SJVIA
San Joaquin Valley Insurance Authority

AGENDA

Meeting Location:
Tulare County Employee Retirement Association Board Chambers
136 N Akers St
Visalia, CA 93921
November 9, 2012
9:00 AM

1. Call to Order
2. Roll Call
3. Approval of Agenda
4. 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.
5. Consent Agenda – Items 5a through 5i.
   - These items are routine in nature and are usually approved by a single vote. Prior to action by the Board, the public will be given the opportunity to remove any item from the Consent Calendar. Items removed from the Consent Calendar may be heard immediately following approval of Consent Calendar or set aside until the department can be notified and its representative is in the board room.

   a. Approval of Minutes – Board Meeting of August 24, 2012

   b. Receive and File SJVIA Executive Claims Summary through September 2012

In compliance with the Americans with Disabilities Act, if you need special assistance to participate in this meeting, please contact the SJVIA Manager at 600-1810 or the Assistant SJVIA Manager at 636-4900. 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.

SJVIA
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c. Receive and File Report on SJVIA Marketing Activity

d. Receive and File Report on SJVIA Wellness Activities

e. Receive and File Quarterly Financial Reports

f. Agreement with McCormick, Barstow, Sheppard, Wayte & Carruth LLP for Special Legal Counsel

g. SJVIA Staff Rotation

h. Approval and Execution of SJVIA Participation Agreements with the County of Fresno and Tulare for Plan Year 2013

i. Approve the proposal from Price, Paige and Company to audit the financial statements for the fiscal year ended June 30, 2012

6. Proposed 2013 Board Meeting Calendar (A)

7. Results of SJVIA External Audit for the period ended June 30, 2011 (I)

8. Adopt Fiscal Year Budget 2012-13 (A)

9. Investment Options for SJVIA Cash Reserves (I)

10. Extension of the Consulting Agreement with Gallagher Benefit Services. (A)

11. Health Reform Effect on SJVIA Health Plans (I)

12. SJVIA Growth and Savings Potential (I)

13. Directors Reports. (I)

14. Adjournment

In compliance with the Americans with Disabilities Act, if you need special assistance to participate in this meeting, please contact the SJVIA Manager at 600-1810 or the Assistant SJVIA Manager at 636-4900. 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.

SJVIA
San Joaquin Valley Insurance Authority

Meeting Minutes

Meeting Location:
Fresno County Employee Retirement Association Board Chambers
1111 H Street
Fresno, CA 93721
August 24, 2012
9:00 AM

1. Call to Order

   Meeting was called to order by President Pete Vander Poel at 9:03 AM

2. Roll Call

   Roll was called by Michele Mills, Gallagher Benefit Services. In attendance were Director Anderson, Director Case, Director Ennis, Director Larson, Director Poochigian, and Director Vander Poel were present. Director Ishida arrived at 9:35 AM.

3. Approval of Agenda

   President Vander Poel asked if there were any additions or corrections to the agenda. Director Ennis moved to approve the agenda with no changes, the motion was seconded by Director Case. The motion passed unanimously.

4. 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.

   President Vander Poel opened the floor for any public comment. No public comment.

5. Consent Agenda – Items 5a through 5d.

   – *These items are routine in nature and are usually approved by a single vote. Prior to action by the Board, the public will be given the opportunity to remove any item from the Consent Calendar. Items removed from the Consent Calendar may be heard immediately following approval of*

Consent Calendar or set aside until the department can be notified and its representative is in the board room.

Director Vander Poel asked if there were any items from the consent agenda that any Board Member would like to have pulled for further discussion. Items 5b and 5d were pulled for discussion.

Director Ennis moved for approval of consent agenda items 5a and 5c. Director Case seconded the motion, which passed unanimously.

a. Approval of Minutes – Board Meeting of July 20, 2012

b. Receive and File SJVIA Executive Claims Summary through June 2012

   Director Case requested the review of the claims during the meeting as she noted higher costs in the HMO cost. Alan Thaxter addressed the question regarding the HMO and the appearance of increased unit costs. He explained that utilization tends to fluctuate during the course of the year and that the HMO has been running higher this year.

c. Receive and File Report on SJVIA Marketing Activity

d. Receive and File Fourth Quarter Financial Statements

   Director Case asked for clarification on the line item for claims management and communication, inquiring as to the use of these funds. Paul Nerland, SJVIA Manager, clarified that claims management is the allocation for the wellness initiatives of the SJVIA. Director Case suggested changing the name of this line item and separating the claims management and communication on future reports. Joseph Nuttman, ACTTC from Fresno County responded that these can be separated and will be completed for the next report.

   Director Case also asked where the money held in reserves for the SJVIA was being held. She asked if the funds were being held in an interest earning account. At this time the account is not earning interest but as the SJVIA grows this position will be reviewed.

Director case also commented that even a portion of the funds should be moved into an account that would earn interest on behalf of the SJVIA.

Director Poochigian asked if there were any outliers in the financial reports. Paul Nerland commented that staff is paying close attention to the administration fee of $2.00 pepm. Costs related to the SJVIA administration have been running higher during the last reporting cycle based on the auditing of financials and start up of the SJVIA. He also mentioned that there are cyclical costs making it appear that there is a deficit at a particular time of the year. Mr. Nerland alluded to a meeting with Vicki Crow, Auditor-Treasurer as to the charges to the SJVIA. Ms. Crow reported in that meeting that additional cost/hours were needed to move the SJVIA to a shared risk model but that it is expected that Auditor-Treasurer labor costs will stabilize.

Director Poochigian also asked if fixed costs such as the administration and consultant fee would go down over time. Paul Nerland stated that moving to a shared risk model achieved efficiencies and reduced the total number of financial transactions. He also mentioned that staff will analyze whether further efficiencies may be achieved. Director Poochigian moved for the approval of item 5d, Director Case seconded the motion. The motion was approved unanimously.

6. Request for use of claims mitigation funds to conduct Mobile Mammography Screenings and authorization for execution of contract with Pacific Coast Medical Services. (A)

Jeffrey Cardell gave an overview of the claims mitigation funds and the request to use a portion the funds available for mobile mammography screenings. The County of Tulare utilized the recommended vendor for their mobile mammography screening services in 2010 with great success. The costs for the tests are less than would be charged through a local facility, so there is savings opportunity for the plan. If any follow up is required, the participant is referred to her physician. Director Ennis moved to approve the request for use of claims mitigation funds for mobile

mammography for SJVIA member entities. Director Anderson seconded the motion, which passed unanimously.

7. Authorization of communication funds expense for the design and production of open enrollment materials for the County of Fresno and the County of Tulare. (A)

   Jeffrey Cardell explained the request for the use of the communication funds to produce the open enrollment materials. The Counties in the past have used their internal print shop to produce materials and will be exploring the option of using outside vendors. The process will remain as cost effective and prudent as in the past but with the goal to improve the effectiveness of the communication materials but be cautious of making them appear costly.

   Paul Nerland added that electronic communication will also be maximized to enhance the past communication procedures. He commented that the use of electronic will not replace the hard copies all together, but will be there for ease of reference and to supplement the materials.

   Director Poochigian moved for the approval of the request to use communication funds to produce the open enrollment materials for the County of Fresno and the County of Tulare. Director Case seconded the motion, which passed unanimously.

8. Approve the selection of US Script as the pharmacy benefit manager and authorize Board Chair to execute the agreement effective December 10, 2012. (A)

   Paul Nerland explained the process of the finalist interviews and explained the difference between the pass through and traditional contract options. Michele Mills, Gallagher Benefit Services, commented on the RFP process and the finalist interview, giving a brief summary of the decision to recommend US Script for the 2013 plan year, replacing Catalyst Rx.

   Pete Clagett, President and CEO of US Script, and Don Anderson, Clinical Pharmacist with US Script were in attendance to be introduced to the Board.

Director Ennis moved for the approval of the selection of US Script and authorization of the Board Chair to execute the agreement effective December 10, 2012. The motion was seconded by Director Anderson and was passed unanimously.

9. Consider additional benefit option for the SJVIA. (A)

    a. Approve the acceptance of proposals from Delta Dental and VSP Vision for the 2013 Plan year

        Jeffrey Cardell gave an overview of the programs in place at each County for vision and dental. The options available to the SJVIA will be with Delta Dental as a PPO and HMO offering, and VSP for a fully insured vision option.

        The approval of the SJVIA Board for these options would provide the opportunity to offer them to their employees. Both options include benefits that are similar to what is in place currently with each County.

        Director Larson moved to approve the proposals received from Delta Dental and VSP vision for the 2013 plan year. Director Poochigian seconded the motion which unanimously passed.

    b. Approve recommendation to reevaluate offering a Kaiser HMO option for plan year 2014

        Paul Nerland explained that at this time Kaiser declined to offer a quote through the SJVIA.

        Director Anderson approved the recommendation for reevaluation of a Kaiser option for the SJVIA for the 2014 plan year. Director Ennis seconded the moment and it was passed unanimously.

10. Approve the release of proposals and authorize the Board President to execute Participation Agreements contingent upon acceptance and approval by the interested entities' governing bodies. (A)

Alan Thaxter, Gallagher Benefit Services, gave an overview of the process of the development of proposals released to potential member entities.

Director Poochigian asked if the SJVIA is mindful in their underwriting of the potential impact to the SJVIA's stability. Mr. Thaxter confirmed and stated that as part of the underwriting process, the SJVIA analyzes the demographics and other aspects of the interested entities, including size, location, and claims history.

Director Poochigian requested a Board briefing report outlining potential administrative savings available as the SJVIA grows. LeRoy Tucker, Gallagher Benefit Services, explained that as the enrollment in the SJVIA grows, there is opportunity to decrease the fixed costs. Also, with a larger group, the stop loss deductible can be increased which impacts premium positively.

11. Approve and adopt the recommended renewal rates for the 2013 plan year. (A)

Jeffrey Cardell reviewed the initial renewal offered to the SJVIA at the July Board meeting of a 7-11% range of increase for the 2013 plan year. The addition of favorable June claims data affected the renewal positively. Following the underwriting guidelines of the SJVIA as adopted by the Board, claims and demographics were analyzed and staff is recommending a 4.9% increase to all plans.

In the last week, new information was delivered to the County of Fresno directly that impacts the SJVIA renewal significantly. Director Poochigian asked how this information is analyzed both on behalf of the SJVIA and on behalf of the member Counties and if there was a conflict of interest potential. Jeffrey Cardell explained that SJVIA management and Gallagher Benefit Services work diligently to make certain that the best interest of the Counties and the SJVIA are considered in all decisions. Crystal Sullivan commented that as time progresses the contracts between GBS and the Counties and/or SJVIA will need to be analyzed to ensure there is no conflict of interest potential.

LeRoy Tucker, Gallagher Benefit Services, explained the recent offering from Kaiser to the County of Fresno which, if accepted, would significantly

impact the renewal offering of the SJVIA. Bruce Caldwell, Gallagher Benefit Services, explained that GBS is committed to presenting the analysis and ramification of all options, both short and long term. If the County of Fresno, at a subsequent Board Meeting elected to accept the renewal proposal from Kaiser, the overall SJVIA renewal would be recalculated based upon actuarial assumptions and assumed migration. Also, due to the projected change in enrollment Anthem offered a revised renewal based on this scenario. The revised enrollment recommendation, taking all factors into consideration, would be at 18.4% overall for the 2013 plan year.

Director Case moved to approve and adopt the recommended 4.9% increase to all plans. The motion was seconded by Director Ennis and passed unanimously.

12. Directors Reports. (I)

    There were no reports.

13. Adjournment

    Meeting adjourned at 11:23 AM by Director Vander Poel.

SJVIA
San Joaquin Valley Insurance Authority

Meeting Location:
Tulare County Employee Retirement Association Board Chambers
136 N. Akers Street
Visalia, CA 93291
November 9, 2012
9:00 AM

AGENDA DATE: November 9, 2012

ITEM NUMBER 5b

SUBJECT Receive and File SJVIA Executive Claims Summary through September 2012

REQUEST(S): That the Board receive and file the Executive Claims Summary

DESCRIPTION:

Gallagher Benefit Services (GBS) has been compiling and delivering the attached Monthly Claims Report to SJVIA staff. The report provides a high level view of several key claims metrics and is useful in the early identification of potential trends and outliers. The Monthly Claims Report is meant to augment the quarterly (and annual) claims report and opportunity analysis developed by Anthem Blue Cross.

As requested by your board, a Large Claim Report has been included in the Monthly Claim Report (page 3). This summary details claims that have reached 50% of the pooling point ($250,000) for the HMO plan as well as claims that have reached 50% of the stop loss deductible ($450,000) for the PPO plans.

AGENDA: San Joaquin Valley Insurance Authority

DATE: November 9, 2012

The attached Monthly Claims Report, dated October 25, 2012, reflects claims data through September 2012. The report consists of the following sections:

- Executive Summary
- Large Claim Report
- Overview of all plans
    - Average Monthly Enrollment
    - Average Monthly Premium
    - Average Monthly Claims
    - Total Premium Breakdown
    - Total Expenses and Premiums (Monthly and Cumulative)
    - Claims Per Employee Per Month – Year over Year and from inception

For comparative purposes, each report includes 2011 data tables and 2010 data tables.

Monthly and Year-to-Date claims totals listed represent gross claims and do not reflect the impact of any reimbursements from either the PPO stop loss carrier (HM Life) or the HMO carrier (Anthem Blue Cross). There are currently over $1.8 million in reimbursements for claims that are in excess of the specific deductible (PPO0 or the pooling point (HMO). Gallagher Benefit Services continues to monitor and report on the overall claims position of the SJVIA.

NOTE: Beginning in 2013, the Executive Claims Summary will begin capturing and reporting claims information from the City of Tulare.

FISCAL IMPACT/FINANCING:

None

AGENDA: San Joaquin Valley Insurance Authority

DATE: November 9, 2012

ADMINISTRATIVE SIGN-OFF:

Paul Nerland
SJVIA Manager

Jeffrey Cardell
Assistant SJVIA Manager

BEFORE THE BOARD OF DIRECTORS
SAN JOAQUIN VALLEY INSURANCE AUTHORITY

IN THE MATTER OF Receive and File SJVIA Executive Claims Summary through September 2012

RESOLUTION NO. _____
AGREEMENT NO. _____

UPON MOTION OF DIRECTOR _____, SECONDED BY DIRECTOR _____, THE FOLLOWING WAS ADOPTED BY THE BOARD OF DIRECTORS, AT AN OFFICIAL MEETING HELD _____ _____, BY THE FOLLOWING VOTE:

AYES:
NOES:
ABSTAIN:
ABSENT:

ATTEST:

BY: _____

* * * * * * * * * * * * * * * * * * *

That the Board received and filed the Executive Claims Summary

Gallagher Benefit Services, Inc.
thinking ahead

2012 SJVIA Monthly Claims Report

Claims Data Through September 2012

www.gallagherbenefits.com

- **Prepared By Gallagher Benefit Services**

October 26, 2012

Large Claim Report - 2012

San Joaquin Valley Insurance Authority

Potential Large Dollar Claimants

HMO Plan

January 1, 2012 through December 31, 2012 as of September 2012

Pooling Point $250,000

Relationship	Paid	Diagnosis	Reimbursment
Subscriber	$ 1,217,051	Blood Disorders(16)	$ 967,051.00
Dependent	$ 701,332	Digestive System (06)	$ 451,332.00
Dependent	$ 423,739	Muscle/Tissue Disorders(08)	$ 173,739.00
Dependent	$ 361,763	Myeloid Disorders (17)	$ 111,763.00
Subscriber	$ 284,991	Myeloid Disorders (17)	$ 34,991.00

Total HMO Pooling Reimbursements **$ 1,738,876.00**

PPO Plan

January 1, 2012 through December 31, 2012 as of September 2012

Stop Loss Deductible $450,000

Relationship	Paid	Diagnosis	Reimbursment
SUB	$ 532,757	Nervous System (01)	$ 82,757.00

*Anthem Blue Cross does not begin reporting large claims until they reach $50,000

Total PPO Stop Loss Reimbursements **$ 82,757.00**

Total SJVIA Pooling and Stop Loss Reimbursements **$ 1,821,633.00**

Large Claim Report - 2011

San Joaquin Valley Insurance Authority

Potential Large Dollar Claimants

HMO Plan

January 1, 2011 through December 31, 2011

Pooling Point $250,000

Relationship	Paid	Diagnosis	Reimbursment
Dependent	$599,053.00	Circulatory System (05)	$ 349,053.00
Subscriber	$495,130.00	Respiratory System (04)	$ 245,130.00
Dependent	$365,880.00	Multiple Significant Trauma (24)	$ 115,880.00
Subscriber	$324,200.00	Muscle/Tissue Disorders(08)	$ 74,200.00
Dependent	$320,918.00	Kidney Disorders (11)	$ 70,918.00
Subscriber	$261,804.00	Blood Disorders (16)	$ 11,804.00

