261	\$258,318	\$234,694	\$23,536	\$258,230	\$88	99.97%
Feb-18	4,249	\$256,569	\$225,524	\$23,442	\$248,966	\$7,603	97.04%
Mar-18	4,249	\$253,280	\$252,469	\$23,074	\$275,543	-\$22,263	108.79%
Apr-18	4,238	\$252,252	\$219,740	\$22,980	\$242,720	\$9,532	96.22%
May-18	4,233	\$248,495	\$231,269	\$22,638	\$253,907	-\$5,412	102.18%
Jun-18	4,233	\$250,769	\$198,181	\$22,845	\$221,026	\$29,743	88.14%
Jul-18	4,242	\$255,838	\$228,629	\$23,307	\$251,936	\$3,902	98.47%
Aug-18	4,242	\$256,986	\$226,470	\$23,411	\$249,881	\$7,105	97.24%
Sep-18	4,242	\$255,734	\$196,886	\$23,297	\$220,183	\$35,551	86.10%
Oct-18	4,219	\$256,471	\$238,396	\$23,365	\$261,761	-\$5,290	102.06%
Nov-18	4,217	\$253,927	\$201,914	\$23,133	\$225,047	\$28,880	88.63%
Dec-18	4,231	\$276,683	\$217,484	\$25,206	\$242,690	\$33,993	87.71%
Jan-19	4,418	\$272,150	\$200,979	\$17,098	\$218,076	\$54,074	80.13%
Feb-19	4,444	\$273,505	\$228,144	\$17,198	\$245,342	\$28,163	89.70%
Mar-19	4,427	\$272,572	\$220,526	\$17,132	\$237,659	\$34,914	87.19%
Apr-19	4,428	\$272,491	\$223,239	\$17,136	\$240,375	\$32,116	88.21%
May-19	4,450	\$273,787	\$254,802	\$17,222	\$272,023	\$1,763	99.36%
Jun-19	4,472	\$275,187	\$218,628	\$17,307	\$235,934	\$39,253	85.74%
Jul-19	4,488	\$275,946	\$217,515	\$17,369	\$234,884	\$41,062	85.12%
Aug-19	4,493	\$276,211	\$280,221	\$17,388	\$297,608	-\$21,398	107.75%
Sep-19	4,489	\$258,168	\$213,712	\$17,372	\$231,084	\$27,084	89.51%
2015	4,026	\$3,191,118	\$2,669,510	\$284,709	\$2,954,219	\$236,900	92.58%
2016	4,073	\$3,109,731	\$2,680,041	\$284,981	\$2,965,023	\$144,709	95.35%
2017	4,160	\$3,113,162	\$2,614,424	\$284,819	\$2,899,244	\$213,918	93.13%
2018	4,238	\$3,075,322	\$2,671,656	\$280,234	\$2,951,890	\$123,432	95.99%
2019 YTD	4,457	\$2,450,017	\$2,057,764	\$155,222	\$2,212,986	\$237,031	90.33%
Current 12 Months	4,398	\$3,237,098	\$2,715,558	\$226,925	\$2,942,483	\$294,615	90.90%

Data Sources: Delta Dental Financial Report Package, Hourglass

Note:

1. The number of primary enrollees may change to include retroactive additions and/or deletions in eligibility.
2. Delta Admin Fee: \$3.87 PEPM (2019); in Mar-Dec 2018, it was estimated at 9.11% of the monthly premium due to the change in Delta's reporting.
3. Effective 12/17/18, DPPO contracts changed to self-funded; DHMO remained fully insured (not included in this report).

San Joaquin Valley Insurance Authority (SJVIA)
Delta Dental Premium and Claims Report as of September 2019
County of Fresno





San Joaquin Valley Insurance Authority (SJVIA)
Delta Dental Premium and Claims Report as of September 2019
County of Tulare

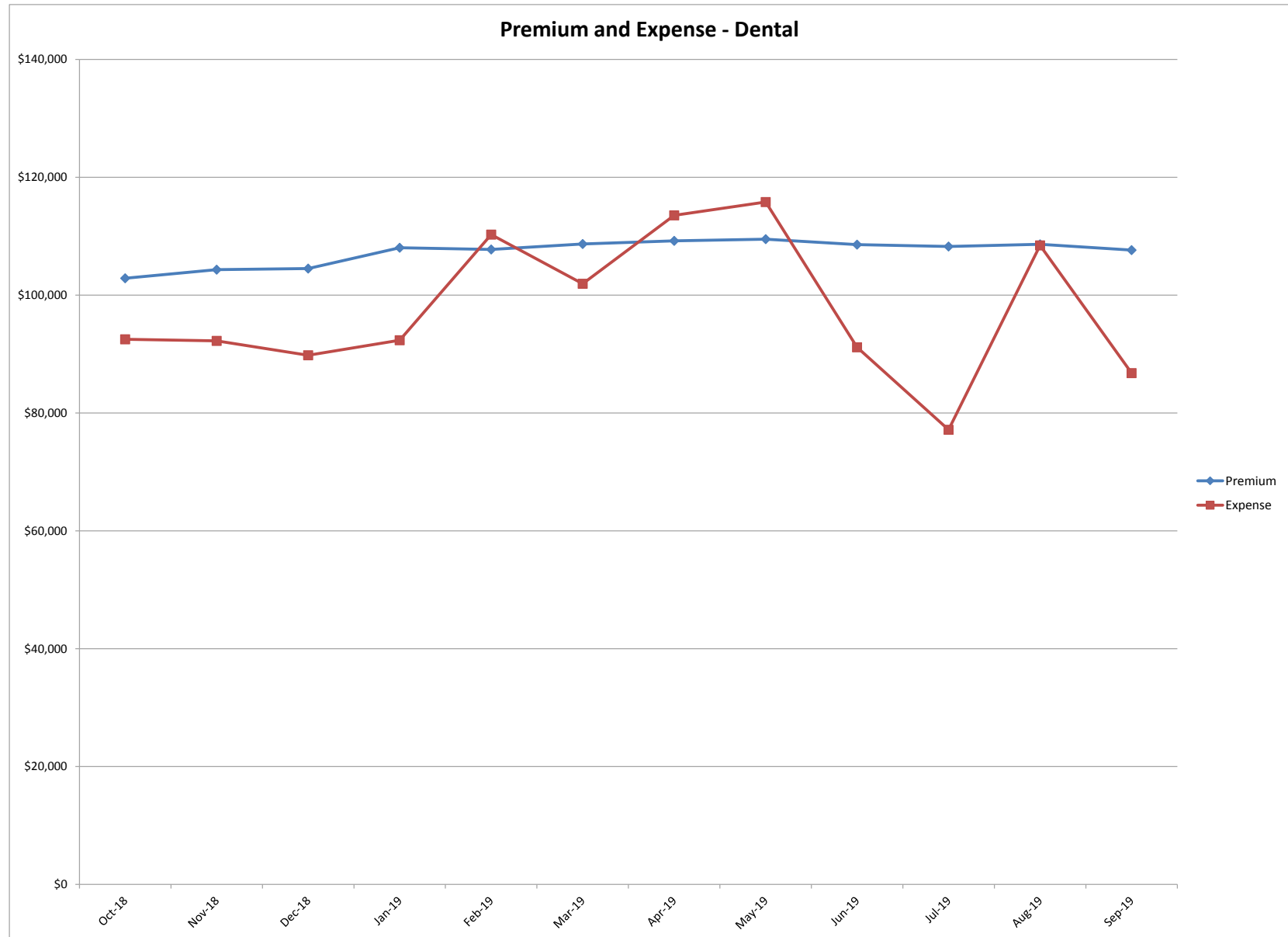
MONTH-YEAR	ENROLLED	FUNDING/ PREMIUM	PAID CLAIMS	DELTA ADMIN	TOTAL EXPENSE	SURPLUS / (DEFICIT)	TOTAL EXPENSE LOSS RATIO
Jan-17	2,505	\$105,238	\$127,647	\$9,651	\$137,298	-\$32,060	130.46%
Feb-17	2,491	\$105,336	\$99,589	\$9,660	\$109,248	-\$3,912	103.71%
Mar-17	2,493	\$104,698	\$115,740	\$9,601	\$125,341	-\$20,643	119.72%
Apr-17	2,478	\$104,958	\$97,336	\$9,625	\$106,961	-\$2,002	101.91%
May-17	2,475	\$103,698	\$98,783	\$9,509	\$108,292	-\$4,594	104.43%
Jun-17	2,464	\$104,168	\$78,893	\$9,552	\$88,445	\$15,723	84.91%
Jul-17	2,485	\$102,649	\$68,710	\$9,413	\$78,123	\$24,525	76.11%
Aug-17	2,500	\$104,967	\$84,469	\$9,626	\$94,095	\$10,872	89.64%
Sep-17	2,492	\$105,670	\$76,556	\$9,690	\$86,246	\$19,423	81.62%
Oct-17	2,489	\$103,445	\$86,268	\$9,486	\$95,754	\$7,691	92.57%
Nov-17	2,508	\$104,602	\$95,818	\$9,592	\$105,410	-\$809	100.77%
Dec-17	2,508	\$103,855	\$74,331	\$9,524	\$83,855	\$20,000	80.74%
Jan-18	2,511	\$104,434	\$123,975	\$9,507	\$133,482	-\$29,048	127.81%
Feb-18	2,520	\$103,272	\$94,068	\$9,418	\$103,487	-\$214	100.21%
Mar-18	2,515	\$103,233	\$100,887	\$9,405	\$110,291	-\$7,058	106.84%
Apr-18	2,521	\$103,773	\$101,085	\$9,454	\$110,539	-\$6,766	106.52%
May-18	2,533	\$103,905	\$95,176	\$9,466	\$104,642	-\$736	100.71%
Jun-18	2,528	\$104,819	\$81,378	\$9,549	\$90,927	\$13,892	86.75%
Jul-18	2,523	\$101,445	\$78,636	\$9,242	\$87,878	\$13,568	86.63%
Aug-18	2,534	\$102,759	\$87,932	\$9,361	\$97,293	\$5,466	94.68%
Sep-18	2,518	\$102,542	\$76,065	\$9,342	\$85,406	\$17,135	83.29%
Oct-18	2,532	\$102,866	\$83,126	\$9,371	\$92,497	\$10,369	89.92%
Nov-18	2,542	\$104,335	\$82,744	\$9,505	\$92,249	\$12,086	88.42%
Dec-18	2,545	\$104,511	\$80,274	\$9,521	\$89,795	\$14,716	85.92%
Jan-19	2,570	\$108,050	\$82,415	\$9,946	\$92,361	\$15,689	85.48%
Feb-19	2,564	\$107,751	\$100,349	\$9,923	\$110,271	-\$2,520	102.34%
Mar-19	2,584	\$108,680	\$91,946	\$10,000	\$101,946	\$6,734	93.80%
Apr-19	2,591	\$109,222	\$103,504	\$10,027	\$113,531	-\$4,309	103.94%
May-19	2,597	\$109,495	\$105,756	\$10,050	\$115,806	-\$6,311	105.76%
Jun-19	2,580	\$108,586	\$81,162	\$9,985	\$91,147	\$17,439	83.94%
Jul-19	2,573	\$108,256	\$67,202	\$9,958	\$77,160	\$31,096	71.28%
Aug-19	2,584	\$108,618	\$98,444	\$10,000	\$108,444	\$174	99.84%
Sep-19	2,564	\$107,644	\$76,846	\$9,923	\$86,769	\$20,875	80.61%
2015	2,431	\$1,305,746	\$1,093,899	\$116,302	\$1,210,201	\$95,545	92.68%
2016	2,440	\$1,242,358	\$1,101,721	\$113,923	\$1,215,644	\$26,714	97.85%
2017	2,491	\$1,253,284	\$1,104,141	\$114,928	\$1,219,069	\$34,215	97.27%
2018	2,527	\$1,241,897	\$1,085,346	\$113,140	\$1,198,485	\$43,411	96.50%
2019 YTD	2,579	\$976,302	\$807,623	\$89,811	\$897,434	\$78,868	91.92%
Current 12 Months	2,569	\$1,288,014	\$1,053,767	\$118,208	\$1,171,975	\$116,040	90.99%