Total HMO Pooling Reimbursements **$ 866,985.00**

PPO Plan

January 1, 2011 through December 31, 2011

Stop Loss Deductible $450,000

As of 1/31/2012

Relationship	Paid	Diagnosis	Reimbursment
Subscriber	$670,164.00	Nervous System (01)	$ 220,164.00
Dependent	$442,273.00	Circulatory System (05)	

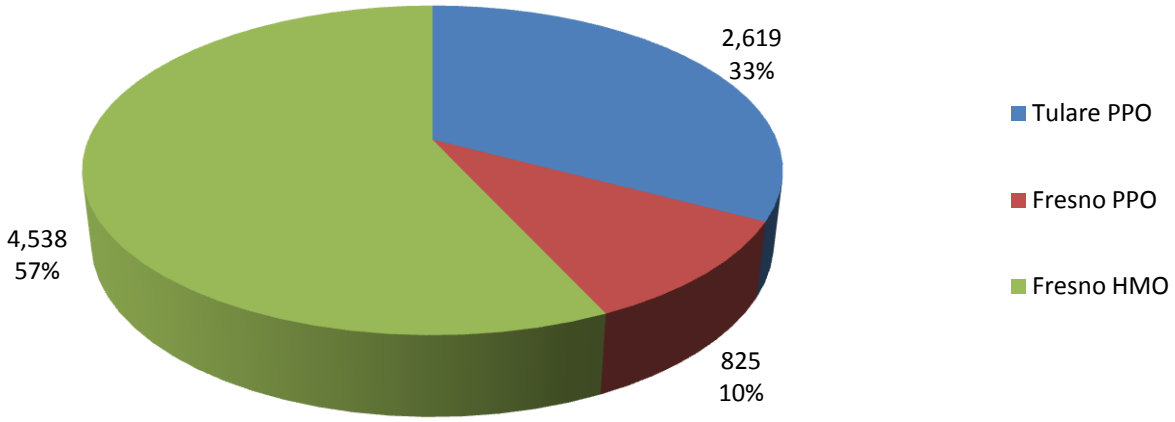
Total PPO Stop Loss Reimbursements **$ 220,164.00**

Total SJVIA Pooling and Stop Loss Reimbursements	**$ 1,087,149.00**

SJVIA - All Plans

SJVIA - All Plans

SJVIA Average Monthly Enrollment - 2012



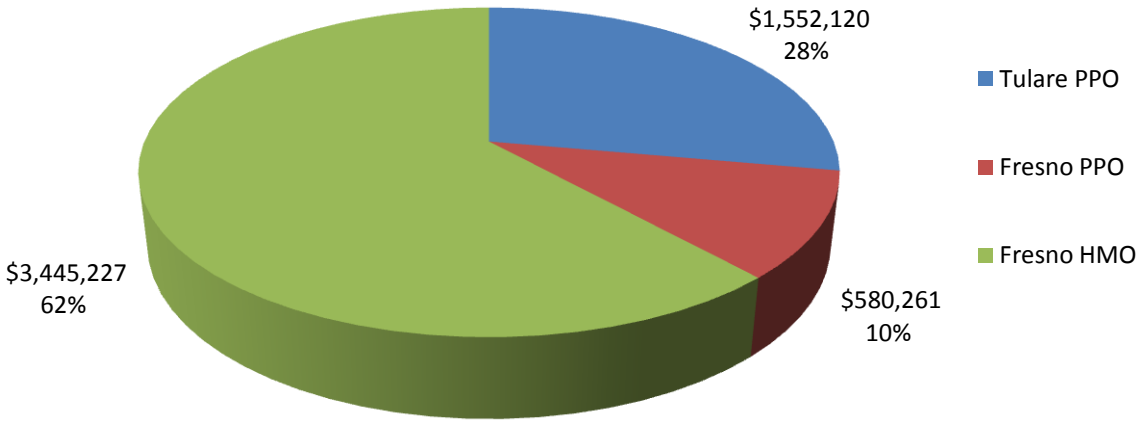
2012 Enrollment - All Plans	January	February	March	April	May	June	July	August	September	October	November	December	YTD Totals
CoT PPO	2,578	2,622	2,603	2,601	2,617	2,633	2,633	2,634	2,649	0	0	0	23,570
CoF PPO	810	810	822	819	823	836	829	837	836	0	0	0	7,422
CoF HMO	4,538	4,542	4,551	4,495	4,455	4,544	4,558	4,569	4,592	0	0	0	40,844
Total	**7,926**	**7,974**	**7,976**	**7,915**	**7,895**	**8,013**	**8,020**	**8,040**	**8,077**				**71,836**

2011 Enrollment - All Plans	January	February	March	April	May	June	July	August	September	October	November	December	YTD Totals
CoT PPO	2,627	2,649	2,633	2,617	2,608	2,574	2,584	2,578	2,577	2,582	2,571	2,569	31,169
CoF PPO	912	901	899	894	890	885	872	864	870	863	853	847	10,550
CoF HMO	5,002	4,986	4,979	4,936	4,932	4,934	4,907	4,901	4,880	4,867	4,877	4,885	59,086
Total	**8,541**	**8,536**	**8,511**	**8,447**	**8,430**	**8,393**	**8,363**	**8,343**	**8,327**	**8,312**	**8,301**	**8,301**	**100,805**

2010 Enrollment - All Plans	January	February	March	April	May	June	July	August	September	October	November	December	YTD Totals
CoT PPO	2,774	2,743	2,737	2,721	2,723	2,739	2,723	2,708	2,706	2,694	2,694	2,698	32,660
CoF PPO	1,009	978	972	1,018	999	985	979	974	968	953	941	909	11,685
CoF HMO	5,100	5,068	5,174	5,163	5,159	5,032	5,010	4,990	4,945	4,955	4,982	5,023	60,601
Total	**8,883**	**8,789**	**8,883**	**8,902**	**8,881**	**8,756**	**8,712**	**8,672**	**8,619**	**8,602**	**8,617**	**8,630**	**104,946**

SJVIA - All Plans

SJVIA Average Monthly Premiums - 2012



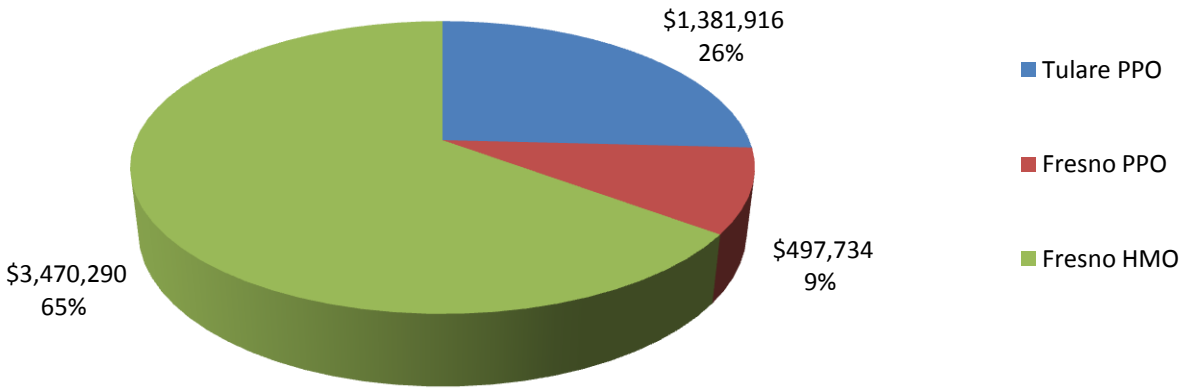
2012 Premiums - All Plans	January	February	March	April	May	June	July	August	September	October	November	December	YTD Totals
CoT PPO	$1,532,991	$1,557,210	$1,545,778	$1,542,574	$ 1,552,519	$1,557,795	$1,557,795	$ 1,557,024	$1,565,391	$ -	$ -	$ -	$ 13,969,076
CoF PPO	$ 573,804	$ 574,013	$ 580,838	$ 579,490	$ 581,428	$ 586,528	$ 580,393	$ 582,946	$ 582,907	$ -	$ -	$ -	$ 5,222,345
CoF HMO	$3,456,547	$3,457,039	$3,458,125	$3,419,330	$ 3,383,249	$3,444,977	$3,454,073	$ 3,460,240	$3,473,467	$ -	$ -	$ -	$ 31,007,047
Total	**$5,563,341**	**$5,588,262**	**$5,584,740**	**$5,541,393**	**$ 5,517,195**	**$5,589,300**	**$5,592,261**	**$ 5,600,210**	**$5,621,765**				**$ 50,198,468**

2011 Premiums - All Plans	January	February	March	April	May	June	July	August	September	October	November	December	YTD Totals
CoT PPO	$1,592,800	$1,600,772	$1,591,108	$1,578,978	$1,572,623	$1,553,821	$1,559,220	$ 1,554,372	$1,546,005	$1,546,501	$1,533,944	$1,532,603	$ 18,762,748
CoF PPO	$ 684,553	$ 675,349	$ 671,720	$ 667,982	$ 659,896	$ 659,650	$ 646,810	$ 640,938	$ 646,434	$ 642,383	$ 633,063	$ 624,270	$ 7,853,047
CoF HMO	$3,796,210	$3,786,616	$3,784,046	$3,757,878	$3,756,403	$3,755,927	$3,737,344	$ 3,733,283	$3,714,626	$3,706,282	$3,711,276	$3,715,393	$ 44,955,284
Total	**$6,073,563**	**$6,062,737**	**$6,046,874**	**$6,004,837**	**$5,988,922**	**$5,969,398**	**$5,943,374**	**$ 5,928,593**	**$5,907,065**	**$5,895,166**	**$5,878,283**	**$5,872,267**	**$ 71,571,079**

2010 Premiums - All Plans	January	February	March	April	May	June	July	August	September	October	November	December	YTD Totals
CoT PPO	$1,516,067	$1,498,594	$1,494,485	$1,495,389	$1,495,268	$1,502,929	$1,494,382	$ 1,487,459	$1,488,058	$1,479,144	$1,479,681	$ 1,480,142	$ 17,911,599
CoF PPO	$ 761,302	$ 738,520	$ 735,453	$ 762,059	$ 747,527	$ 739,978	$ 734,572	$ 732,670	$ 729,357	$ 717,265	$ 709,468	$ 664,075	$ 8,772,247
CoF HMO	$3,534,072	$3,515,747	$3,581,081	$3,585,780	$3,585,623	$3,503,691	$3,495,565	$ 3,485,105	$3,453,230	$3,460,027	$3,475,826	$ 3,504,586	$ 42,180,333
Total	**$5,811,441**	**$5,752,861**	**$5,811,020**	**$5,843,228**	**$5,828,418**	**$5,746,598**	**$5,724,520**	**$ 5,705,233**	**$5,670,645**	**$5,656,436**	**$5,664,975**	**$ 5,648,803**	**$ 68,864,178**

SJVIA - All Plans

SJVIA Average Monthly Claims - 2012

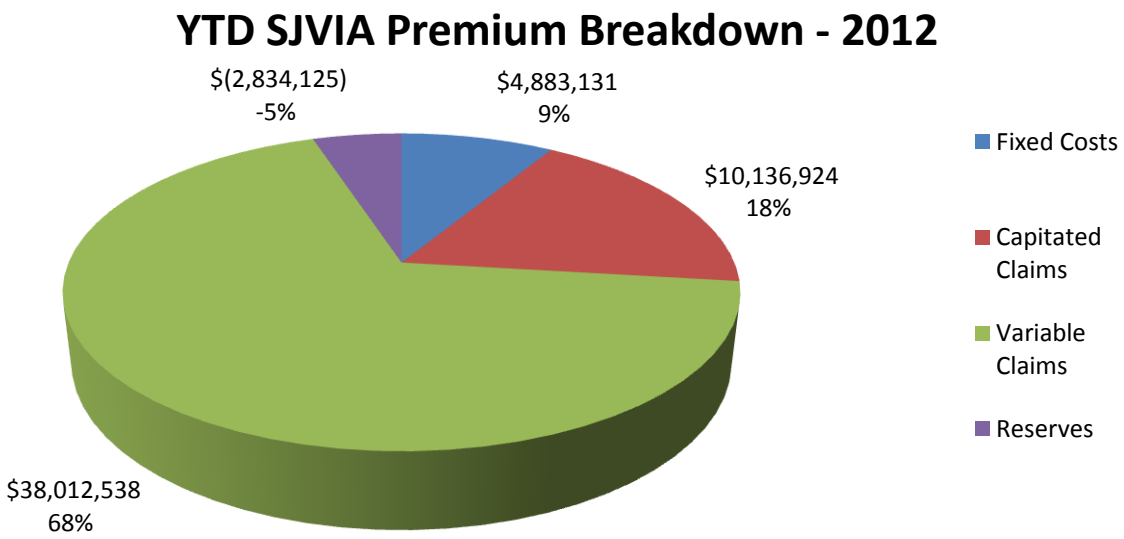


2012 Claims - All Plans	January	February	March	April	May	June	July	August	September	October	November	December	YTD Totals
CoT PPO	$1,347,900	$1,417,340	$1,637,712	$1,363,071	$ 1,265,474	$1,392,625	$1,320,460	$ 1,192,627	$1,500,032	$ -	$ -	$ -	$ 12,437,241
CoF PPO	$ 385,926	$ 490,303	$ 526,293	$ 500,279	$ 437,872	$ 517,707	$ 432,823	$ 650,127	$ 538,280	$ -	$ -	$ -	$ 4,479,610
CoF HMO	$2,914,797	$3,715,713	$3,167,391	$3,532,502	$ 4,064,812	$3,374,399	$3,821,018	$ 3,468,350	$3,173,628	$ -	$ -	$ -	$ 31,232,611
Total	**$4,648,623**	**$5,623,356**	**$5,331,396**	**$5,395,852**	**$ 5,768,158**	**$5,284,731**	**$5,574,301**	**$ 5,311,104**	**$5,211,941**	**$ -**	**$ -**	**$ -**	**$ 48,149,462**

2011 Claims - All Plans	January	February	March	April	May	June	July	August	September	October	November	December	YTD Totals
CoT PPO	$1,256,050	$1,060,066	$1,476,111	$1,234,501	$1,308,598	$1,591,586	$1,194,338	$ 1,587,940	$1,532,560	$1,339,380	$1,282,913	$1,219,091	$ 16,083,134
CoF PPO	$ 690,411	$ 399,817	$ 654,688	$ 423,453	$ 609,769	$ 720,386	$ 625,458	$ 596,721	$ 520,499	$ 509,449	$ 688,233	$ 575,391	$ 7,014,275
CoF HMO	$3,280,026	$2,680,428	$3,208,836	$3,193,916	$3,186,527	$3,413,616	$3,700,784	$ 3,946,698	$3,489,436	$3,479,613	$3,417,317	$3,244,097	$ 40,241,294
Total	**$5,226,487**	**$4,140,311**	**$5,339,635**	**$4,851,870**	**$5,104,894**	**$5,725,588**	**$5,520,580**	**$ 6,131,359**	**$5,542,495**	**$5,328,442**	**$5,388,463**	**$5,038,579**	**$ 63,338,703**

2010 Claims - All Plans	January	February	March	April	May	June	July	August	September	October	November	December	YTD Totals
CoT PPO	$ 408,232	$ 977,011	$1,481,424	$1,400,115	$1,337,312	$1,453,184	$1,182,271	$ 1,210,043	$1,281,284	$1,302,975	$1,810,903	$ 1,532,398	$ 15,377,152
CoF PPO	$ 189,847	$ 289,988	$ 611,860	$ 512,418	$ 558,441	$ 865,929	$ 523,529	$ 1,014,825	$ 497,751	$ 326,333	$ 626,108	$ 560,439	$ 6,577,468
CoF HMO	$2,383,122	$2,513,494	$3,413,474	$3,068,387	$2,843,819	$3,032,195	$2,750,642	$ 2,725,565	$2,823,718	$3,294,441	$3,707,387	$ 2,965,015	$ 35,521,259
Total	**$2,981,201**	**$3,780,493**	**$5,506,758**	**$4,980,920**	**$4,739,572**	**$5,351,308**	**$4,456,442**	**$ 4,950,433**	**$4,602,753**	**$4,923,749**	**$6,144,398**	**$ 5,057,852**	**$ 57,475,879**