Data Sources: Delta Dental Financial Report Package, Hourglass

Note:

1. The number of primary enrollees may change to include retroactive additions and/or deletions in eligibility.
2. Delta Admin Fee: \$3.87 PEPM (2019); in Mar-Dec 2018, it was estimated at 9.11% of the monthly premium due to the change in Delta's reporting.
3. Effective 12/17/18, DPPO contracts changed to self-funded; DHMO remained fully insured (not included in this report).

San Joaquin Valley Insurance Authority (SJVIA)
Delta Dental Premium and Claims Report as of September 2019
County of Tulare





San Joaquin Valley Insurance Authority (SJVIA)
VSP Premium and Claims Report as of September 2019
County of Fresno and County of Tulare

MONTH-YEAR	ENROLLED	FUNDING/ PREMIUM	PAID CLAIMS	VSP ADMIN	TOTAL EXPENSE	SURPLUS / (DEFICIT)	TOTAL EXPENSE LOSS RATIO
Jan-17	7,556	\$64,987	\$64,907	\$8,448	\$73,355	-\$8,368	112.88%
Feb-17	7,494	\$63,014	\$56,355	\$8,192	\$64,547	-\$1,533	102.43%
Mar-17	7,475	\$62,650	\$64,115	\$8,145	\$72,260	-\$9,610	115.34%
Apr-17	7,437	\$62,499	\$56,804	\$8,125	\$64,929	-\$2,430	103.89%
May-17	7,425	\$65,113	\$61,958	\$8,465	\$70,423	-\$5,310	108.15%
Jun-17	7,439	\$65,343	\$50,692	\$8,495	\$59,187	\$6,156	90.58%
Jul-17	7,481	\$65,509	\$41,567	\$8,516	\$50,083	\$15,426	76.45%
Aug-17	7,491	\$65,482	\$57,956	\$8,513	\$66,469	-\$987	101.51%
Sep-17	7,480	\$65,178	\$53,186	\$8,473	\$61,659	\$3,519	94.60%
Oct-17	7,464	\$64,860	\$57,272	\$8,432	\$65,704	-\$844	101.30%
Nov-17	7,441	\$66,185	\$46,782	\$8,604	\$55,386	\$10,799	83.68%
Dec-17	7,484	\$61,476	\$53,221	\$7,992	\$61,213	\$263	99.57%
Jan-18	7,203	\$59,729	\$52,458	\$7,765	\$60,223	-\$494	100.83%
Feb-18	7,192	\$61,901	\$54,857	\$8,047	\$62,904	-\$1,003	101.62%
Mar-18	7,187	\$61,872	\$57,170	\$8,043	\$65,213	-\$3,341	105.40%
Apr-18	7,178	\$63,952	\$54,731	\$8,314	\$63,045	\$907	98.58%
May-18	7,183	\$61,574	\$53,064	\$8,005	\$61,069	\$505	99.18%
Jun-18	7,196	\$61,662	\$47,857	\$8,016	\$55,873	\$5,789	90.61%
Jul-18	7,249	\$62,117	\$45,205	\$8,075	\$53,280	\$8,837	85.77%
Aug-18	7,265	\$61,885	\$45,924	\$8,045	\$53,969	\$7,916	87.21%
Sep-18	7,201	\$61,491	\$41,472	\$7,994	\$49,466	\$12,025	80.44%
Oct-18	7,208	\$61,416	\$54,540	\$7,984	\$62,524	-\$1,108	101.80%
Nov-18	7,203	\$61,581	\$43,562	\$8,006	\$51,568	\$10,013	83.74%
Dec-18	7,235	\$61,499	\$51,463	\$7,995	\$59,458	\$2,041	96.68%
Jan-19	7,189	\$61,110	\$51,856	\$7,944	\$59,800	\$1,310	97.86%
Feb-19	7,189	\$61,113	\$50,041	\$7,945	\$57,986	\$3,127	94.88%
Mar-19	7,212	\$62,651	\$61,504	\$8,145	\$69,649	-\$6,998	111.17%
Apr-19	7,180	\$60,847	\$59,582	\$7,910	\$67,492	-\$6,645	110.92%
May-19	7,194	\$60,929	\$56,586	\$7,921	\$64,507	-\$3,578	105.87%
Jun-19	7,196	\$60,994	\$50,863	\$7,929	\$58,792	\$2,202	96.39%
Jul-19	7,190	\$60,906	\$45,854	\$7,918	\$53,772	\$7,134	88.29%
Aug-19	7,188	\$60,867	\$47,559	\$7,913	\$55,472	\$5,395	91.14%
Sep-19	7,154	\$60,579	\$47,435	\$7,875	\$55,310	\$5,269	91.30%
2015	8,115	\$899,664	\$773,471	\$107,960	\$881,431	\$18,233	97.97%
2016	7,669	\$809,032	\$681,007	\$105,174	\$786,181	\$22,851	97.18%
2017	7,472	\$772,296	\$664,815	\$100,398	\$765,213	\$7,083	99.08%
2018	7,208	\$740,679	\$602,303	\$96,288	\$698,591	\$42,088	94.32%
2019	7,188	\$549,996	\$471,280	\$71,499	\$542,779	\$7,217	98.69%
Current 12 Months	7,195	\$734,492	\$620,845	\$95,484	\$716,329	\$18,163	97.53%

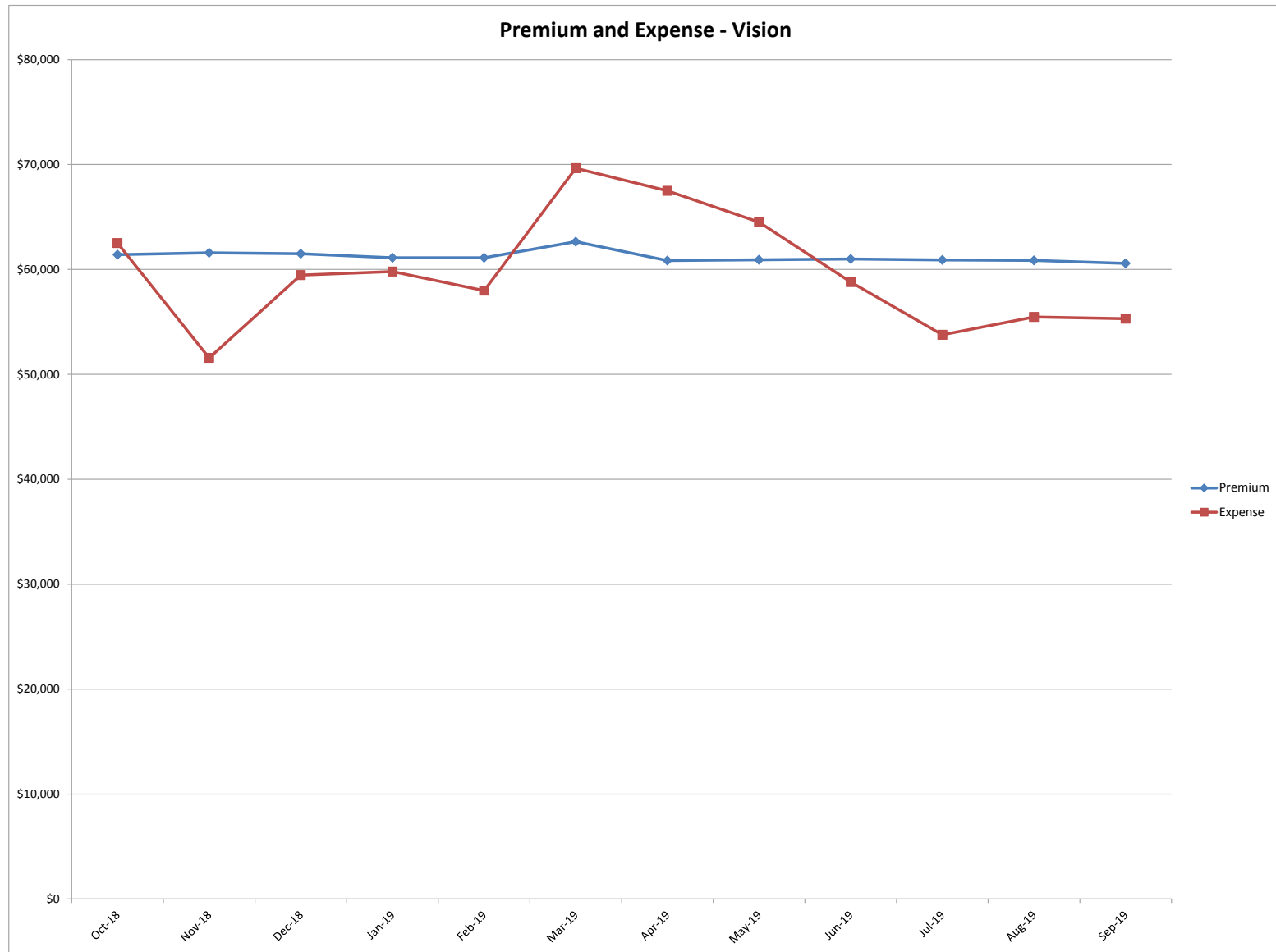
Data Source: VSP SJVIA Utilization Reports

Note:

1. The above figures include all the divisions under the County of Fresno, County of Tulare, and City of Ceres.
2. VSP Admin is the retention fee - % of premium (2015: 12%; 2016-2019: 13%).
3. City of Ceres is included in the 2017 figures; however, the City terminated their coverage effective 12/31/17.



San Joaquin Valley Insurance Authority (SJVIA)
VSP Premium and Claims Report as of September 2019
County of Fresno and County of Tulare





San Joaquin Valley Insurance Authority (SJVIA)
VSP Premium and Claims Report as of September 2019
County of Fresno

MONTH-YEAR	ENROLLED	FUNDING/ PREMIUM	PAID CLAIMS	VSP ADMIN	TOTAL EXPENSE	SURPLUS / (DEFICIT)	TOTAL EXPENSE LOSS RATIO
Jan-17	4,703	\$47,373	\$43,737	\$6,158	\$49,895	-\$2,522	105.32%
Feb-17	4,648	\$45,450	\$41,439	\$5,909	\$47,348	-\$1,898	104.17%
Mar-17	4,627	\$45,068	\$43,578	\$5,859	\$49,437	-\$4,369	109.69%
Apr-17	4,597	\$44,929	\$38,667	\$5,841	\$44,508	\$421	99.06%
May-17	4,570	\$47,528	\$39,306	\$6,179	\$45,485	\$2,043	95.70%
Jun-17	4,590	\$47,788	\$34,962	\$6,212	\$41,174	\$6,614	86.16%
Jul-17	4,599	\$47,773	\$25,191	\$6,210	\$31,401	\$16,372	65.73%
Aug-17	4,601	\$47,681	\$39,158	\$6,199	\$45,357	\$2,324	95.12%
Sep-17	4,579	\$47,308	\$37,755	\$6,150	\$43,905	\$3,403	92.81%
Oct-17	4,567	\$47,107	\$40,351	\$6,124	\$46,475	\$632	98.66%
Nov-17	4,539	\$48,295	\$34,174	\$6,278	\$40,452	\$7,843	83.76%
Dec-17	4,564	\$43,819	\$36,257	\$5,696	\$41,953	\$1,866	95.74%
Jan-18	4,450	\$43,952	\$34,937	\$5,714	\$40,651	\$3,301	92.49%
Feb-18	4,437	\$46,456	\$36,204	\$6,039	\$42,243	\$4,213	90.93%
Mar-18	4,431	\$46,406	\$42,069	\$6,033	\$48,102	-\$1,696	103.65%
Apr-18	4,417	\$48,396	\$38,693	\$6,291	\$44,984	\$3,412	92.95%
May-18	4,387	\$45,913	\$36,384	\$5,969	\$42,353	\$3,560	92.25%
Jun-18	4,379	\$45,853	\$34,035	\$5,961	\$39,996	\$5,857	87.23%
Jul-18	4,424	\$46,262	\$29,472	\$6,014	\$35,486	\$10,776	76.71%
Aug-18	4,439	\$46,376	\$35,331	\$6,029	\$41,360	\$5,016	89.18%
Sep-18	4,412	\$45,936	\$27,407	\$5,972	\$33,379	\$12,557	72.66%
Oct-18	4,399	\$45,787	\$39,201	\$5,952	\$45,153	\$634	98.62%
Nov-18	4,390	\$45,702	\$31,469	\$5,941	\$37,410	\$8,292	81.86%
Dec-18	4,397	\$45,670	\$33,844	\$5,937	\$39,781	\$5,889	87.11%
Jan-19	4,336	\$45,176	\$34,419	\$5,873	\$40,292	\$4,884	89.19%
Feb-19	4,342	\$45,097	\$34,368	\$5,863	\$40,231	\$4,866	89.21%
Mar-19	4,345	\$46,567	\$40,471	\$6,054	\$46,525	\$42	99.91%
Apr-19	4,310	\$44,725	\$39,132	\$5,814	\$44,946	-\$221	100.49%
May-19	4,316	\$44,753	\$36,110	\$5,818	\$41,928	\$2,825	93.69%
Jun-19	4,333	\$44,913	\$32,758	\$5,839	\$38,597	\$6,316	85.94%
Jul-19	4,325	\$44,841	\$28,879	\$5,829	\$34,708	\$10,133	77.40%
Aug-19	4,306	\$44,712	\$32,281	\$5,813	\$38,094	\$6,618	85.20%
Sep-19	4,295	\$44,570	\$32,078	\$5,794	\$37,872	\$6,698	84.97%
2015	5,375	\$700,261	\$566,975	\$84,031	\$651,006	\$49,255	92.97%
2016	4,886	\$604,807	\$472,715	\$78,625	\$551,340	\$53,467	91.16%
2017	4,599	\$560,119	\$454,575	\$72,815	\$527,390	\$32,729	94.16%
2018	4,414	\$552,709	\$419,046	\$71,852	\$490,898	\$61,811	88.82%
2019	4,323	\$405,354	\$310,496	\$52,696	\$363,192	\$42,162	89.60%
Current 12 Months	4,341	\$542,513	\$415,010	\$70,527	\$485,537	\$56,976	89.50%