SJVIA - All Plans

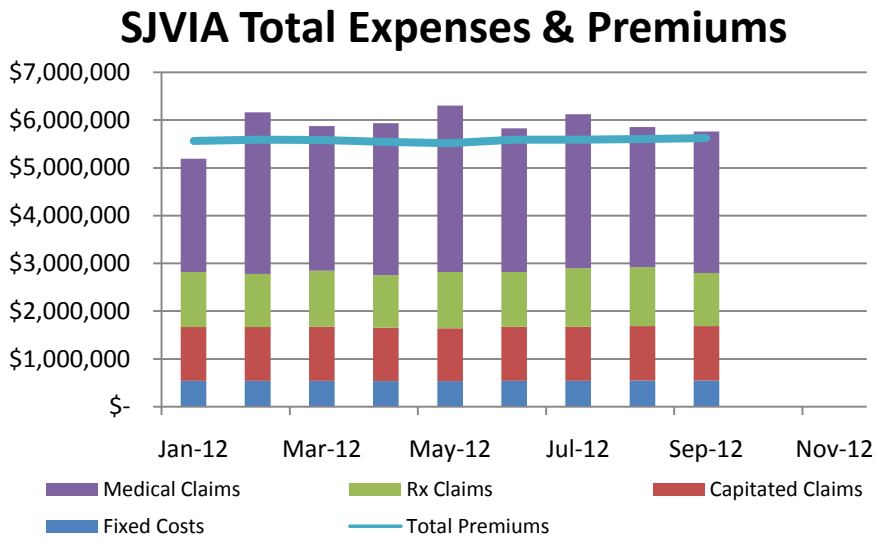


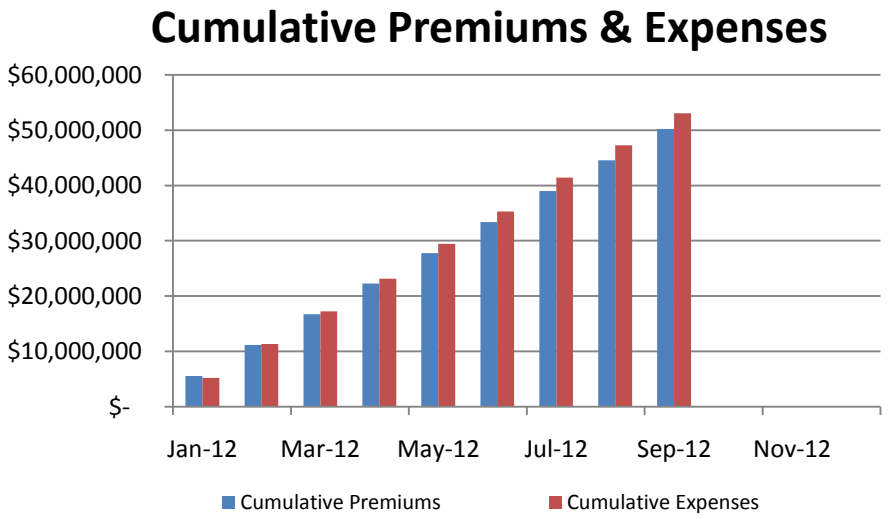
2012 Premium Breakdown - All Plans	January	February	March	April	May	June	July	August	September	October	November	December	YTD Totals
Fixed Costs	$ 539,562	$ 542,245	$ 542,577	$ 537,900	$ 535,828	$ 544,395	$ 545,120	$ 546,470	$ 549,034	$ -	$ -	$ -	$ 4,883,131
Capitated Claims	$1,125,742	$1,126,734	$1,128,967	$1,115,075	$ 1,105,152	$1,126,982	$1,130,703	$ 1,138,432	$1,139,137	$ -	$ -	$ -	$ 10,136,924
Variable Claims	$3,522,881	$4,496,622	$4,202,429	$4,280,777	$ 4,663,006	$4,157,749	$4,443,598	$ 4,172,672	$4,072,804	$ -	$ -	$ -	$ 38,012,538
Reserves	$ 375,156	$ (577,340)	$ (289,233)	$ (392,359)	$ (786,791)	$ (239,826)	$ (527,159)	$ (257,364)	$ (139,210)	$ -	$ -	$ -	$ (2,834,125)

2011 Premium Breakdown - All Plans	January	February	March	April	May	June	July	August	September	October	November	December	YTD Totals
Fixed Costs	$ 572,465	$ 571,769	$ 570,304	$ 565,862	$ 564,887	$ 563,061	$ 560,790	$ 559,607	$ 558,214	$ 557,092	$ 556,809	$ 557,030	$ 6,757,890
Capitated Claims	$1,207,019	$1,200,272	$1,198,826	$1,189,669	$1,185,331	$1,187,259	$1,182,681	$ 1,180,271	$1,175,934	$1,172,801	$1,175,211	$1,177,138	$ 14,232,412
Variable Claims	$4,019,468	$2,940,039	$4,140,809	$3,662,201	$3,919,563	$4,538,329	$4,337,899	$ 4,951,088	$4,366,561	$4,155,641	$4,213,252	$3,861,441	$ 49,106,291
Reserves	$ 274,611	$1,350,658	$ 136,935	$ 587,105	$ 319,141	$ (319,251)	$ (137,996)	$ (762,373)	$ (193,644)	$ 9,633	$ (66,989)	$ 276,658	$ 1,474,487

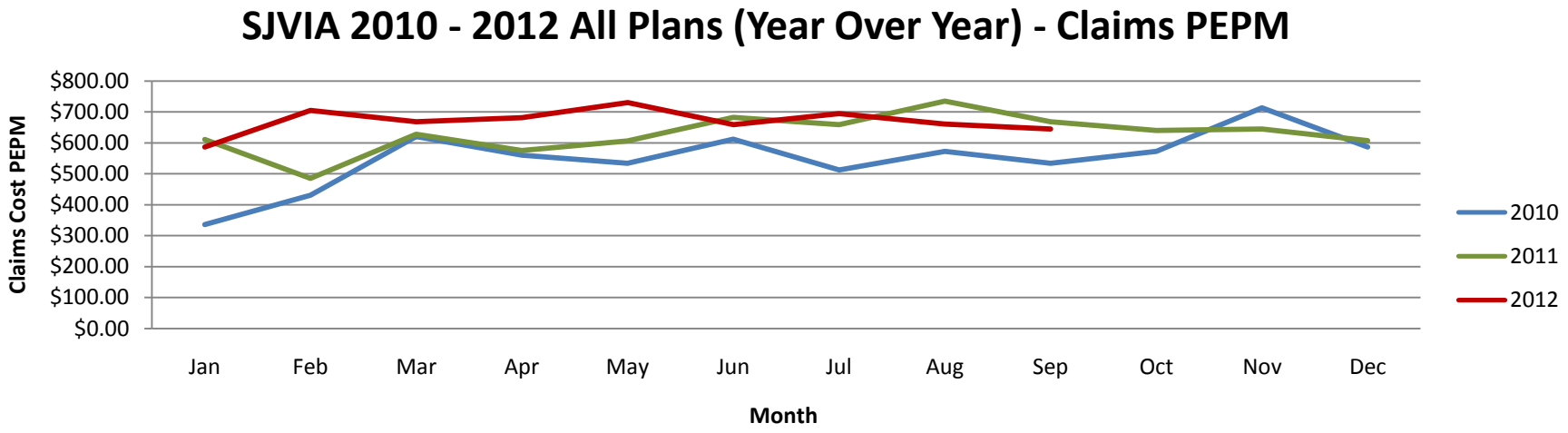
2010 Premium Breakdown - All Plans	January	February	March	April	May	June	July	August	September	October	November	December	YTD Totals
Fixed Costs	$ 532,723	$ 527,513	$ 534,162	$ 534,875	$ 533,773	$ 525,202	$ 522,627	$ 520,286	$ 516,824	$ 516,189	$ 517,446	$ 518,877	$ 6,300,498
Capitated Claims	$1,127,559	$1,120,494	$1,143,920	$1,141,471	$1,140,603	$1,112,525	$1,107,661	$ 1,103,239	$1,093,290	$1,095,501	$1,101,470	$ 1,110,535	$ 13,398,268
Variable Claims	$1,853,642	$2,659,999	$4,362,838	$3,839,449	$3,598,969	$4,238,783	$3,348,781	$ 3,847,194	$3,509,463	$3,828,248	$5,042,928	$ 3,947,317	$ 44,077,611
Reserves	$2,297,516	$1,444,855	$ (229,900)	$ 327,433	$ 555,074	$ (129,912)	$ 745,451	$ 234,514	$ 551,068	$ 216,498	$ (996,869)	$ 72,074	$ 5,087,802

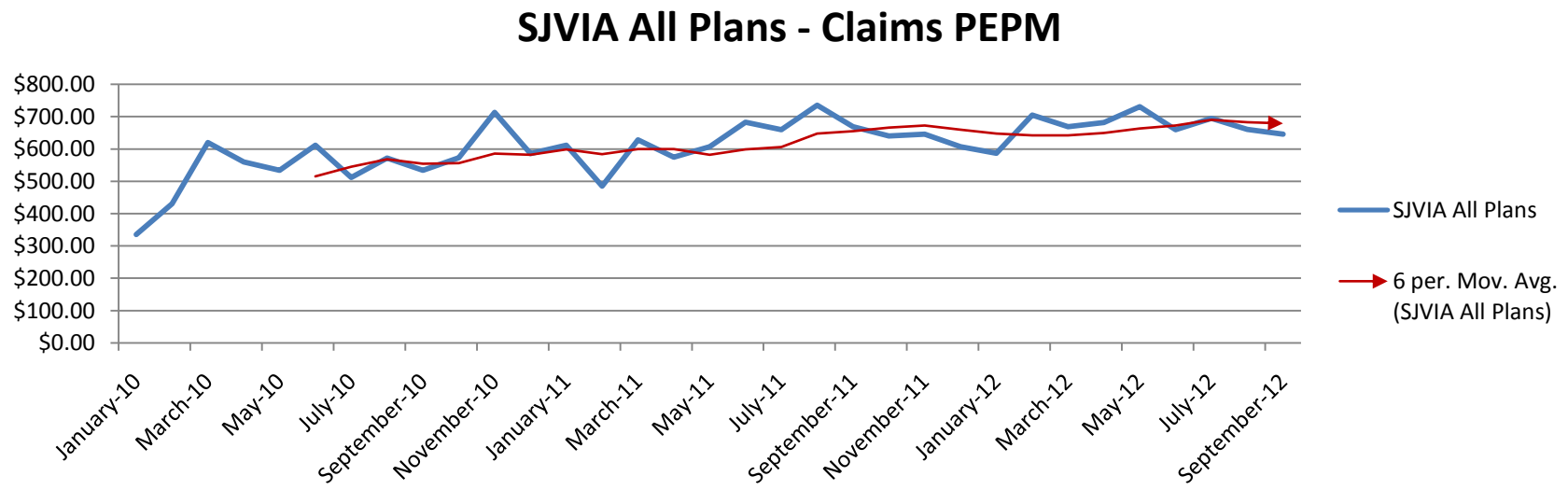
SJVIA – All Plans





SJVIA - All Plans



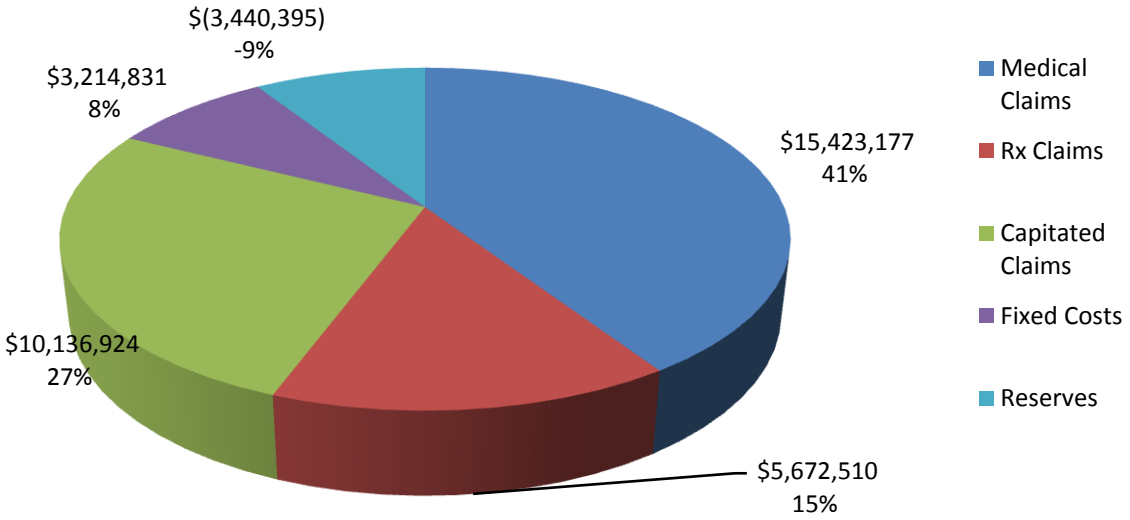


*PEPM – Per Employee Per Month

SJVIA - HMO

SJVIA - HMO

YTD HMO Premium Breakdown - 2012

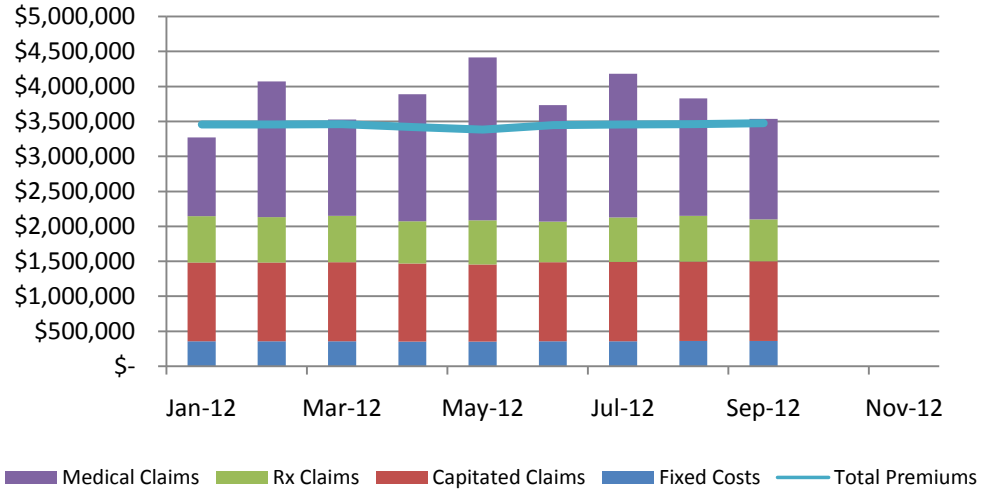


2012 Premium Breakdown - HMO	January	February	March	April	May	June	July	August	September	October	November	December	YTD Totals
Fixed Costs	$ 357,186	$ 357,501	$ 358,209	$ 353,801	$ 350,653	$ 357,658	$ 358,760	$ 359,626	$ 361,436	$ -	$ -	$ -	$ 3,214,831
Capitated Claims	$1,125,742	$1,126,734	$1,128,967	$1,115,075	$ 1,105,152	$1,126,982	$1,130,703	$ 1,138,432	$1,139,137	$ -	$ -	$ -	$ 10,136,924
Medical Claims	$1,128,332	$1,941,584	$1,376,948	$1,816,134	$ 2,330,814	$1,662,356	$2,054,136	$ 1,679,713	$1,433,160	$ -	$ -	$ -	$ 15,423,177
Rx Claims	$ 660,723	$ 647,395	$ 661,476	$ 601,293	$ 628,846	$ 585,061	$ 636,179	$ 650,205	$ 601,331	$ -	$ -	$ -	$ 5,672,510
Reserves	$ 184,564	$ (616,175)	$ (67,475)	$ (466,974)	$(1,032,216)	$ (287,080)	$ (725,705)	$ (367,736)	$ (61,597)	$ -	$ -	$ -	$ (3,440,395)