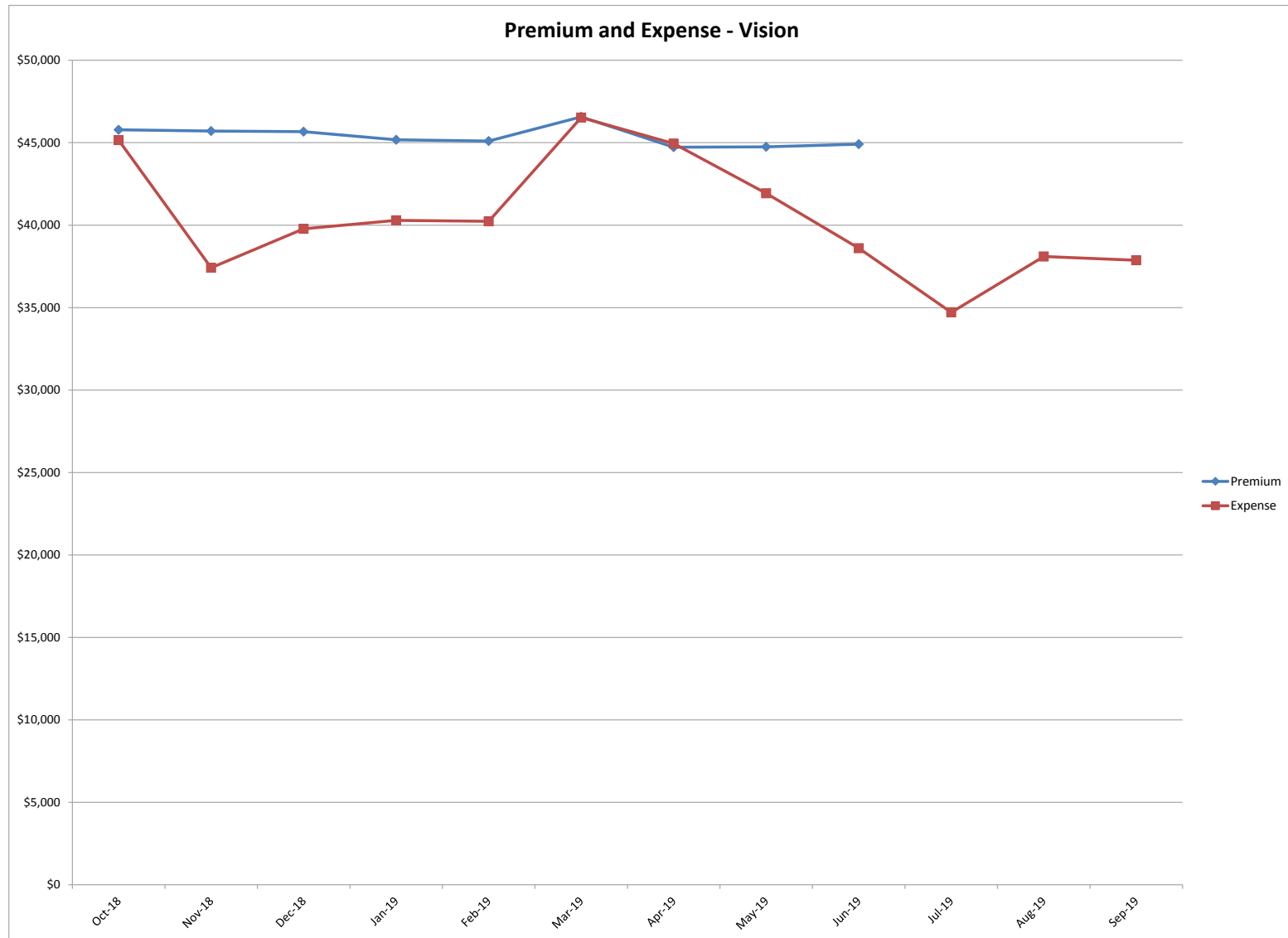
Data Source: VSP SJVIA Utilization Reports

Note:

1. The above figures include the following divisions: 0015, 0016, 0017, 0018, 0019, 0020, and 0021.



San Joaquin Valley Insurance Authority (SJVIA)
VSP Premium and Claims Report as of September 2019
County of Fresno