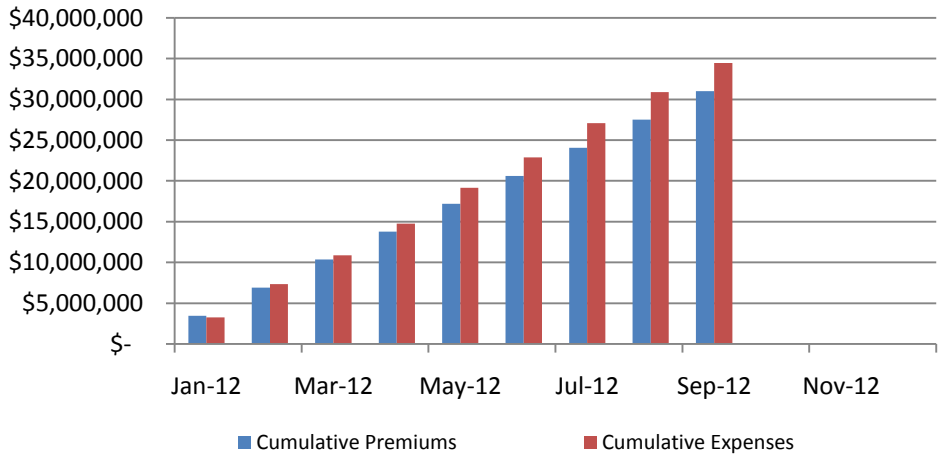
2011 Premium Breakdown - HMO	January	February	March	April	May	June	July	August	September	October	November	December	YTD Totals
Fixed Costs	$ 392,507	$ 391,251	$ 390,702	$ 387,328	$ 387,014	$ 387,171	$ 385,052	$ 384,581	$ 382,934	$ 381,913	$ 382,698	$ 383,326	$ 4,636,478
Capitated Claims	$1,207,019	$1,200,272	$1,198,826	$1,189,669	$1,185,331	$1,187,259	$1,182,681	$ 1,180,271	$1,175,934	$1,172,801	$1,175,211	$1,177,138	$ 14,232,412
Medical Claims	$1,456,998	$ 949,741	$1,408,225	$1,383,120	$1,418,729	$1,637,044	$1,922,731	$ 2,132,702	$1,683,604	$1,665,758	$1,627,475	$1,472,804	$ 18,758,931
Rx Claims	$ 616,009	$ 530,415	$ 601,785	$ 621,127	$ 582,467	$ 589,313	$ 595,372	$ 633,725	$ 629,898	$ 641,054	$ 614,631	$ 594,155	$ 7,249,951
Reserves	$ 123,677	$ 714,937	$ 184,508	$ 176,634	$ 182,862	$ (44,860)	$ (348,493)	$ (597,997)	$ (157,743)	$ (155,244)	$ (88,739)	$ 87,970	$ 77,511

SJVIA – HMO

HMO Total Expenses & Premiums - 2012

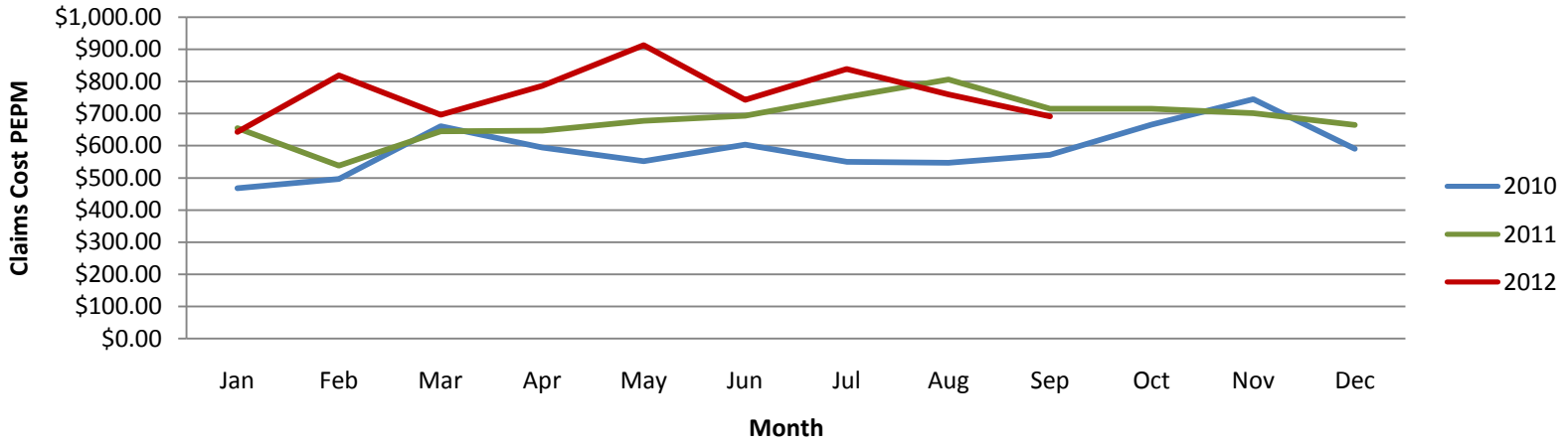


HMO Cumulative Premiums & Expenses -2012

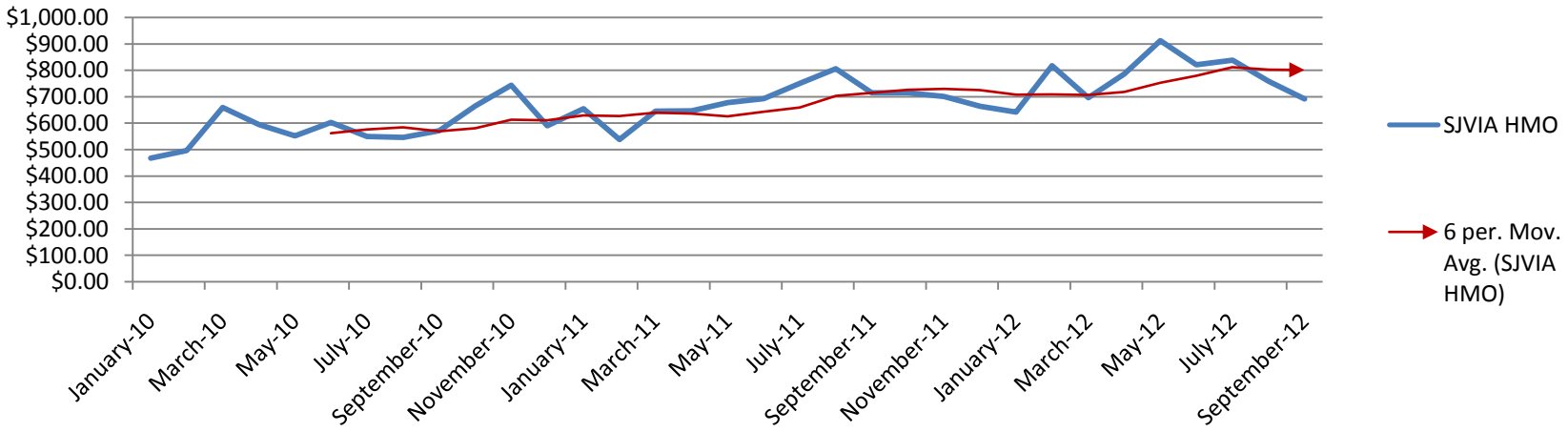


SJVIA – HMO

SJVIA 2010 - 2012 HMO (Year Over Year) - Claims PEPM



SJVIA HMO – Claims PEPM

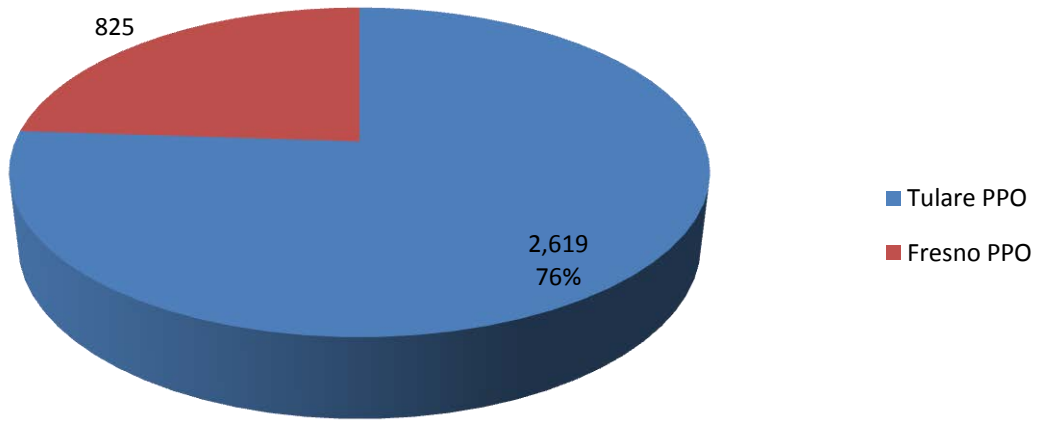


*PEPM – Per Employee Per Month

SJVIA - PPO

SJVIA - PPO

PPO Plans Average Monthly Enrollment - 2012



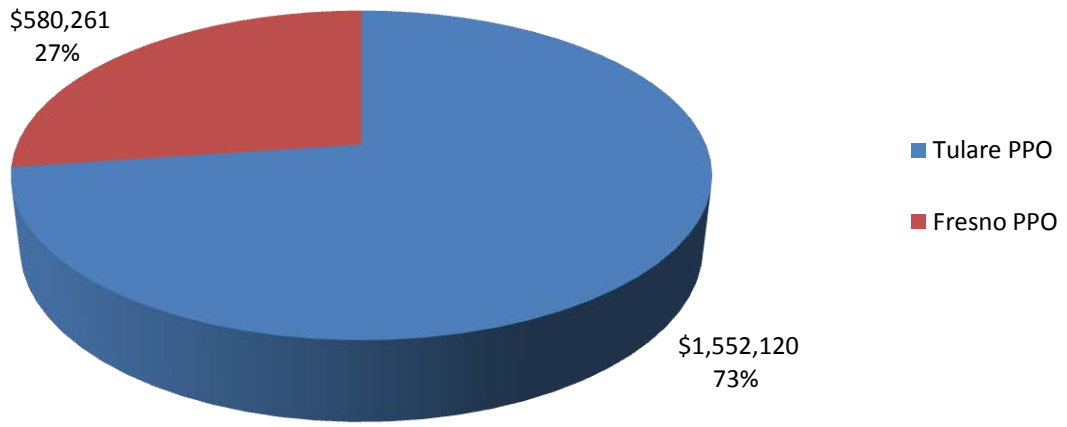
2012 Enrollment - PPO Plans	January	February	March	April	May	June	July	August	September	October	November	December	YTD Totals
CoT PPO	2,578	2,622	2,603	2,601	2,617	2,633	2,633	2,634	2,649	0	0	0	23,570
CoF PPO	810	810	822	819	823	836	829	837	836	0	0	0	7,422
Total	**3,388**	**3,432**	**3,425**	**3,420**	**3,440**	**3,469**	**3,462**	**3,471**	**3,485**	**0**	**0**	**0**	**30,992**

2011 Enrollment - PPO Plans	January	February	March	April	May	June	July	August	September	October	November	December	YTD Totals
CoT PPO	2,627	2,649	2,633	2,617	2,608	2,574	2,584	2,578	2,577	2,582	2,571	2,569	31,169
CoF PPO	912	901	899	894	890	885	872	864	870	863	853	847	10,550
Total	**3,539**	**3,550**	**3,532**	**3,511**	**3,498**	**3,459**	**3,456**	**3,442**	**3,447**	**3,445**	**3,424**	**3,416**	**41,719**

2010 Enrollment - PPO Plans	January	February	March	April	May	June	July	August	September	October	November	December	YTD Totals
CoT PPO	2,774	2,743	2,737	2,721	2,723	2,739	2,723	2,708	2,706	2,694	2,694	2,698	32,660
CoF PPO	1,009	978	972	1,018	999	985	979	974	968	953	941	909	11,685
Total	**3,783**	**3,721**	**3,709**	**3,739**	**3,722**	**3,724**	**3,702**	**3,682**	**3,674**	**3,647**	**3,635**	**3,607**	**44,345**

SJVIA - PPO

PPO Plans Average Monthly Premiums - 2012



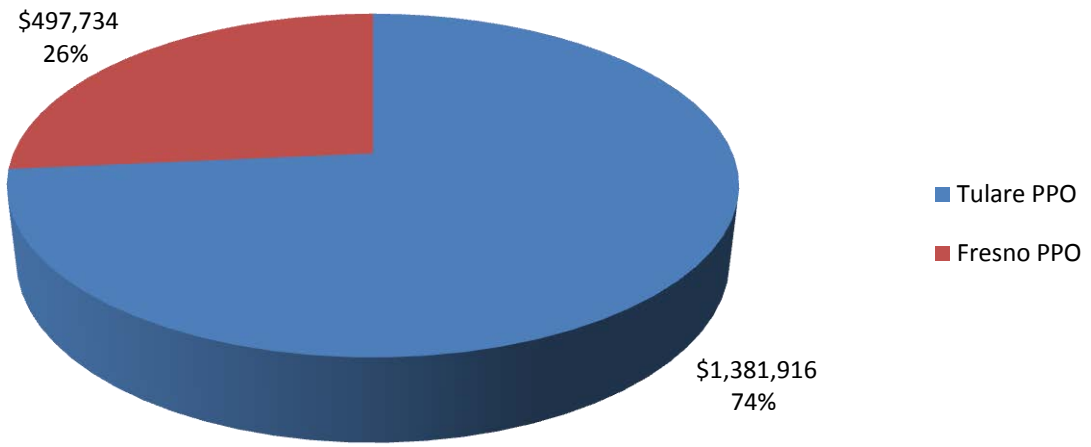
2012 Premium - PPO Plans	January	February	March	April	May	June	July	August	September	October	November	December	YTD Totals
CoT PPO	$ 1,532,991	$ 1,557,210	$ 1,545,778	$ 1,542,574	$ 1,552,519	$ 1,557,795	$ 1,557,795	$ 1,557,024	$ 1,565,391	$ -	$ -	$ -	$ 13,969,076
CoF PPO	$ 573,804	$ 574,013	$ 580,838	$ 579,490	$ 581,428	$ 586,528	$ 580,393	$ 582,946	$ 582,907	$ -	$ -	$ -	$ 5,222,345
Total	**$ 2,106,794**	**$ 2,131,223**	**$ 2,126,615**	**$ 2,122,064**	**$ 2,133,947**	**$ 2,144,322**	**$ 2,138,188**	**$ 2,139,970**	**$ 2,148,298**	**$ -**	**$ -**	**$ -**	**$ 19,191,421**

2011 Premium - PPO Plans	January	February	March	April	May	June	July	August	September	October	November	December	YTD Totals
CoT PPO	$ 1,592,800	$ 1,600,772	$ 1,591,108	$ 1,578,978	$ 1,572,623	$ 1,553,821	$ 1,559,220	$ 1,554,372	$ 1,546,005	$ 1,546,501	$ 1,533,944	$ 1,532,603	$ 18,762,748
CoF PPO	$ 684,553	$ 675,349	$ 671,720	$ 667,982	$ 659,896	$ 659,650	$ 646,810	$ 640,938	$ 646,434	$ 642,383	$ 633,063	$ 624,270	$ 7,853,047
Total	**$ 2,277,353**	**$ 2,276,121**	**$ 2,262,828**	**$ 2,246,960**	**$ 2,232,519**	**$ 2,213,472**	**$ 2,206,030**	**$ 2,195,310**	**$ 2,192,438**	**$ 2,188,884**	**$ 2,167,007**	**$ 2,156,873**	**$ 26,615,795**

2010 Premium - PPO Plans	January	February	March	April	May	June	July	August	September	October	November	December	YTD Totals
CoT PPO	$ 1,516,067	$ 1,498,594	$ 1,494,485	$ 1,495,389	$ 1,495,268	$ 1,502,929	$ 1,494,382	$ 1,487,459	$ 1,488,058	$ 1,479,144	$ 1,479,681	$ 1,480,142	$ 17,911,599
CoF PPO	$ 761,302	$ 738,520	$ 735,453	$ 762,059	$ 747,527	$ 739,978	$ 734,572	$ 732,670	$ 729,357	$ 717,265	$ 709,468	$ 664,075	$ 8,772,247
Total	**$ 2,277,369**	**$ 2,237,114**	**$ 2,229,938**	**$ 2,257,448**	**$ 2,242,795**	**$ 2,242,907**	**$ 2,228,954**	**$ 2,220,128**	**$ 2,217,415**	**$ 2,196,410**	**$ 2,189,149**	**$ 2,144,217**	**$ 26,683,845**

SJVIA - PPO

PPO Plans Average Monthly Claims - 2012

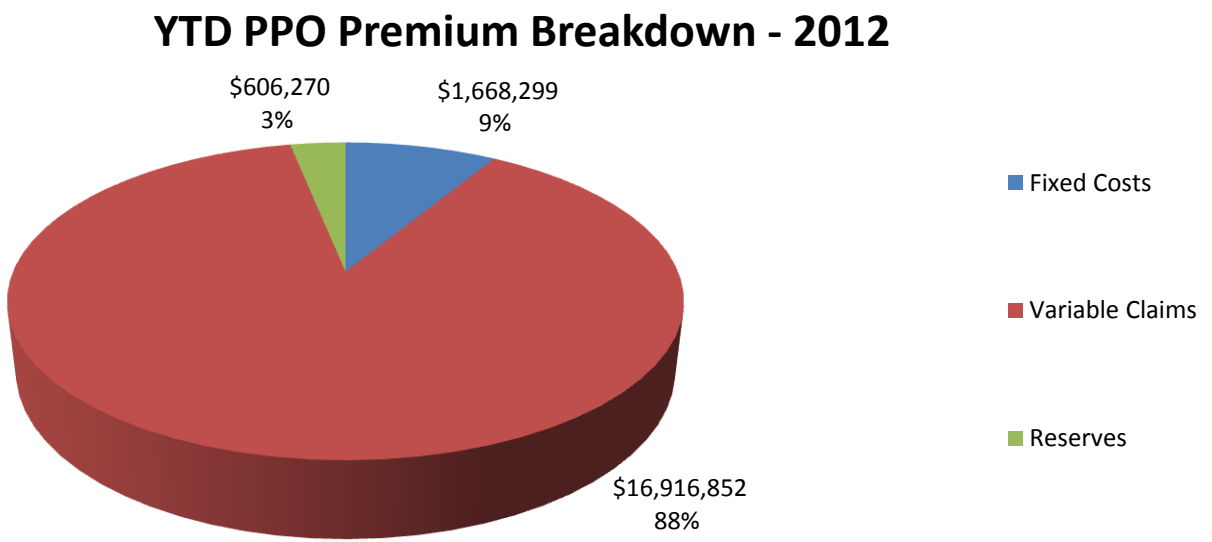


2012 Claims - PPO Plans	January	February	March	April	May	June	July	August	September	October	November	December	YTD Totals
CoT PPO	$ 1,347,900	$ 1,417,340	$ 1,637,712	$ 1,363,071	$ 1,265,474	$ 1,392,625	$ 1,320,460	$ 1,192,627	$ 1,500,032	$ -	$ -	$ -	$ 12,437,241
CoF PPO	$ 385,926	$ 490,303	$ 526,293	$ 500,279	$ 437,872	$ 517,707	$ 432,823	$ 650,127	$ 538,280	$ -	$ -	$ -	$ 4,479,610
Total	**$ 1,733,826**	**$ 1,907,643**	**$ 2,164,005**	**$ 1,863,350**	**$ 1,703,346**	**$ 1,910,332**	**$ 1,753,283**	**$ 1,842,754**	**$ 2,038,313**	**$ -**	**$ -**	**$ -**	**$ 16,916,852**

2011 Claims - PPO Plans	January	February	March	April	May	June	July	August	September	October	November	December	YTD Totals
CoT PPO	$ 1,256,050	$ 1,060,066	$ 1,476,111	$ 1,234,501	$ 1,308,598	$ 1,591,586	$ 1,194,338	$ 1,587,940	$ 1,532,560	$ 1,339,380	$ 1,282,913	$ 1,219,091	$ 16,083,134
CoF PPO	$ 690,411	$ 399,817	$ 654,688	$ 423,453	$ 609,769	$ 720,386	$ 625,458	$ 596,721	$ 520,499	$ 509,449	$ 688,233	$ 575,391	$ 7,014,275
Total	**$ 1,946,461**	**$ 1,459,883**	**$ 2,130,799**	**$ 1,657,954**	**$ 1,918,367**	**$ 2,311,972**	**$ 1,819,796**	**$ 2,184,661**	**$ 2,053,059**	**$ 1,848,829**	**$ 1,971,146**	**$ 1,794,482**	**$ 23,097,409**

2010 Claims - PPO Plans	January	February	March	April	May	June	July	August	September	October	November	December	YTD Totals
CoT PPO	$ 408,232	$ 977,011	$ 1,481,424	$ 1,400,115	$ 1,337,312	$ 1,453,184	$ 1,182,271	$ 1,210,043	$ 1,281,284	$ 1,302,975	$ 1,810,903	$ 1,532,398	$ 15,377,152
CoF PPO	$ 189,847	$ 289,988	$ 611,860	$ 512,418	$ 558,441	$ 865,929	$ 523,529	$ 1,014,825	$ 497,751	$ 326,333	$ 626,108	$ 560,439	$ 6,577,468
Total	**$ 598,079**	**$ 1,266,999**	**$ 2,093,284**	**$ 1,912,533**	**$ 1,895,753**	**$ 2,319,113**	**$ 1,705,800**	**$ 2,224,868**	**$ 1,779,035**	**$ 1,629,308**	**$ 2,437,011**	**$ 2,092,837**	**$ 21,954,620**

SJVIA - PPO Premium Breakdown



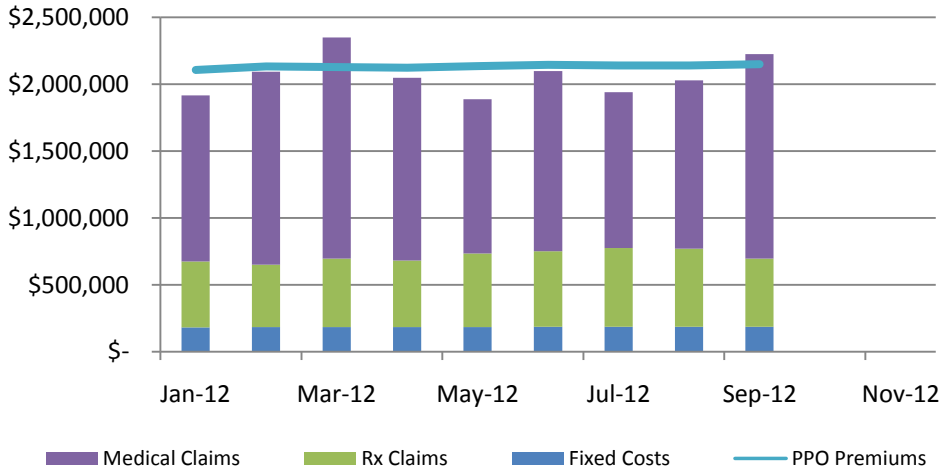
2012 Premium Breakdown - PPO	January	February	March	April	May	June	July	August	September	October	November	December	YTD Totals
Fixed Costs	$ 182,376	$ 184,745	$ 184,368	$ 184,099	$ 185,175	$ 186,736	$ 186,359	$ 186,844	$ 187,598	$ -	$ -	$ -	$ 1,668,299
Variable Claims	$ 1,733,826	$ 1,907,643	$ 2,164,005	$ 1,863,350	$ 1,703,346	$ 1,910,332	$ 1,753,283	$ 1,842,754	$ 2,038,313	$ -	$ -	$ -	$ 16,916,852
Reserves	$ 190,592	$ 38,835	$ (221,757)	$ 74,615	$ 245,425	$ 47,254	$ 198,546	$ 110,372	$ (77,613)	$ -	$ -	$ -	$ 606,270

2011 Premium Breakdown - PPO	January	February	March	April	May	June	July	August	September	October	November	December	YTD Totals
Fixed Costs	$ 179,958	$ 180,518	$ 179,602	$ 178,534	$ 177,873	$ 175,890	$ 175,738	$ 175,026	$ 175,280	$ 175,178	$ 174,110	$ 173,704	$ 2,121,411
Variable Claims	$ 1,946,461	$ 1,459,883	$ 2,130,799	$ 1,657,954	$ 1,918,367	$ 2,311,972	$ 1,819,796	$ 2,184,661	$ 2,053,059	$ 1,848,829	$ 1,971,146	$ 1,794,482	$ 23,097,409
Reserves	$ 150,934	$ 635,721	$ (47,573)	$ 410,471	$ 136,278	$ (274,390)	$ 210,497	$ (164,377)	$ (35,901)	$ 164,877	$ 21,750	$ 188,688	$ 1,396,975

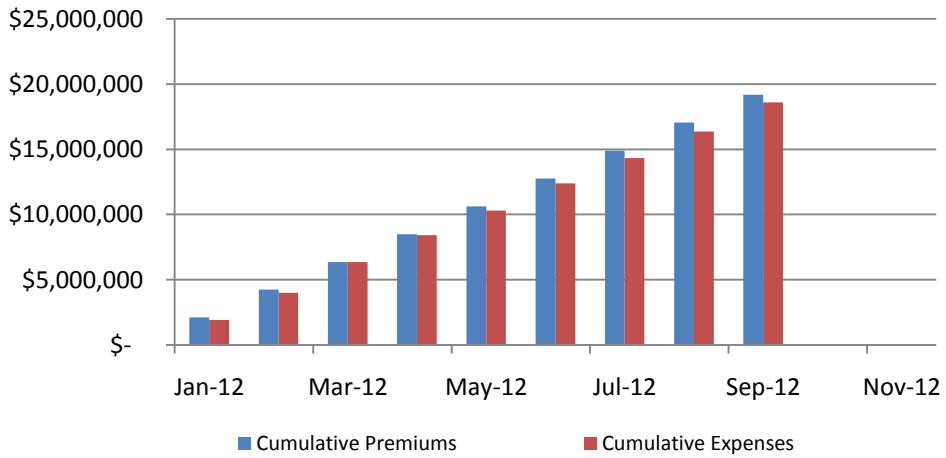
2010 Premium Breakdown - PPO	January	February	March	April	May	June	July	August	September	October	November	December	YTD Totals
Fixed Costs	$ 184,648	$ 181,622	$ 181,036	$ 182,501	$ 181,671	$ 181,768	$ 180,695	$ 179,718	$ 179,328	$ 178,010	$ 177,424	$ 176,058	$ 2,164,479
Variable Claims	$ 598,079	$ 1,266,999	$ 2,093,284	$ 1,912,533	$ 1,895,753	$ 2,319,113	$ 1,705,800	$ 2,224,868	$ 1,779,035	$ 1,629,308	$ 2,437,011	$ 2,092,837	$ 21,954,620
Reserves	$ 1,494,641	$ 788,493	$ (44,382)	$ 162,415	$ 165,372	$ (257,975)	$ 342,460	$ (184,458)	$ 259,052	$ 389,092	$ (425,286)	$ (124,677)	$ 2,564,746

SJVIA - PPO Plans

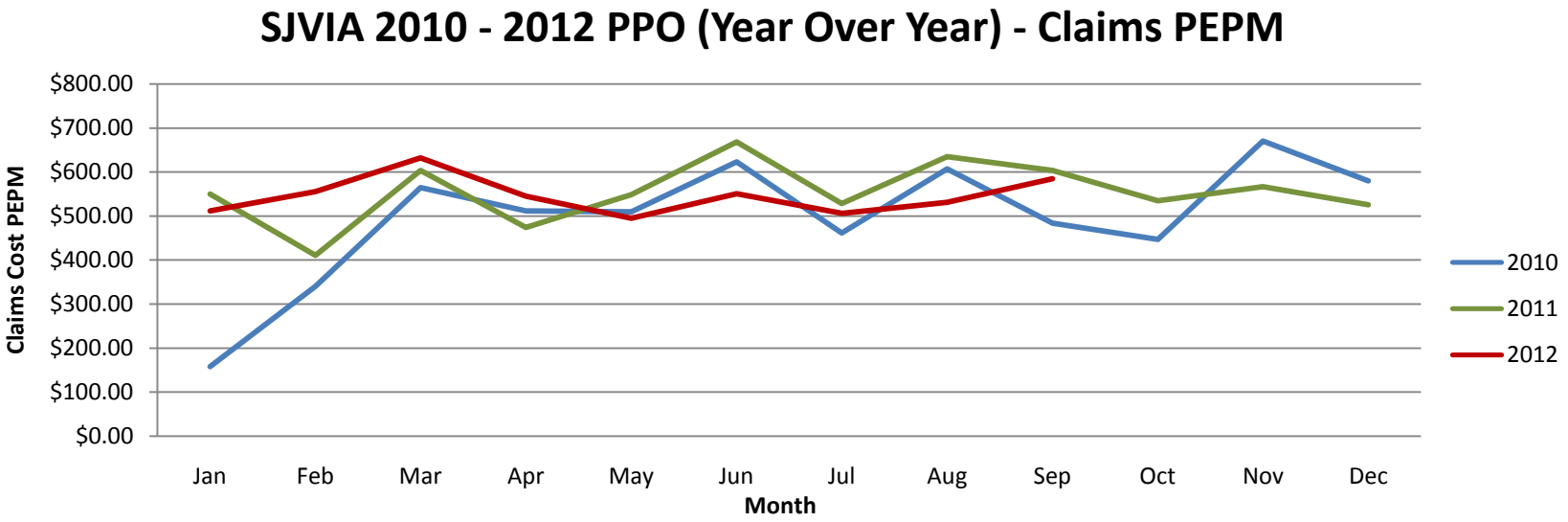
PPO Total Expenses & Premiums - 2012

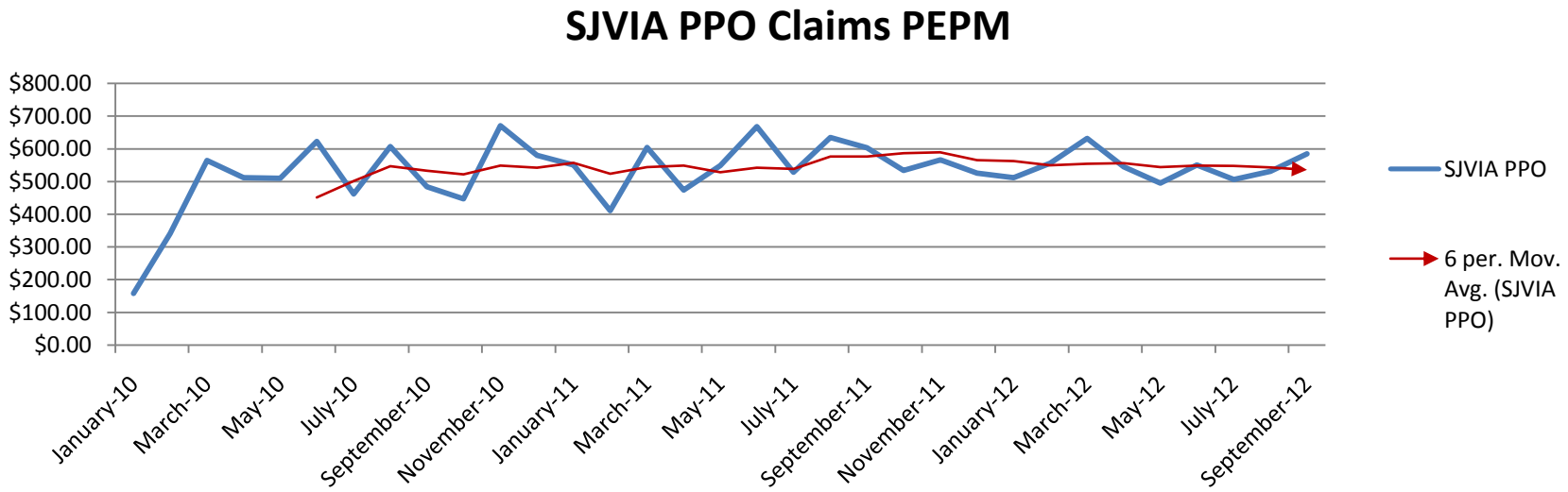


PPO Cumulative Premiums & Expenses - 2012



SJVIA – PPO Claims PEPM





***PEPM – Per Employee Per Month**

SJVIA - Monthly Data

SJVIA - All Plans

SJVIA Enrollment - All Plans	January	February	March	April	May	June	July	August	September	October	November	December
- Employee Only	4,682	4,721	4,737	4,700	4,713	4,800	4,807	4,829	4,858	0	0	0
- Employee + Spouse	1,045	1,047	1,043	1,030	1,011	1,021	1,017	1,014	1,017	0	0	0
- Employee + Child(ren)	1,499	1,508	1,498	1,492	1,484	1,498	1,499	1,501	1,505	0	0	0
- Employee + Family	700	698	698	693	687	694	697	696	697	0	0	0
SJVIA Total Enrollment	**7,926**	**7,974**	**7,976**	**7,915**	**7,895**	**8,013**	**8,020**	**8,040**	**8,077**	**0**	**0**	**0**
SJVIA Total Premiums	**$5,563,341**	**$5,588,262**	**$5,584,740**	**$5,541,393**	**$ 5,517,195**	**$5,589,300**	**$5,592,261**	**$ 5,600,210**	**$5,621,765**	**$ -**	**$ -**	**$ -**
SJVIA Premiums PEPM	$ 701.91	$ 700.81	$ 700.19	$ 700.11	$ 698.82	$ 697.53	$ 697.29	$ 696.54	$ 696.02			
SJVIA Total Claims	**January**	**February**	**March**	**April**	**May**	**June**	**July**	**August**	**September**	**October**	**November**	**December**
- Medical Claims	$2,369,761	$3,384,425	$3,028,105	$3,182,932	$ 3,484,310	$3,008,518	$3,217,785	$ 2,938,236	$2,962,069	$ -	$ -	$ -
- Rx Claims	$1,153,120	$1,112,197	$1,174,324	$1,097,845	$ 1,178,696	$1,149,231	$1,225,813	$ 1,234,436	$1,110,735	$ -	$ -	$ -
- Stop-Loss Refunds	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
- Capitated Claims (HMO)	$1,125,742	$1,126,734	$1,128,967	$1,115,075	$ 1,105,152	$1,126,982	$1,130,703	$ 1,138,432	$1,139,137	$ -	$ -	$ -
SJVIA Total Claims	**$4,648,623**	**$5,623,356**	**$5,331,396**	**$5,395,852**	**$ 5,768,158**	**$5,284,731**	**$5,574,301**	**$ 5,311,104**	**$5,211,941**	**$ -**	**$ -**	**$ -**
SJVIA Claims PEPM	$ 586.50	$ 705.21	$ 668.43	$ 681.72	$ 730.61	$ 659.52	$ 695.05	$ 660.59	$ 645.28			
SJVIA Fixed Costs	**$ 539,562**	**$ 542,245**	**$ 542,577**	**$ 537,900**	**$ 535,828**	**$ 544,395**	**$ 545,120**	**$ 546,470**	**$ 549,034**	**$ -**	**$ -**	**$ -**
SJVIA Total Costs	**$5,188,185**	**$6,165,601**	**$5,873,973**	**$5,933,752**	**$ 6,303,986**	**$5,829,126**	**$6,119,421**	**$ 5,857,574**	**$5,760,975**	**$ -**	**$ -**	**$ -**
SJVIA Cost PEPM	$ 654.58	$ 773.21	$ 736.46	$ 749.68	$ 798.48	$ 727.46	$ 763.02	$ 728.55	$ 713.26			
SJVIA Total Reserve - Increase/(Decrease)	**$ 375,156**	**$ (577,340)**	**$ (289,233)**	**$ (392,359)**	**$ (786,791)**	**$ (239,826)**	**$ (527,159)**	**$ (257,364)**	**$ (139,210)**	**$ -**	**$ -**	**$ -**
Reserve % of Non Cap. Claims	**10.6%**	**-12.8%**	**-6.9%**	**-9.2%**	**-16.9%**	**-5.8%**	**-11.9%**	**-6.2%**	**-3.4%**			