**San Joaquin Valley Insurance Authority (SJVIA)
VSP Premium and Claims Report as of September 2019
County of Tulare**

MONTH-YEAR	ENROLLED	FUNDING/ PREMIUM	PAID CLAIMS	VSP ADMIN	TOTAL EXPENSE	SURPLUS / (DEFICIT)	TOTAL EXPENSE LOSS RATIO
Jan-17	2,671	\$14,716	\$19,445	\$1,913	\$21,358	-\$6,642	145.14%
Feb-17	2,665	\$14,701	\$13,138	\$1,911	\$15,049	-\$348	102.37%
Mar-17	2,670	\$14,765	\$17,657	\$1,919	\$19,576	-\$4,811	132.59%
Apr-17	2,664	\$14,732	\$16,072	\$1,915	\$17,987	-\$3,255	122.10%
May-17	2,681	\$14,807	\$18,906	\$1,925	\$20,831	-\$6,024	140.68%
Jun-17	2,674	\$14,741	\$14,269	\$1,916	\$16,185	-\$1,444	109.80%
Jul-17	2,704	\$14,913	\$14,622	\$1,939	\$16,561	-\$1,648	111.05%
Aug-17	2,711	\$14,964	\$15,530	\$1,945	\$17,475	-\$2,511	116.78%
Sep-17	2,724	\$15,012	\$13,374	\$1,952	\$15,326	-\$314	102.09%
Oct-17	2,716	\$14,868	\$15,071	\$1,933	\$17,004	-\$2,136	114.37%
Nov-17	2,724	\$15,005	\$10,714	\$1,951	\$12,665	\$2,340	84.40%
Dec-17	2,740	\$14,918	\$13,651	\$1,939	\$15,590	-\$672	104.51%
Jan-18	2,753	\$15,777	\$16,139	\$2,051	\$18,190	-\$2,413	115.29%
Feb-18	2,755	\$15,445	\$18,549	\$2,008	\$20,557	-\$5,112	133.10%
Mar-18	2,756	\$15,466	\$15,101	\$2,011	\$17,112	-\$1,646	110.64%
Apr-18	2,761	\$15,556	\$16,038	\$2,022	\$18,060	-\$2,504	116.10%
May-18	2,796	\$15,661	\$16,680	\$2,036	\$18,716	-\$3,055	119.51%
Jun-18	2,817	\$15,809	\$13,822	\$2,055	\$15,877	-\$68	100.43%
Jul-18	2,825	\$15,855	\$15,733	\$2,061	\$17,794	-\$1,939	112.23%
Aug-18	2,826	\$15,509	\$10,593	\$2,016	\$12,609	\$2,900	81.30%
Sep-18	2,789	\$15,555	\$14,065	\$2,022	\$16,087	-\$532	103.42%
Oct-18	2,809	\$15,629	\$15,339	\$2,032	\$17,371	-\$1,742	111.14%
Nov-18	2,813	\$15,879	\$12,093	\$2,064	\$14,157	\$1,722	89.16%
Dec-18	2,838	\$15,829	\$17,619	\$2,058	\$19,677	-\$3,848	124.31%
Jan-19	2,853	\$15,934	\$17,437	\$2,071	\$19,508	-\$3,574	122.43%
Feb-19	2,847	\$16,016	\$15,673	\$2,082	\$17,755	-\$1,739	110.86%
Mar-19	2,867	\$16,084	\$21,033	\$2,091	\$23,124	-\$7,040	143.77%
Apr-19	2,870	\$16,122	\$20,450	\$2,096	\$22,546	-\$6,424	139.85%
May-19	2,878	\$16,176	\$20,476	\$2,103	\$22,579	-\$6,403	139.58%
Jun-19	2,863	\$16,081	\$18,105	\$2,091	\$20,196	-\$4,115	125.59%
Jul-19	2,865	\$16,065	\$16,975	\$2,088	\$19,063	-\$2,998	118.66%
Aug-19	2,882	\$16,155	\$15,278	\$2,100	\$17,378	-\$1,223	107.57%
Sep-19	2,859	\$16,009	\$15,357	\$2,081	\$17,438	-\$1,429	108.93%
2015	2,613	\$175,579	\$186,768	\$21,069	\$207,837	-\$32,258	118.37%
2016	2,649	\$177,979	\$185,607	\$23,137	\$208,744	-\$30,765	117.29%
2017	2,695	\$178,142	\$182,449	\$23,158	\$205,607	-\$27,465	115.42%
2018	2,795	\$187,970	\$181,771	\$24,436	\$206,207	-\$18,237	109.70%
2019	2,865	\$144,642	\$160,784	\$18,803	\$179,587	-\$34,945	124.16%
Current 12 Months	2,854	\$191,979	\$205,835	\$24,957	\$230,792	-\$38,813	120.22%

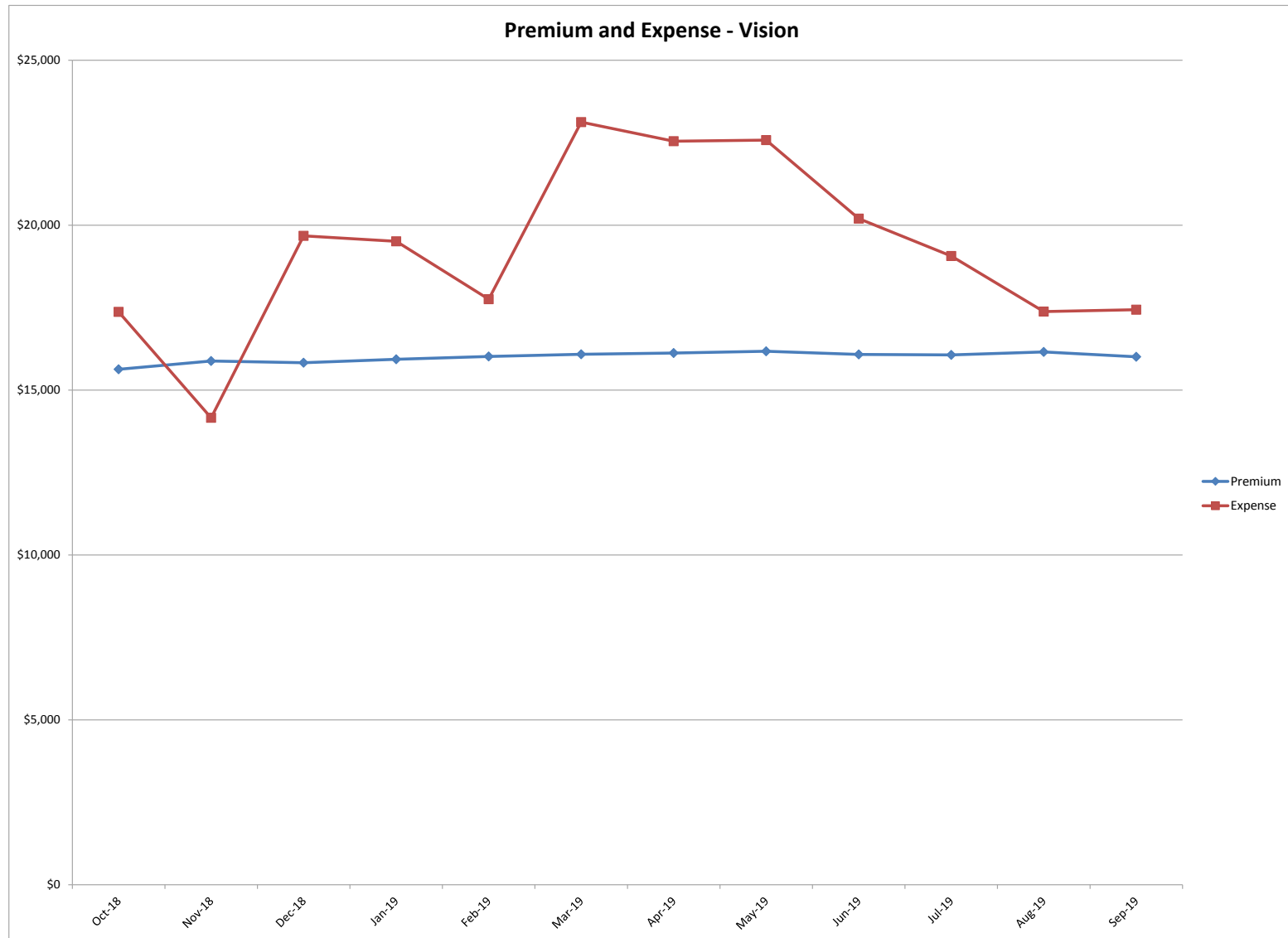
Data Source: VSP SJVIA Utilization Reports

Note:

1. The above figures include the following divisions: 0001, 0002, 0003, and 0004.



San Joaquin Valley Insurance Authority (SJVIA)
VSP Premium and Claims Report as of September 2019
County of Tulare



Meeting Location:
County of Fresno
Board of Supervisors Chambers
2281 Tulare Street, #301
Fresno, CA 93721

AGENDA DATE: November 8, 2019

ITEM NUMBER: Item 17

SUBJECT: Receive Consultant's Report on Plan Year 2020 Stop Loss/Reinsurance Renewal and Marketing Results and Authorize President to Execute Agreement Subject to Approval of SJVIA Counsel and Staff (A)

REQUEST(S): That the Board approve the recommended vendor and authorize the President to execute agreement subject to approval of SJVIA Counsel and Staff.

DESCRIPTION:

As part of the Plan Year 2020 SJVIA self-funded medical and prescription renewal, Keenan conducted a reinsurance marketing to secure the most competitive stop loss/reinsurance rates. It is recommended that the SJVIA:

- Select Voya, the incumbent carrier, as the reinsurer for the 2020 Plan Year;
- Renew at the \$450,000 reinsurance level; and
- Accept the increase of 5% and reallocate the 10% difference, or \$195,548, to reserve accumulation.

FISCAL IMPACT/FINANCING:

The reinsurance rate used in the development of the 2020 Plan Year rates was 15% over the 2019 reinsurance rates. The reinsurance renewal came in with a 5% increase. It is recommended that 2020 rates not be revised and the 10% difference, or \$195,548, be reallocated for reserve accumulation.

AGENDA: San Joaquin Valley Insurance Authority

DATE: November 8, 2019

ADMINISTRATIVE SIGN-OFF:



Rhonda Sjostrom
SJVIA Manager



Paul Nerland
SJVIA Assistant Manager

SAN JOAQUIN VALLEY INSURANCE AUTHORITY (SJVIA)

2020 Stop Loss Renewal/Marketing Presentation

Presented by:



SAN JOAQUIN VALLEY INSURANCE AUTHORITY (SJVIA)

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SAN JOAQUIN VALLEY INSURANCE AUTHORITY (SJVIA)

EXECUTIVE SUMMARY

FINAL RESULTS

Effective Date: January 1, 2020

I. Stop Loss Marketing and Renewal Results:

- Stop loss RFP marketed to eleven (11) stop loss carriers. Six (6) carriers quoted and five (5) declined.
- Requested to match current Voya coverage and conditions

II. Voya Renewal:

- **Initial** - Renewal offer is an approximate **9.0% increase**, or an additional \$162,903, in annual premium when compared to current
- **Final** - Renewal offer is an approximate **5.0% increase**, or an additional \$90,510, in annual premium when compared to current and a savings of \$72,393 in annual premium when compared to the final renewal offer
- **Projected Experience Credit Refund of \$275,020 (Based on claims paid October 1, 2019) subject to renewal with Voya**
- Includes - Alternate deductible options of \$400,000 and \$375,000 for a 18.9% and 30.8% increase to current
- **Includes - Experience Credit Advantage with a maximum premium refund (25% of net profit)**
- No New Lasers at Renewal and a 50% Rate Cap
- Includes Mirroring Endorsement
- **Individual Gapless Renewal**
- Medicare is primary for retirees age 65 and over
- **No Re-Disclosure required**

III. Berkshire Hathaway:

- **Proposed** - Renewal offer is an approximate **4.3% increase**, or an additional \$77,401 in annual premium when compared to current
- Includes - Alternate deductible options of \$400,000 and \$375,000 for a 14.6% and 25.8% increase to current
- No New Lasers at Renewal and a 50% Rate Cap
- Includes Mirroring Endorsement
- Medicare is primary for retirees age 65 and over
- Disclosure required

SAN JOAQUIN VALLEY INSURANCE AUTHORITY (SJVIA)
Stop Loss RFP Analysis
Carrier Responses

Carrier	Financial Rating	Status	Notes
Voya Financial (Incumbent)	A (Excellent)	Quoted	Finalist
Berkshire Hathaway	A++ (Superior)	Quoted	Finalist
Liberty	A+ (Superior)	Quoted	Uncompetitive with proposed rates 7% above current
Reliance Standard	A+ (Superior)	Quoted	\$450K Spec. Deductible only (Not Firm) 0.4% below current
Anthem	A (Excellent)	Declined	Uncompetitive with current rates
Evolution Risk MGU	A (Excellent)	Declined	Uncompetitive with current rates
Optum	A (Excellent)	Quoted	Uncompetitive with proposed rates 7% above current
Partner Re	A+ (Superior)	Declined	Uncompetitive with current rates
QBE	A (Excellent)	Declined	Uncompetitive with current rates
Symetra	A (Excellent)	Quoted	Uncompetitive with proposed rates 50% above current
TM HCC	A++ (Superior)	Declined	Uncompetitive with current rates

SAN JOAQUIN VALLEY INSURANCE AUTHORITY (SJVIA)

FINANCIAL SUMMARY

Effective Date: January 1, 2020

QUOTED DEDUCTIBLE OPTIONS	\$450,000	\$450,000	\$450,000	\$400,000	\$375,000
	Current Annual Premium	Initial Renewal	Final Renewal	Annual Premium	Annual Premium
Voya	\$1,810,472	\$1,973,375	\$1,900,982	\$2,152,943	\$2,368,294
% Increase/Decrease over Current		9.0%	5.0%	18.9%	30.8%
\$ Increase/Decrease over Current		\$162,903	\$90,510	\$342,471	\$557,823
Berkshire Hathaway			\$1,887,873	\$2,074,431	\$2,277,499
% Increase/Decrease over Current			4.3%	14.6%	25.8%
\$ Increase/Decrease over Current			\$77,401	\$263,959	\$467,028

Voya Assumptions/Contingencies

No fully insured lives are covered.

Plan must have medical case management and utilization review.

All claims are reported/paid in U.S. dollars.

Any costs charged by the claim administrator for reports required to substantiate claims will be paid by the employer.

The proposal is based on the data submitted. Any changes to this data may allow us to modify the proposal.

We reserve the right to (i) recalculate Individual Excess Risk Monthly Premium Rates as shown on the Excess Risk Schedule and continue this Policy, or (ii) terminate this Policy in accordance with the Policy Termination provision of this Policy if an increase or decrease in the number of Covered Persons and Covered Dependents that exceeds 15% of the current number covered under the Employee Benefit Plan.

Plan designs and contribution levels are assumed as submitted to underwriting. Any changes may require an adjustment to the individual excess risk rates and/or monthly aggregate corridor.

Renewal Rate Cap Endorsement guarantees your subsequent year's renewal will be capped at 50% and no new individual adjusted deductible will apply (laser free renewal).

Medicare is primary for retirees age 65 and over.

This proposal includes a Dividend Eligible Agreement.

SAN JOAQUIN VALLEY INSURANCE AUTHORITY (SJVIA)
STOP LOSS MARKETING ANALYSIS - SPECIFIC DEDUCTIBLE LEVELS OF \$450,000, \$400,000 and \$375,000
Effective Date: January 1, 2020

	Current	Initial Renewal	Final Renewal	Proposed Option 1	Renewal Option 1	Proposed Option 2	Renewal Option 2	Proposed Option 3
Carrier Name	Voya			Berkshire Hathaway	Voya	Berkshire Hathaway	Voya	Berkshire Hathaway
Rate Guarantee / Cap	1 Year				1 Year		1 Year	
Specific Stop Loss (SSL)								
Specific Deductible		\$450,000		\$450,000	\$400,000		\$375,000	
Annual Maximum Reimbursement		Unlimited		Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Contract Basis		12/18		12/18	12/18	12/18	12/18	12/18
Covered Expense		Medical, Rx		Medical, Rx	Medical, Rx	Medical, Rx	Medical, Rx	Medical, Rx
Specific Premium								
Single (4,792)	\$15.81	\$16.67	\$16.06	\$22.87	\$18.19	\$25.13	\$20.01	\$27.59
Family (2,087)	\$35.99	\$40.52	\$39.03	\$22.87	\$44.20	\$25.13	\$48.62	\$27.59
Composite (6,879)	\$21.93	\$23.91	\$23.03	\$22.87	\$26.08	\$25.13	\$28.69	\$27.59
Specific Monthly Premium	\$150,873	\$164,448	\$158,415	\$157,323	\$179,412	\$172,869	\$197,358	\$189,792
Specific Annual Premium	\$1,810,472	\$1,973,375	\$1,900,982	\$1,887,873	\$2,152,943	\$2,074,431	\$2,368,294	\$2,277,499
% Increase/Decrease over Current		9.0%	5.0%	4.3%	18.9%	14.6%	30.8%	25.8%
\$ Increase/Decrease over Current		\$162,903	\$90,510	\$77,401	\$342,471	\$263,959	\$557,823	\$467,028
2019 Projected Experience Credit Refund (Claims as of 10/1/19) *				\$275,020	\$275,020	\$275,020	\$275,020	
<u>Projected Annual Cost Summary</u>				<u>\$1,900,982</u>	<u>\$2,152,943</u>	<u>\$2,074,431</u>	<u>\$2,368,294</u>	
Experience Credit Refund				(\$275,020)	(\$275,020)	(\$275,020)	(\$275,020)	
Projected Annual Premium (after Experience Credit)				\$1,625,962	\$1,877,923	\$1,800,411	\$2,093,274	
% Increase/Decrease over Current				-10.2%	3.7%	3.7%	15.6%	
\$ Increase/Decrease over Current				(\$184,510)	\$67,451	\$67,451	\$282,803	

*Voya paid claims as of 10.1.2019. Claims payments could change by policy end, resulting in a different refund amount.