SJVIA - HMO

2012 HMO Enrollment	January	February	March	April	May	June	July	August	September	October	November	December	YTD Totals
- Employee Only	1,940	1,943	1,962	1,930	1,924	1,977	1,988	1,998	2,018	0	0	0	17,680
- Employee + Spouse	631	632	633	622	608	620	617	618	617	0	0	0	5,598
- Employee + Child(ren)	1,352	1,357	1,348	1,338	1,327	1,343	1,346	1,346	1,349	0	0	0	12,106
- Employee + Family	615	610	608	605	596	604	607	607	608	0	0	0	5,460
HMO Total Enroll.	**4,538**	**4,542**	**4,551**	**4,495**	**4,455**	**4,544**	**4,558**	**4,569**	**4,592**	**0**	**0**	**0**	**40,844**
HMO Premiums	**$ 3,456,547**	**$ 3,457,039**	**$ 3,458,125**	**$ 3,419,330**	**$ 3,383,249**	**$ 3,444,977**	**$ 3,454,073**	**$ 3,460,240**	**$ 3,473,467**	**$ -**	**$ -**	**$ -**	**$ 31,007,047**
HMO Premiums PEPM	$ 761.69	$ 761.13	$ 759.86	$ 760.70	$ 759.43	$ 758.14	$ 757.80	$ 757.33	$ 756.42				$ 759.16
HMO Claims	**January**	**February**	**March**	**April**	**May**	**June**	**July**	**August**	**September**	**October**	**November**	**December**	**YTD Totals**
- Medical Claims	$ 1,128,332	$ 1,941,584	$ 1,376,948	$ 1,816,134	$ 2,330,814	$ 1,662,356	$ 2,054,136	$ 1,679,713	$ 1,433,160	$ -	$ -	$ -	$ 15,423,177
- Rx Claims	$ 660,723	$ 647,395	$ 661,476	$ 601,293	$ 628,846	$ 585,061	$ 636,179	$ 650,205	$ 601,331	$ -	$ -	$ -	$ 5,672,510
- Capitated Claims	$ 1,125,742	$ 1,126,734	$ 1,128,967	$ 1,115,075	$ 1,105,152	$ 1,126,982	$ 1,130,703	$ 1,138,432	$ 1,139,137	$ -	$ -	$ -	$ 10,136,924
HMO Total Claims	**$ 2,914,797**	**$ 3,715,713**	**$ 3,167,391**	**$ 3,532,502**	**$ 4,064,812**	**$ 3,374,399**	**$ 3,821,018**	**$ 3,468,350**	**$ 3,173,628**	**$ -**	**$ -**	**$ -**	**$ 31,232,611**
HMO Claims PEPM	$ 642.31	$ 818.08	$ 695.98	$ 785.87	$ 912.42	$ 742.61	$ 838.31	$ 759.10	$ 691.12				$ 764.68
HMO Fixed Costs	**$ 357,186**	**$ 357,501**	**$ 358,209**	**$ 353,801**	**$ 350,653**	**$ 357,658**	**$ 358,760**	**$ 359,626**	**$ 361,436**	**$ -**	**$ -**	**$ -**	**$ 3,214,831**
HMO Total Costs	**$ 3,271,983**	**$ 4,073,214**	**$ 3,525,600**	**$ 3,886,303**	**$ 4,415,465**	**$ 3,732,057**	**$ 4,179,778**	**$ 3,827,976**	**$ 3,535,065**	**$ -**	**$ -**	**$ -**	**$ 34,447,442**
HMO Costs PEPM	$ 721.02	$ 896.79	$ 774.69	$ 864.58	$ 991.13	$ 821.32	$ 917.02	$ 837.81	$ 769.83				$ 843.39
HMO Plan Reserve - Increase/(Decrease)	**$ 184,564**	**$ (616,175)**	**$ (67,475)**	**$ (466,974)**	**$ (1,032,216)**	**$ (287,080)**	**$ (725,705)**	**$ (367,736)**	**$ (61,597)**	**$ -**	**$ -**	**$ -**	**$ (3,440,395)**
Reserve % of Non Cap. Claims	**10.3%**	**-23.8%**	**-3.3%**	**-19.3%**	**-34.9%**	**-12.8%**	**-27.0%**	**-15.8%**	**-3.0%**				**-16.3%**

SJVIA - PPO

PPO Enrollment - All Plans	January	February	March	April	May	June	July	August	September	October	November	December	YTD Totals
- Employee Only	2,742	2,778	2,775	2,770	2,789	2,823	2,819	2,831	2,840	0	0	0	25,167
- Employee + Spouse	414	415	410	408	403	401	400	396	400	0	0	0	3,647
- Employee + Child(ren)	147	151	150	154	157	155	153	155	156	0	0	0	1,378
- Employee + Family	85	88	90	88	91	90	90	89	89	0	0	0	800
PPO Plans Total Enrollment	**3,388**	**3,432**	**3,425**	**3,420**	**3,440**	**3,469**	**3,462**	**3,471**	**3,485**	**0**	**0**	**0**	**30,992**
PPO Plans Total Premiums	**$ 2,106,794**	**$ 2,131,223**	**$ 2,126,615**	**$ 2,122,064**	**$ 2,133,947**	**$ 2,144,322**	**$ 2,138,188**	**$ 2,139,970**	**$ 2,148,298**	**$ -**	**$ -**	**$ -**	**$ 19,191,421**
PPO Premiums PEPM	$ 621.84	$ 620.99	$ 620.91	$ 620.49	$ 620.33	$ 618.14	$ 617.62	$ 616.53	$ 616.44				$ 619.24
PPO Plans Total Claims	**January**	**February**	**March**	**April**	**May**	**June**	**July**	**August**	**September**	**October**	**November**	**December**	**YTD Totals**
- Medical Claims	$ 1,241,429	$ 1,442,841	$ 1,651,157	$ 1,366,798	$ 1,153,496	$ 1,346,162	$ 1,163,649	$ 1,258,523	$ 1,528,909	$ -	$ -	$ -	$ 12,152,964
- Rx Claims	$ 492,397	$ 464,802	$ 512,848	$ 496,552	$ 549,850	$ 564,170	$ 589,634	$ 584,231	$ 509,404	$ -	$ -	$ -	$ 4,763,888
- Stop-Loss Refunds	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
PPO Plans Net Claims	**$ 1,733,826**	**$ 1,907,643**	**$ 2,164,005**	**$ 1,863,350**	**$ 1,703,346**	**$ 1,910,332**	**$ 1,753,283**	**$ 1,842,754**	**$ 2,038,313**	**$ -**	**$ -**	**$ -**	**$ 16,916,852**
PPO Plans Claims PEPM	$ 511.76	$ 555.84	$ 631.83	$ 544.84	$ 495.16	$ 550.69	$ 506.44	$ 530.90	$ 584.88				$ 545.85
PPO Plans Fixed Costs	**$ 182,376**	**$ 184,745**	**$ 184,368**	**$ 184,099**	**$ 185,175**	**$ 186,736**	**$ 186,359**	**$ 186,844**	**$ 187,598**	**$ -**	**$ -**	**$ -**	**$ 1,668,299**
PPO Plans Total Costs	**$ 1,916,202**	**$ 2,092,388**	**$ 2,348,373**	**$ 2,047,449**	**$ 1,888,521**	**$ 2,097,068**	**$ 1,939,642**	**$ 2,029,598**	**$ 2,225,910**	**$ -**	**$ -**	**$ -**	**$ 18,585,151**
PPO Plans Cost PEPM	$ 565.59	$ 609.67	$ 685.66	$ 598.67	$ 548.99	$ 604.52	$ 560.27	$ 584.73	$ 638.71				$ 599.68
PPO Plans Total Reserve - Increase/(Decrease)	**$ 190,592**	**$ 38,835**	**$ (221,757)**	**$ 74,615**	**$ 245,425**	**$ 47,254**	**$ 198,546**	**$ 110,372**	**$ (77,613)**	**$ -**	**$ -**	**$ -**	**$ 606,270**
Reserve % of Net Claims	**11.0%**	**2.0%**	**-10.2%**	**4.0%**	**14.4%**	**2.5%**	**11.3%**	**6.0%**	**-3.8%**				**3.6%**

SJVIA
San Joaquin Valley Insurance Authority

Meeting Location:
Tulare County Employee Retirement Association Board Chambers
136 N. Akers Street
Visalia, CA 93291
November 9, 2012
9:00 AM

AGENDA DATE: November 9, 2012

ITEM NUMBER 5c

SUBJECT Receive and File Report on SJVIA Marketing Activity

REQUEST(S): That the Board receive and file a report on SJVIA Marketing Activity.

DESCRIPTION:

Since our last report in August GBS attended the San Joaquin Valley Regional Association of CA Counties Fall Conference. Contact was made with Board of Supervisors from Kern, Tulare, Madera, and Kings Counties. Additionally, GBS will be an exhibitor at the California Public Employees Labor Relations Annual (CalPELRA) Conference in Monterey in December.

The SJVIA continues to pursue opportunities with the Central San Joaquin Valley Risk Management Authority (RMA). The RMA established an AdHoc Committee to evaluate SJVIA Membership. This Committee met with Gallagher and SJVIA staff in February with follow up meetings in April and October. Many of the RMA members have expressed individual interest in joining the SJVIA and these opportunities are being explored on an ongoing basis. At this point, a commitment from the RMA as a single entity to join has not been made pending further evaluation Although the RMA has not made a decision to add the SJVIA benefit program to their membership requirements or made a formal endorsement, they have encouraged members to explore the SJVIA option independently.

Additional direct marketing efforts have been under way to prospective members who are not affiliated with the RMA. These include several larger cities, counties, and special districts. See attached (we need to attach) spreadsheet that identifies the entities that have expressed interest. For many prospective entities, these discussions, while not immediately resulting in SJVIA membership, are positive steps toward movement in future years. SJVIA staff and Gallagher will continue to foster these longer term growth opportunities as the SJVIA matures and continues to experience positive growth with stable costs.

While there are no entities joining the SJVIA in January 2013, most of the potential participants expressed interest in receiving a quote or joining the SJVIA at a later date. Renewed marketing activities will begin after the first of the year for potential July 1st entry to the SJVIA.

FISCAL IMPACT/FINANCING:

None

ADMINISTRATIVE SIGN-OFF:

Paul Nerland	Jeffrey Cardell
SJVIA Manager	Assistant SJVIA Manager

BEFORE THE BOARD OF DIRECTORS SAN JOAQUIN VALLEY INSURANCE AUTHORITY

IN THE MATTER OF SJVIA Marketing Activity

RESOLUTION NO. _____
AGREEMENT NO. _____

UPON MOTION OF DIRECTOR _____, SECONDED BY DIRECTOR _____, THE FOLLOWING WAS ADOPTED BY THE BOARD OF DIRECTORS, AT AN OFFICIAL MEETING HELD _____ _____, BY THE FOLLOWING VOTE:

AYES:
NOES:
ABSTAIN:
ABSENT:

ATTEST:

BY: _____

* * * * * * * * * * * * * * * * * * *

The Board received and filed a report of SJVIA marketing activity.

SJVIA Summary of Marketing Activity
As of November 1, 2012

	Potential SJVIA Participant	To Underwriting Committee	Proposal Presented	Status	Next Steps	Renewal:	Active EE's
1	County of Santa Cruz	X	Yes	Proposal Presented	Considering for 2014	January	2930
2	County of Madera	X	No	Gave concept presentation to CAO	Considering for 2014	January	1230
3	County of Kings	X	Yes	Proposal Presented	Considering for 2014	July	1021
4	County of Calaveras		No	Expressed interest			
5	County of Mendicino		No	Expressed interest			
6	Merced Irrigation District	X	Yes	Proposal Presented	Considering for 2014	August	172
7	Nevada Irrigation District	X	No	Considering for 2014		January	225
8	Superior Courts of Kings County	X	No	Considering for 2014		January	100

	Central San Joaquin Valley Risk Management Authority (CSJVRMA) Account	To Underwriting Committee	Met / Proposal Presented	Status	Next Steps	Renewal:	Active EE's
1	Arvin			Received data form - no response	Gather required information	January	45
2	Avenal	X	Yes	Proposal Presented	Consider for 2014	October	47
3	Ceres	X	Yes	Proposal Presented		January	115
4	Chowchilla		No	Moved to EIA	Requested SJVIA stay in contact	June	44
5	Clovis	X	Yes	Proposed: Declined to Join SJVIA for 2013	Consider for 2014	January	384
6	Corcoran	X	Yes	Proposed: No Decision to Join SJVIA for 2013	Consider for 2014	July	60
7	Delano	X	Yes	Proposed (post-renewal): Declined to Join SJVIA for 2013	Consider for 2014	July	197
8	Dinuba			Data form received	Gather required information	July	122
9	Dos Palos			Data form received	Preparing proposal	August	17
10	Escalon	X	Yes	Proposed for 2013		Jan	23
11	Exeter			Expressed interest - have not received data	Gather required information	February	38
12	Firebaugh			Received data form - no response	Gather required information	January	
13	Fowler	X	Yes	Proposal Presented	Consider for 2014	September	20
14	Gustine			Expressed interest - have not received data	Gather required information	January	17
15	Huron			Expressed interest - have not received data	Gather required information	July	15
16	Kerman	X	No	Proposal ready	Meeting scheduled	July	53
17	Kingsburg			Data form received	Preparing proposal	Feb	45
18	Lathrop			Expressed interest	Gather required information	January	78
19	Madera			Expressed interest for 2014		July	246
20	Mendota	X	Yes	Proposed: No Decision to Join SJVIA for 2013	Consider for 2014	May	28
21	Newman			Received data form - no response	Gather required information	January	29
22	Orange Cove			Received data form - no response	Gather required information	July	37

	RMA Account	To Underwriting Committee	Met / Proposal Presented	Status	Next Steps	Renewal:	Active EE's
23	**Reedley**	X	Yes	Proposal Presented	Consider for 2014	January	115
24	**Ripon**			Data form received	Preparing proposal	January	88
25	**Riverbank**	X	Yes	Proposed for 2013		July	45
26	**Sanger**	X	Yes	Proposed for 2013	Consider for 2014		
27	**Shafter**	X		Proposed 10/2012	Scheduling meeting to present	July	60
28	**Sonora**			Received data form - no response	Gather required information	June	35
29	**Tehachapi**			Received data form - no response	Gather required information	January	50
30	**Tulare**	X	Yes	Joined SJVIA 2012		July	334
31	**Wasco**			Received data form - no response	Gather required information	January	54
32	**Waterford**	X	Yes	Proposed for 2013	Meeting scheduled	June	12
33	**Woodlake**			Received data form - no response	Gather required information	December	28

SJVIA
San Joaquin Valley Insurance Authority

Meeting Location:
Tulare County Employee Retirement Association Board Chambers
136 N. Akers Street
Visalia, CA 93291
November 9, 2012
9:00 AM

AGENDA DATE: November 9, 2012

ITEM NUMBER 5c

SUBJECT Receive and File Report on SJVIA Marketing Activity

REQUEST(S): That the Board receive and file a report of current SJVIA Marketing Activity.