**Per dividend agreement, refund is capped at 15% of premium.

***The above numbers are projections. Final accounting will be based off of updated claims and terms of the 2019 agreement.

****Contract period does not end until 6/30/2020. Groups are not reviewed for a premium refund until 6 months after the contract period.

SAN JOAQUIN VALLEY INSURANCE AUTHORITY (SJVIA)

ESTIMATED LOSS RATIO

Contract Year	Carrier	Spec. Deductible	Basis	Covg.	Monthly Premium	Claims Over Sepc. Ded.	Stop Loss Recovery
YTD 10/2019	Voya	\$450,000	12/18	MED/RX	\$1,534,403	\$23,296	1.5%
CY 2018	Voya	\$450,000	12/18	MED/RX	\$1,748,131	\$543,555	31.1%
					\$3,282,534	\$566,851	17.3%

Voya Employee Benefits

Premium Refund

SJVIA Projected 2018 Refund:

Eligible Premium	\$1,748,131
Loss Threshold	0.650
Threshold Dollar Amount	\$1,136,285
End of Year Loss Ratio	31%
Actual Incurred Claims	\$543,555
Total Excess	\$592,730
Share Proportion	25.00%
Eligible Refund	\$148,182

Additional Assumptions and Definitions:

Eligible Clients Include: Clients that renew with Voya for the following year. The client must be in force with Voya at the time the refund payment is paid.

Loss Threshold: This represents the amount of premium that is available to share with the client.

Loss Ratio: Must be below 65% of net premium to achieve a refund. Net premium means premium without commissions

Total Excess: Equals the threshold dollar amount minus actual incurred claims

Eligible Refunds: Will be calculated and paid 8 months following the end of the policy incurred period.

Please note: Additional premium may be assessed in exchange for adding this program.

Voya Employee Benefits

Premium Refund

SJVIA Projected 2019 Refund:

2019 Eligible *Projected* Premium \$1,833,467

Loss Threshold 0.650

Threshold Dollar Amount \$1,191,753

Actual Incurred Claims \$23,295*

Total Excess \$1,168,458

Share Proportion 25.00%

Eligible Refund \$275,020**

*Voya paid claims as of 10.1.2019. Claims payments could change by policy end, resulting in a different refund amount.

**Per dividend agreement, refund is capped at 15% of premium.

***The above numbers are projections. Final accounting will be based off of updated claims and terms of the 2019 agreement.

****Contract period does not end until 6/30/2020. Groups are not reviewed for a premium refund until 6 months after the contract period

Additional Assumptions and Definitions:

Eligible Clients Include: Clients that renew with Voya for the following year. The client must be in force with Voya at the time the refund payment is paid.

Loss Threshold: This represents the amount of premium that is available to share with the client.

Loss Ratio: Must be below 65% of net premium to achieve a refund. Net premium means premium without commissions

Total Excess: Equals the threshold dollar amount minus actual incurred claims

Eligible Refunds: Will be calculated and paid 8 months following the end of the policy incurred period.

Please note: Additional premium may be assessed in exchange for adding this program.

Meeting Location:
County of Fresno
Board of Supervisors Chambers
2281 Tulare Street, #301
Fresno, CA 93721

AGENDA DATE: November 8, 2019

ITEM NUMBER: Item 18

SUBJECT: Approve Kaiser HMO Plan Design Changes for the County of Fresno to Create Parity with the Anthem EPO Plan (A)

REQUEST(S): That the Board approve the recommended plan design changes for the County of Fresno's Kaiser HMO plan.

DESCRIPTION:

At the August 23, 2019 Board meeting, the Board approved the pricing parity for the County of Fresno's Anthem EPO and Kaiser HMO plans to reduce or eliminate adverse selection in the plans.

After the August 23, 2019 Board meeting, Kaiser requested plan design parity between the Anthem EPO and Kaiser HMO plans at no additional cost. Specifically, Kaiser requested the following plan design changes:

- Change the Out-of-Pocket (single/family) Maximum from \$1,500/\$3,000 to \$1,000/\$2,000
- Change Medical Transportation from \$50/trip to \$0/trip

FISCAL IMPACT/FINANCING:

None.

ADMINISTRATIVE SIGN-OFF:



Rhonda Sjostrom
SJVIA Manager



Paul Nerland
SJVIA Assistant Manager

Meeting Location:
County of Fresno
Board of Supervisors Chambers
2281 Tulare Street, #301
Fresno, CA 93721

AGENDA DATE: November 8, 2019

ITEM NUMBER: Item 19

SUBJECT: Receive and Approve County of Tulare's New Anthem \$750 Deductible Plan Design Enhancements (A)

REQUEST(S): That the Board approve the County of Tulare's new Anthem \$750 Deductible Plan Design Enhancements.

DESCRIPTION:

At the August 23, 2019 Board meeting, the Board approved the recommendation to apply plan design changes by decreasing the Anthem \$1,000 Deductible Plan to a \$750 Deductible Plan.

The chart below shows, in greater detail, the plan design enhancements made by moving from the \$1,000 Deductible Plan to the \$750 Deductible Plan.

Plan Design Changes from BC \$1000 to BC \$750 DED PPO Plan

	<u>From</u>	<u>To</u>
Decreased Deductible (Ind./Family)	\$1,000/\$2,000	\$750/\$1,500
Decreased Out of Pocket Max (Ind./Family)	\$4,000/\$8,000	\$3,500/\$7,000
Decreased Co-Pay Office Visit (Primary)	\$45	\$25
Decreased Co-Pay Office Visit (Specialist)	\$45	\$35
Decreased Hospital Inpatient	\$1,000/CY+20%	+20%
Decreased Urgent Care	\$45	\$25

FISCAL IMPACT/FINANCING:

There will be no change to adopted rates and premiums.

AGENDA: San Joaquin Valley Insurance Authority

DATE: November 8, 2019

ADMINISTRATIVE SIGN-OFF:



Rhonda Sjostrom
SJVIA Manager



Paul Nerland
SJVIA Assistant Manager

County of Tulare
Anthem Blue Cross PPO \$1000 Deductible Change to PPO \$750 Deductible
Plan Design Changes Effective: 1/1/2020

 Anthem	Anthem BC PPO \$1000 Deductible	Anthem BC PPO \$750 Deductible
Covered Services	In-Network	In-Network
Annual Deductible		
Individual	\$1,000	\$750
Family	\$2,000	\$1,500
Annual Out-of-Pocket Max		
Individual	\$4,000	\$3,500
Family	\$8,000	\$7,000
Lifetime Max	Unlimited	Unlimited
Office Visit – Primary	\$45 copay	\$25 copay
Office Visit – Specialist	\$45 copay	\$35 copay
Preventive Services	Plan pays 100%	Plan pays 100%
Chiropractic Care	\$25 copay (up to 12 visits per year)	\$25 copay (up to 12 visits per year)
Diagnostic X-ray & Lab	Plan pays 100%	Plan pays 100%
Complex Imaging	20% (after deductible)	20% (after deductible)
Inpatient Hospitalization	\$1,000/yr + 20% (after deductible)	20% (after deductible)
Outpatient Surgery	20% (after deductible)	20% (after deductible)
Urgent Care	\$45 copay	\$25 copay
Emergency Room	\$100 copay (waived if admitted) + 20% (after deductible)	\$100 copay (waived if admitted) + 20% (after deductible)

Meeting Location:
County of Fresno
Board of Supervisors Chambers
2281 Tulare Street, #301
Fresno, CA 93721

AGENDA DATE: November 8, 2019

ITEM NUMBER: Item 20

SUBJECT: Receive Update and Approve Change to County of Fresno's Anthem \$1,500 HDHP, Effective with the 2020 Plan Year, to be in Compliance with ACA Guidelines (A)

REQUEST(S): That the Board approve the change to the Per Member Deductible on the Anthem \$1,500 HDHP, effective with the 2020 plan year.

DESCRIPTION:

The Department of Health & Human Services (HHS) released its Notice of Benefit and Payment Parameters for 2020. This final rule describes benefit and payment parameters under the Affordable Care Act (ACA) that apply for the 2020 benefit year. More specifically, the notice provided updated limits for High Deductible Health Plan deductibles and out-of-pocket limitations.

As a result, the County of Fresno's \$1,500 High Deductible Plan Per Member Calendar Year Deductible is amended as follows:

Calendar Year Deductible	Single	Member	Family
Amount Prior to 1/1/2020:	\$1,500	\$2,700	\$3,000
Effective 1/1/2020:	\$1,500	\$2,800	\$3,000

In all other respects, the County of Fresno's Anthem \$1,500 High Deductible Plan meets ACA requirements.

FISCAL IMPACT/FINANCING:

None.

AGENDA: San Joaquin Valley Insurance Authority

DATE: November 8, 2019

ADMINISTRATIVE SIGN-OFF:



Rhonda Sjostrom
SJVIA Manager



Paul Nerland
SJVIA Assistant Manager

Meeting Location:
County of Fresno
Board of Supervisors Chambers
2281 Tulare Street, #301
Fresno, CA 93721

AGENDA DATE: November 8, 2019

ITEM NUMBER: Item 21

SUBJECT: Receive Update and Approve Change to County of Tulare's Anthem \$2,500 HDHP, Effective January 1, 2020, to be in Compliance with ACA Guidelines (A)

REQUEST(S): That the Board approve the change to the Family Out-of-Pocket Maximum on the Anthem \$2,500 HDHP, effective January 1, 2020.

DESCRIPTION:

The Department of Health & Human Services (HHS) released its Notice of Benefit and Payment Parameters for 2020. This final rule describes benefit and payment parameters under the Affordable Care Act (ACA) that apply for the 2020 benefit year. More specifically, the notice provided updated limits for High Deductible Health Plan deductibles and out-of-pocket limitations.

As a result, the County of Tulare's \$2,500 High Deductible Health Plan's Out-of-Pocket Maximum for Family is amended as follows:

Out-of-Pocket Maximum	Single	Family
Amount Prior to 1/1/2020:	\$5,000	\$10,000
Effective 1/1/2020:	\$5,000	\$8,150

Please note, the County of Tulare's HDHP is a "grandfathered" plan and, as such, does not have an embedded individual deductible. In other words, the family out-of-pocket maximum is non-embedded meaning the cost shares of all family members apply to one shared family out-of-pocket. The individual out-of-pocket only applies to individuals enrolled under single coverage. Additionally, since the amended Family Out-of-Pocket maximum is an enhancement to benefits, the plan is to retain its "grandfathered" status.

AGENDA: San Joaquin Valley Insurance Authority

DATE: November 8, 2019

FISCAL IMPACT/FINANCING:

There will be no change to adopted rates or premiums.

ADMINISTRATIVE SIGN-OFF:



Rhonda Sjostrom
SJVIA Manager



Paul Nerland
SJVIA Assistant Manager

**BOARD OF DIRECTORS**

STEVE BRANDAU
KUYLER CROCKER
NATHAN MAGSIG
BUDDY MENDES
BRIAN PACHECO
AMY SHUKLIAN
PETE VANDER POEL

Meeting Location:
County of Fresno
Board of Supervisors Chambers
2281 Tulare Street, #301
Fresno, CA 93721

AGENDA DATE: November 8, 2019

ITEM NUMBER: Item 22

SUBJECT: Receive Update on the Delta Dental DHMO Employee Only Rate for Plan Year 2020 (I)

REQUEST(S): That the Board receive the update on Delta Dental DHMO Employee Only rate.

DESCRIPTION:

At the August 23, 2019 Board Meeting, the final Plan Year 2020 Renewal was presented for Board approval; however, the cost for the Delta Dental DHMO Employee Only rate was incorrectly shown.

Delta Dental DHMO Employee Only Rate

Rate Shown in Delta Dental DHMO Renewal	Rate Approved by the SJVIA Board	Difference
\$27.68	\$27.38	\$0.30

Delta Dental has agreed to adjust the rate to match the DHMO Employee Only rate approved by the SJVIA Board for Plan Year 2020.

FISCAL IMPACT/FINANCING:

Savings of \$7,081.

ADMINISTRATIVE SIGN-OFF:

Rhonda Sjostrom
SJVIA Manager

Paul Nerland
SJVIA Assistant Manager

**BOARD OF DIRECTORS**

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PETE VANDER POEL

Meeting Location:
County of Fresno
Board of Supervisors Chambers
2281 Tulare Street, #301
Fresno, CA 93721

AGENDA DATE: November 8, 2019

ITEM NUMBER: Item 23

SUBJECT: Receive Update on the Anthem Future Moms Program Cost for Plan Year 2020 (I)

REQUEST(S): That the Board receive the update on Anthem's Future Moms Program cost.

DESCRIPTION:

At the July 19, 2019 meeting, your Board approved the recommendation to implement the Anthem Future Moms Program for a minimum of two consecutive years. The estimated annual cost was \$24,360. At the August 23, 2019 Board Meeting, the final Plan Year 2020 Renewal was presented for Board approval; however, the cost for the Anthem Future Moms Program was inadvertently left out.

Anthem offered to waive the fee for the Future Moms Program for Plan Year 2020. The cost will be included with the 2021 Plan Year renewal.

FISCAL IMPACT/FINANCING:

Savings of \$24,360.

ADMINISTRATIVE SIGN-OFF:

A handwritten signature in black ink that reads "Rhonda Sjostrom".

Rhonda Sjostrom
SJVIA Manager

A handwritten signature in black ink that reads "Paul Nerland".

Paul Nerland
SJVIA Assistant Manager

**BOARD OF DIRECTORS**

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Meeting Location:
County of Fresno
Board of Supervisors Chambers
2281 Tulare Street, #301
Fresno, CA 93721

AGENDA DATE: November 8, 2019

ITEM NUMBER: Item 24

SUBJECT: Approve SJVIA Wellness Funds Allocation
Procedure Recommendation for Plan Year Roll-
Overs (A)

REQUEST(S): That the Board approve the recommended
procedure for wellness funds allocation for plan
year roll-overs.

DESCRIPTION:

At the July 19, 2019 SJVIA Board meeting, your Board approved an allocation of wellness funds for each entity starting with 2019. In the past, any unused wellness funds from the \$2.50 PEPM wellness fee were redirected to the SJVIA's margin reserve accumulation. It is requested that upon the close of each calendar year, any unused wellness balances from the \$2.50 PEPM wellness fee roll over to the following calendar year for each entity's wellness usage.

FISCAL IMPACT/FINANCING:

Below is the 2019 wellness budget allocation for the \$2.50 PEPM fee approved at the July 19, 2019 SJVIA Board meeting:

SJVIA	County of Fresno	County of Tulare	City of Marysville
\$2.50 PEPM Allocation	\$195,240	\$95,280	\$1,500

Any unused wellness funds for calendar year 2019 would be added to the calendar year 2020 allocation.

ADMINISTRATIVE SIGN-OFF:

Rhonda Sjostrom
SJVIA Manager

Paul Nerland
SJVIA Assistant Manager

**BOARD OF DIRECTORS**

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AMY SHUKLIAN

PETE VANDER POEL

Meeting Location:
County of Fresno
Board of Supervisors Chambers
2281 Tulare Street, #301
Fresno, CA 93721

AGENDA DATE: November 8, 2019

ITEM NUMBER: Item 25

SUBJECT: Receive Consultant's Update on Upcoming Annual SJVIA Strategy Meeting (I)

REQUEST(S): That the Board receive the update on the upcoming SJVIA strategy meeting.

DESCRIPTION:

Each year in January, the SJVIA Chair, Vice Chair, CAOs from both the County of Fresno and County of Tulare, SJVIA staff, and Keenan & Associates meet to review the SJVIA plan performance, determine key objectives and goals, and review the overall strategic direction of the SJVIA. The SJVIA staff is once again preparing to hold the strategic planning meeting in January 2020 and will report any outcome at the February 2020 SJVIA Board meeting.

FISCAL IMPACT/FINANCING:

None.

ADMINISTRATIVE SIGN-OFF:

A handwritten signature in black ink that reads "Rhonda Sjostrom".

Rhonda Sjostrom
SJVIA Manager

A handwritten signature in black ink that reads "Paul Nerland".

Paul Nerland
SJVIA Assistant Manager