DESCRIPTION:

As an update to the August 24, 2012 report on marketing activity, this report is intended to provide overview of recent marketing activities. Gallagher Benefit Services (GBS) at the direction of SJVIA Staff have undertaken several marketing efforts to identify and make contact with prospective member entities to consider joining the JPA. These efforts have included participating in various events and highlighting the benefits of joining the SJVIA. On October 12th, GBS attended the San Joaquin Valley Regional Association of CA Counties Fall Conference. Contact was made with Board of Supervisors from Kern, Tulare, Madera, and Kings Counties. This is the third year that GBS has attended this event to promote the benefits of the SJVIA to other Valley Counties. Additionally, GBS will be an Exhibitor at the California Public Employees Labor Relations Annual Conference in Monterey in December.

The SJVIA continues to pursue opportunities with the Central San Joaquin Valley Risk Management Authority (RMA). The RMA, consisting of 55 members of incorporated municipalities from Kern County in the south to Sutter County in the North, established an AdHoc Committee to evaluate SJVIA Membership.

AGENDA: San Joaquin Valley Insurance Authority

DATE: November 9, 2012

This Committee met with Gallagher and SJVIA staff in February with a follow up meeting in April. Most recently, a committee meeting on October 25th was attended. Many of the RMA members have expressed individual interest in joining the SJVIA and these opportunities are being explored on an ongoing basis. At this point, a commitment from the RMA as a single entity to join has not been made. Although the RMA has not made a decision to add the SJVIA benefit program to their membership requirements or made a formal endorsement, they have encouraged members to explore the SJVIA option independently.

Additional direct marketing efforts have been under way to prospective members who are not affiliated with the RMA. These include several larger cities, counties, and special districts. For many prospective CalPERS entities, this is the first time they have begun to exploring any alternatives since moving. These discussions, while not immediately resulting in SJVIA membership, are positive steps toward movement in future years. Gallagher will continue to foster these longer term growth opportunities as the SJVIA matures and continues to experience positive growth with stable costs.

Activity for January 2013 has tapered off at this point but most entities contacted or quoted continue to show interest in joining the SJVIA at a later date. We anticipate renewed marketing activities after the first of the year for potential July 1st entry.

FISCAL IMPACT/FINANCING:

None

ADMINISTRATIVE SIGN-OFF:

Paul Nerland
SJVIA Manager

Jeffrey Cardell
Assistant SJVIA Manager

BEFORE THE BOARD OF DIRECTORS
SAN JOAQUIN VALLEY INSURANCE AUTHORITY

IN THE MATTER OF Receive and File Report on SJVIA Marketing Activity

RESOLUTION NO. _____
AGREEMENT NO. _____

UPON MOTION OF DIRECTOR _____, SECONDED BY DIRECTOR _____, THE FOLLOWING WAS ADOPTED BY THE BOARD OF DIRECTORS, AT AN OFFICIAL MEETING HELD _____ _____, BY THE FOLLOWING VOTE:

AYES:
NOES:
ABSTAIN:
ABSENT:

ATTEST:

BY: _____

* * * * * * * * * * * * * * * * * * *

That the Board received and filed a report of current SJVIA Marketing Activity.

SJVIA Summary of Marketing Activity
As of November 1, 2012

		Presented SJVIA	Status to Date:	Renewal:	Active EE's
1	**County of Santa Cruz**	Yes	Considering Joining 2014	January	2930
2	**County of Madera**	No	Considering Joining 2014	January	1230
3	**County of Kings**	Yes	Considering Joining 2013	July	1021
4	**County of Calaveras**	No	asked questions, still gathering info.		
5	**County of Mendicino**	No	asked questions, still gathering info.		
6	**Merced Irrigation District**	Yes	Considering Joining 2013	August	172
7	**Nevada Irrigation District**	No	Considering Joining 2014	January	225
8	**Superior Courts of Kings County**	No	Considering Joining 2014	January	100

RMA Member Cities		**Presented SJVIA**	**Status to Date:**	**Renewal:**	**Active EE's**
1	**Arvin**		No response	January	45
2	**Avenal**		Offered to meet in August, no response back	October	47
3	**Ceres**	Yes	**Finalist Presentation**	January	115
4	**Chowchilla**		asked questions, still gathering info.	June	44
5	**Clovis**	Yes	**Finalist Presentation: Declined to Join SJVIA for 2013**	January	384
6	**Corcoran**	**Yes**	**Finalist Presentation: No Decision to Join SJVIA for 2013**	July	60
7	**Delano**	Yes	**Finalist Presentation: Declined to Join SJVIA for 2013**	July	197
8	**Dinuba**		Sent information- saved in S drive	July	122
9	**Dos Palos**		Sent information- saved in S drive	August	17
10	**Escalon**	Yes	**Finalist Presentation**	Jan	23
11	**Exeter**		Putting Feliz Ortiz on it- will send info.	February	38
12	**Firebaugh**		No response to emails since August, have some info.	January	37
13	**Fowler**		Sent Initial Proposal for review, declined to meet	September	20
14	**Gustine**		asked questions, is gathering info.	January	17
15	**Huron**		No response/ Do Not pursue	July	15
16	**Kerman**		First Presentation ready	July	53
17	**Kingsburg**		Sent information- saved in S drive	Feb	45
18	**Lathrop**		Sent information- saved in S drive, with PERS	January	78
19	**Madera**		asked questions, is gathering info.	July	246
20	**Mendota**	Yes	**Finalist Presentation: No Decision to Join SJVIA for 2013**	May	28
21	**Newman**		No response	January	29
22	**Orange Cove**		No response	July	37
23	**Reedley**	Yes	**Initial Presentation/Meeting for Jan 2014**	January	115
24	**Ripon**		No response	January	88
25	**Riverbank**	**Yes**	**Finalist Presentation**	July	45
26	**Shafter**		First Presentation ready	July	60
27	**Sonora**		No response	June	35
28	**Tehachapi**		No response	January	50
29	**Tulare**	Yes	Joined SJVIA 2012	July	334
30	**Wasco**		No response	January	54
31	**Waterford**		Sent information- saved in S drive	June	12
32	**Woodlake**		No response	December	28

SJVIA
San Joaquin Valley Insurance Authority

Meeting Location:
Tulare County Employee Retirement Association Board Chambers
136 N. Akers Street
Visalia, CA 93291
November 9, 2012
9:00 AM

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AGENDA DATE: November 9, 2012

ITEM NUMBER: 5d

SUBJECT: Receive and File Report on SJVIA Wellness Activities

REQUEST(S): That the Board Receive and File the Report on SJVIA Wellness Activities

DESCRIPTION:

At the April 30, 2012 Board meeting, your Board approved Staff's recommended wellness activities for 2012-13. Staff at both Fresno and Tulare County has continued to promote and plan wellness activities as part of this ongoing effort to promote healthy living.

1. Health & Wellness Fairs: The County of Tulare held their annual Health Fair and Open Enrollment Kickoff on September 27th with booths from many vendors from around the valley promoting well being and healthy living. Employees were given the opportunity to participate in flu shots at no cost and also to sign up for the mobile mammography to take place in November. The County of Fresno's Health & Wellness Fair took place on October 26th with information on healthy foods, exercise, disease awareness and prevention, free flu shots, blood pressure screening and much more.

2. Mobile Mammography: As approved by your Board on August 24, 2012, both counties will be offering free on site mammograms in the coming months. Pacific Coast Medical Services will be on location at the County of Tulare for 6 days in November and also at the County of Fresno for 6 days in December. This service will give SJVIA health plan participants the chance to access this valuable preventive care service at a convenient location and at no charge. The cost to the SJVIA is lower than what would normally be charged through Anthem Blue Cross as a standard claim. Overall results from the screenings will be shared with your Board at a future meeting. The cost of this effort is expected to be approximately $39,900.

3. Onsite Biometric Health Screening: All three participating entities of the SJVIA are beginning the planning process for the Delta TeamCare screenings that will commence in January. Participants will be completing health risk assessments and having a full 35 panel blood test to identify any current or potential health risks. This will be the second year of the wellness program. A report providing year over year participation results and changes in health data will be presented to Board when the information becomes available throughout the 2013 plan year. The cost of these screenings at $195 per participant is expected to be approximately $175,000 with the hope of increased participation over last year.

4. Online Education: The County of Fresno has utilized resources available from Anthem Blue Cross and other health partners to create a monthly web page feature as part of the "KNOW" campaign. This effort has no direct cost besides the staff time expended creating the information. The attachment to this item summarizes KNOW campaign themes used in 2012 and available to member entities.

FISCAL IMPACT/FINANCING:

The estimated costs of the mammography and the biometric screenings at $39,900 and $175,000 respectively will be funded by the $251,000 claims mitigation component of $2.50 per employee per month included in the budgeted rates for plan years 2012 and 2013.

AGENDA: San Joaquin Valley Insurance Authority

DATE: November 9, 2012

ADMINISTRATIVE SIGN-OFF:

Paul Nerland
SJVIA Manager

Jeffrey Cardell
Assistant SJVIA Manager

BEFORE THE BOARD OF DIRECTORS
SAN JOAQUIN VALLEY INSURANCE AUTHORITY

IN THE MATTER OF Receive and File Report on SJVIA Wellness Activities

RESOLUTION NO. _____
AGREEMENT NO. _____

UPON MOTION OF DIRECTOR _____, SECONDED BY DIRECTOR _____, THE FOLLOWING WAS ADOPTED BY THE BOARD OF DIRECTORS, AT AN OFFICIAL MEETING HELD _____ _____, BY THE FOLLOWING VOTE:

AYES:
NOES:
ABSTAIN:
ABSENT:

ATTEST:

BY: _____

* * * * * * * * * * * * * * * * * * *

That the Board Received and Filed the Report on SJVIA Wellness Activities

SJVIA
San Joaquin Valley
Insurance Authority

AGENDA ITEM 5D ATTACHMENTS
WELLNESS ACTIVITY - THE "KNOW" ACRONYMN

KNOW KNOW

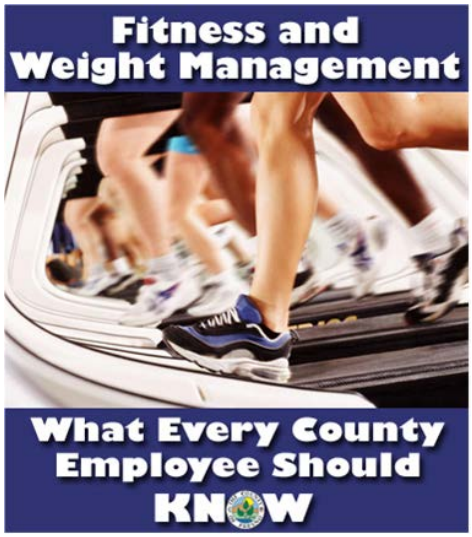
1. **Knowledge**: Employees who know and use the information will be healthier and live longer. This includes regular check-ups and health screenings as recommended based on risk factors. Knowing your numbers, for example, could literally save your life (i.e. - blood pressure, cholesterol levels).

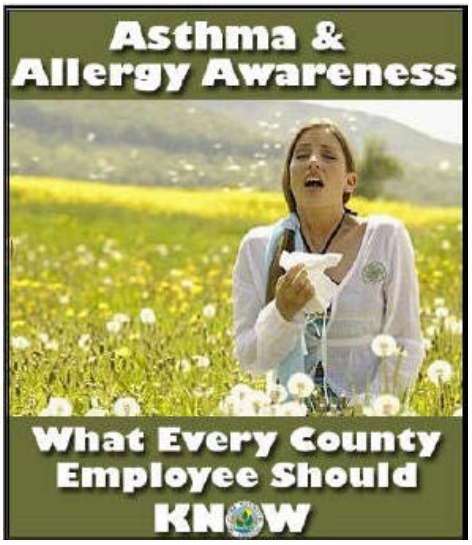
2. **Necessary Care**: Many employees know they have a medical condition but do not know how to appropriately manage it. For example, prescription utilization suggests that many employees do not refill maintenance medications as often as they should. This campaign will provide tools, education and resources to help employees get the necessary care at the right time.

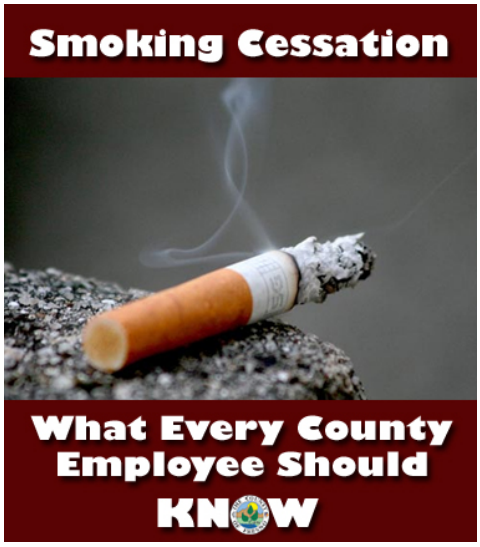
3. **Opportunity**: This program will provide opportunities to learn more and participate in programs that benefit employees and the County. Stay tuned to learn about opportunities, resources and programs that you may not have known were available to you as an employee.

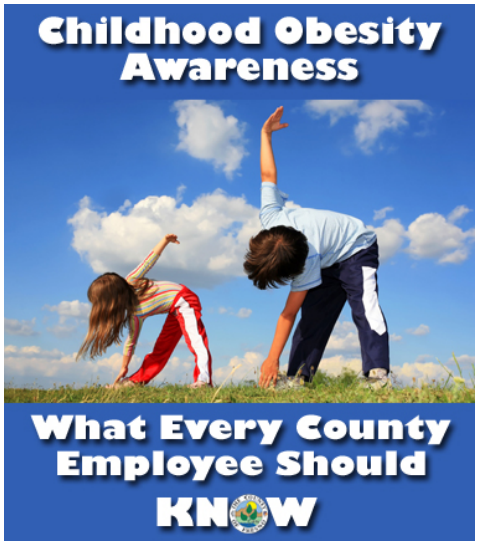
4. **Win/Win**: Healthy employees and families make this effort a win/win endeavor. Healthy employees are more productive and happier. Being proactive with your health contributes to saving money in the long-run for you and the County's health insurance program.

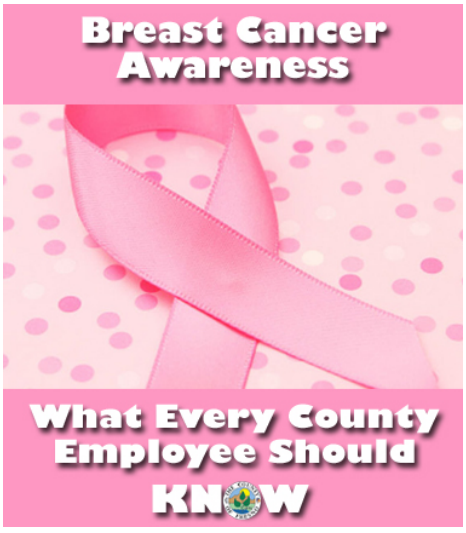
WELLNESS ACTIVITY
SUMMARY OF KNOW CAMPAIGN THEMES 2012

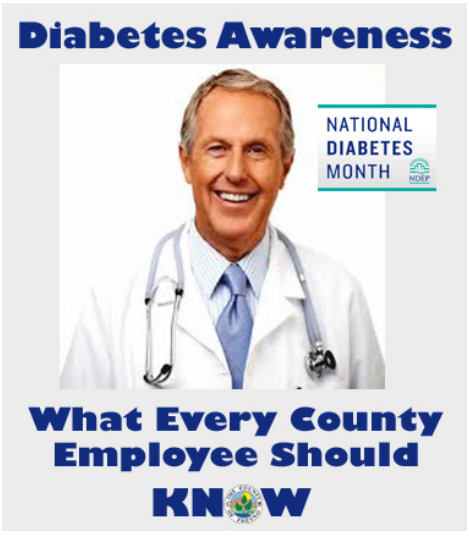












SJVIA
San Joaquin Valley Insurance Authority

Meeting Location:
Tulare County Employee Retirement Association Board Chambers
136 N Akers St
Visalia, CA 93921
November 9, 2012
9:00 AM

AGENDA DATE: November 9, 2012

ITEM NUMBER: 5(e)

SUBJECT: Quarterly SJVIA Financial Update

REQUEST(S): That the Board receives the Financial Update through 1st Quarter, 2012-13

DESCRIPTION: Informational Item. Please see attached report.

FISCAL IMPACT/FINANCING: None.

ADMINISTRATIVE SIGN-OFF:

Vicki Crow

Vicki Crow
SJVIA Auditor-Treasurer

BEFORE THE BOARD OF DIRECTORS SAN JOAQUIN VALLEY INSURANCE AUTHORITY

IN THE MATTER OF

RESOLUTION NO. _____
AGREEMENT NO. _____

UPON MOTION OF DIRECTOR _____, SECONDED BY DIRECTOR _____, THE FOLLOWING WAS ADOPTED BY THE BOARD OF DIRECTORS, AT AN OFFICIAL MEETING HELD _____ _____, BY THE FOLLOWING VOTE:

AYES:
NOES:
ABSTAIN:
ABSENT:

ATTEST:

BY: _____

* * * * * * * * * * * * * * * * * * * *

SAN JOAQUIN VALLEY INSURANCE AUTHORITY

ACTUALS VS. BUDGETED REVENUES & EXPENSES

FOR THE THREE MONTHS ENDED SEPTEMBER 30, 2012

	Year-To-Date			
	ACTUALS	BUDGET	(OVER) / UNDER BUDGET	% VARIANCE
REVENUE				
County of Fresno & County of Tulare Health Plan Revenue	**$14,552,264**	**$14,528,838**	**($23,426)**	**(0%)**
COT (Anthem Medical, Rx, Vendor Services)				
COF (Anthem Medical, Vendor Services)				
EXPENSES: Fixed				
1 Specific & Aggregate Stop Loss Insurance (PPO)	124,469	106,520	(17,949)	(17%)
2 Anthem ASO Administration & Network Fees (PPO)	309,255	266,498	(42,757)	(16%)
3 Chimenti Associates/Hourglass Administration(PPO & Anthem HMO)	175,738	151,798	(23,940)	(16%)
4 GBS Consulting	96,369	93,414	(2,955)	(3%)
5 SJVIA Association Fee	33,461	46,707	13,246	28%
6 Claims Management	0	70,036	70,036	100%
7 Communications	0	0	0	0%
8 Anthem HMO Pooling	345,838	358,503	12,665	4%
9 Anthem HMO Administration/Retention	460,562	477,386	16,824	4%
TOTAL FIXED EXPENSES	**1,545,692**	**1,570,862**	**25,170**	**2%**
EXPENSES: Claims				
10 Projected Paid Medical Claims PPO and Non-Cap HMO, & Projected Paid Rx Claims PPO (All CoT and Only CoF HDPPO)	10,058,840	9,365,763	(693,077)	(7%)
11 Anthem MMP HMO Capitation	3,165,043	3,280,478	115,435	4%
TOTAL CLAIMS EXPENSES	**13,223,883**	**12,646,241**	**(577,642)**	**(5%)**
TOTAL EXPENSES	**14,769,575**	**14,217,103**	**(552,472)**	**(4%)**
12 Reserve Deficit/Surplus	(217,311)	311,735	529,046	170%
COMBINED EXPENSES & RESERVES	**$14,552,264**	**$14,528,838**	**($23,426)**	**(0%)**

Glossary of Terms:

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 **Anthem ASO Administration & Network Fees (PPO):**

ASO is "Administrative Services Only". This definition includes Anthem Blue Cross administration fees and includes access fees to use the Blue Cross network of providers. This is the administration fee for the PPO plan(s), not the HMO plan.

3 **Chimienti Associates/Hourglass Administration (PPO & Anthem HMO)**

Chimienti & Associates is an independent vendor providing consolidated billing, eligibility, automated enrollment and Section 125 administrative services. Hourglass and ASI are subcontractors to Chimienti Associates that assist in these administrative processes. This line is for non-Kaiser business.

4 **GBS Consulting**

Gallagher Benefit Services (GBS) is a national 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. GBS played a significant role in the formation and establishment of SJVIA.

5 **SJVIA Association Fee**

The association fee 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.

6 **Claims Management/Communications**

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. This rate category is also 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.

7 **Anthem HMO Pooling**

This is for the specific stop loss pooling insurance for claims in excess of $250k within the HMO (not PPO).

8 **Anthem HMO Administration/Retention**

Anthem Blue Cross plan administration fee and network access fee for the HMO plan

9 **Blue View Vision**

Anthem Blue Cross Vision plan utilized by County of Tulare through 2011. There will be no participants in this plan as of January 1, 2012

10 **Projected Paid Medical Claims PPO and Non-Cap HMO, & Projected Paid Rx Claims PPO (All CoT and Only CoF HDPPO)**

Projected self-insured PPO claims for medical and non-capitated HMO claims (hospital). Also, projected self-insured Rx claims for all County of Tulare plans and only County of Fresno HDPPO Plan.

11 **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

12 **Reserve Surplus/Deficit**

Projected excess revenue over projected claims and fixed costs

SAN JOAQUIN VALLEY INSURANCE AUTHORITY

ANALYSIS OF ADMINISTRATION, CLAIMS & COMMUNICATIONS (FEES) - REVENUES & EXPENSES

FOR THE THREE MONTHS ENDED SEPTEMBER 30, 2012

	Year-To-Date		
	SJVIA FEES		
	Administration (*Line 5)	Claims Management (*Line 6)	Communications (*Line 7)
FY12-13			
Revenue**	**$47,384**	**$58,402**	**$11,681**
Expenses:			
Auditor-Treasurer Services			
County Counsel Services			
Personnel Services	5,577		
Membership Fees			
Insurance (Liability, Bond, Etc)	22,668		
Audit Fees	3,530		
Bank Service Fees	1,686		
Claims Management			
Communications			
Total Expenses	**33,461**		
Administration, Claims & Communications Surplus	**$13,923**	**$58,402**	**$11,681**

*Total expenses for each column correspond to the line number shown on the "ACTUALS VS. BUDGETED REVENUES & EXPENSES" report.

**Revenue consists of fees collected from enrollees at the following rates per employee per month: $4.00 for SJVIA association/non-founding member fees($2.00 for SJVIA association & $2.00 for non-founding member) & $3.00 for claims management/communications fees($2.50 for claims management & $.50 for communications).

SJVIA
Schedule of Cash Flow by Month
For the Three Months Ended September 30, 2012

	JULY	AUGUST	SEPTEMBER	TOTAL
BEGINNING CASH BALANCES:				
Claims Funding Account-844535294	$709,397	$348,046	$574,059	$709,397
Fixed Cost Account-844535120	301,657	331,453	337,327	301,657
Claims Reserve Account-428255819	8,177,407	8,611,368	9,708,781	8,177,407
Total Beginning Balances	9,188,461	9,290,867	10,620,167	9,188,461
RECEIPTS:				
Claims Funding Account-844535294	2,415,008	3,197,799	2,339,349	7,952,156
Fixed Cost Account-844535120	1,614,381	1,667,875	1,519,225	4,801,481
Claims Reserve Account-428255819	3,207,310	4,809,857	1,804,804	9,821,971
TOTAL RECEIPTS	7,236,699	9,675,531	5,663,378	22,575,608
DISBURSEMENTS:				
Claims Funding Account-844535294	2,776,359	2,971,786	2,426,480	8,174,625
Fixed Cost Account-844535120	1,584,585	1,662,001	1,492,694	4,739,280
Claims Reserve Account-428255819	2,773,349	3,712,444	3,041,240	9,527,033
TOTAL DISBURSEMENTS	7,134,293	8,346,231	6,960,414	22,440,938
ENDING CASH BALANCES:				
Claims Funding Account-844535294	348,046	574,059	486,928	486,928
Fixed Cost Account-844535120	331,453	337,327	363,858	363,858
Claims Reserve Account-428255819	8,611,368	9,708,781	8,472,345	8,472,345
Total Ending Balances	$9,290,867	$10,620,167	$9,323,131	$9,323,131

Investments:
No investments made at this time.

SJVIA
San Joaquin Valley Insurance Authority

Meeting Location:
Tulare County Employee Retirement Association Board Chambers
136 N. Akers Street
Visalia, CA 93291
November 9, 2012
9:00 AM

AGENDA DATE: November 9, 2012

ITEM NUMBER: 5f

SUBJECT: Agreement with McCormick, Barstow, Sheppard, Wayte & Carruth LLP for Special Legal Counsel

REQUEST(S): That the Board Authorize the Board Chair to Execute the Agreement with McCormick, Barstow, Sheppard, Wayte & Carruth LLP for Special Legal Counsel

DESCRIPTION:

At the July 20, 2012 meeting, your board directed staff to secure a contract with the recommended vendor special legal counsel for the SJVIA, McCormick, Barstow, Sheppard, Wayte & Carruth LLP. The recommendation came at the conclusion of a competitive bidding process overseen by SJVIA staff.

The attached agreement has been reviewed by SJVIA staff, legal counsel and Gallagher staff and provides the SJVIA with the opportunity to engage special counsel on an as needed basis under the direction of SJVIA Counsel.

Today's requested action by the Board will authorize execution of this agreement.

AGENDA: San Joaquin Valley Insurance Authority

DATE: November 9, 2012

FISCAL IMPACT/FINANCING:

Expenses associated with special legal counsel are funded by the "SJVIA Fee" of $2.00 per employee per month paid by each member entity. Usage of this agreement will be based on operational need. The hourly rates are based on the type of issue and Attorney required to deliver the required services.

ADMINISTRATIVE SIGN-OFF:

Paul Nerland
SJVIA Manager

Jeffrey Cardell
Assistant SJVIA Manager

BEFORE THE BOARD OF DIRECTORS SAN JOAQUIN VALLEY INSURANCE AUTHORITY

IN THE MATTER OF Agreement with McCormick, Barstow, Sheppard, Wayte & Carruth LLP for Special Legal Counsel

RESOLUTION NO. _____
AGREEMENT NO. _____

UPON MOTION OF DIRECTOR _____, SECONDED BY DIRECTOR _____, THE FOLLOWING WAS ADOPTED BY THE BOARD OF DIRECTORS, AT AN OFFICIAL MEETING HELD _____ _____, BY THE FOLLOWING VOTE:

AYES:
NOES:
ABSTAIN:
ABSENT:

ATTEST:

BY: _____

* * * * * * * * * * * * * * * * * * *

That the Board Authorized Board Chair to Execute the Agreement with McCormick, Barstow, Sheppard, Wayte & Carruth LLP for Special Legal Counsel

SJVIA
San Joaquin Valley Insurance Authority

Meeting Location:
Tulare County Employee Retirement Association Board Chambers
136 N. Akers Street
Visalia, CA 93291
November 9, 2012
9:00 AM

AGENDA DATE: November 9, 2012

ITEM NUMBER: 5g

SUBJECT: SJVIA Staff Rotation

REQUEST(S): That the Board of Directors Appoint Jeffrey Cardell as the SJVIA Manager and Paul Nerland as the SJVIA Assistant Manager effective January 2, 2013.

DESCRIPTION:

Pursuant to the Joint Exercise of Powers Agreement creating the San Joaquin Valley Insurance Authority, certain staff members shall be appointed to serve at the pleasure of the Board of Directors. The Agreement reads that the SJVIA Manager shall be either the Humans Resources Director of the County of Tulare (COT) or the Director of Personnel Services or Employee Benefits Manager at the County of Fresno (COF).

At the inaugural Board meeting for the SJVIA, Tim Huntley and Paul Nerland were appointed Manager and Assistant Manager, respectively. Due to the retirement of Mr. Huntley from the County of Tulare on January 14, 2011, your Board appointed Paul Nerland as SJVIA Manager and on July 22, 2011 Jeff Cardell as the SJVIA Assistant Manager. As approved by your Board at the November 5, 2010 these two positions shall serve two year terms. Today's recommended action is to appoint Mr. Cardell as SJVIA Manager and Mr. Nerland as SJVIA Assistant Manager commencing January 2, 2013 for the next

two years. Mr. Cardell and Mr. Nerland will continue to share administrative duties required to oversee the SJVIA.

FISCAL IMPACT/FINANCING:

None.

ADMINISTRATIVE SIGN-OFF:

Paul Nerland
SJVIA Manager

Jeffrey Cardell
Assistant SJVIA Manager

BEFORE THE BOARD OF DIRECTORS
SAN JOAQUIN VALLEY INSURANCE AUTHORITY

IN THE MATTER OF SJVIA Staff Rotation

RESOLUTION NO. _____
AGREEMENT NO. _____

UPON MOTION OF DIRECTOR _____, SECONDED BY DIRECTOR _____, THE FOLLOWING WAS ADOPTED BY THE BOARD OF DIRECTORS, AT AN OFFICIAL MEETING HELD _____ _____, BY THE FOLLOWING VOTE:

AYES:
NOES:
ABSTAIN:
ABSENT:

ATTEST:

BY: _____

* * * * * * * * * * * * * * * * * * *

That the Board of Directors appointed Jeffrey Cardell as the SJVIA Manager and Paul Nerland as the SJVIA Assistant Manager effective January 2, 2013.

SJVIA PARTICIPATION AGREEMENT

THIS AGREEMENT ("Agreement") is made and entered into this 10th day of December, 2012, 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".

W I T N E S S E T H:

WHEREAS, the purpose of the SJVIA is to develop and provide various health insurance programs, 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 Health Benefits"), for the benefit of participating entities; and

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

WHEREAS, the COUNTY OF FRESNO elects to participate in the SJVIA health insurance program (Anthem Blue Cross HMO, PPO, HDPPO), pharmacy program (US Script), dental program (Delta Dental DHMO, DPPO) and vision program (VSP); 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 Health Benefits to be provided under the Insurance Contract and by the SJVIA and its agents and consultants, as provided herein.

WHEREAS, a true and correct copy of a summary of applicable SJVIA 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 Health Benefits under the terms and conditions of a written contract between the SJVIA and the Insurance Provider (the "Insurance Contract") for each of COUNTY OF FRESNO's participating employees; and

WHEREAS, the SJVIA represents that the rates for the health benefits 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 health 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, hereinafter set forth, the sufficiency of which is acknowledged, the Parties agree as follows:

1. **COUNTY OF FRESNO'S OBLIGATIONS:** 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. COUNTY OF FRESNO acknowledges that this agreement requires a commitment to participate in said SJVIA health benefits effective December 10, 2012 through December 8, 2013 for employees and January 1, 2013 through December 31, 2013 for retirees.

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 business hours, and as often as the COUNTY OF FRESNO may deem necessary, make available to the COUNTY OF FRESNO for examination all of its records and data with respect to the matters covered by this Agreement. The SJVIA shall, upon request by the COUNTY OF FRESNO, permit the COUNTY OF FRESNO to audit and inspect all such records and data necessary to ensure SJVIA's compliance with the terms of 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	SJVIA
Beth Bandy Director of Personnel Services 2220 Tulare St, 16th Floor Fresno, CA 93721 Bbandv@co.fresno.ca.us	Paul Nerland SJVIA Manager 2220 Tulare St, 14th Floor Fresno, CA 93721 Pnerland@co.fresno.ca.us

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

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

8. TERM: This Agreement shall become effective on December 10, 2012 and shall terminate on December 31, 2013.

9. TERMINATION:

a. The terms of this Agreement, and the health benefits, 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.

9. 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.

10. 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.

11. 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.

12. 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 _____
Pete Vander Poel
SJVIA Board President

Date: _____

REVIEWED & RECOMMENDED FOR APPROVAL

By _____
Paul Nerland
SJVIA Manager

COUNTY OF FRESNO

By _____
Debbie Poochigian
Chair, Board of Supervisors

Date: _____

BERNICE E. SEIDEL, CLERK
BOARD OF SUPERVISORS

By _____

APPROVED AS TO LEGAL FORM:
KEVIN BRIGGS, COUNTY COUNSEL

By _____

APPROVED AS TO ACCOUNTING FORM:
VICKI CROW
AUDITOR-CONTROLLER/TREASURER-TAX COLLECTOR

By _____

REVIEWED & RECOMMENDED FOR APPROVAL

_____
Beth Bandy
Director of Personnel Services

Your Summary of Benefits
County of Fresno

Anthem Blue Cross

Custom Premier HMO 15

This Summary of Benefits is a brief overview of your plan's benefits only. For more detailed information about the benefits in your plan, please refer to your Certificate of Insurance or Evidence of Coverage (EOC), which explains the full range of covered services, as well as any exclusions and limitations for your plan.

Anthem Blue Cross HMO benefits are covered only when services are provided or coordinated by the primary care physician and authorized by the participating medical group or independent practice association (IPA), except services provided under the "ReadyAccess" program, OB/GYN services received within the member's medical group/IPA, and services for all mental and nervous disorders and substance abuse. Benefits are subject to all terms, conditions, limitations, and exclusions of the Policy.

Annual copay maximum: Individual $1,000; Family $2,000

The following copay does not apply to the annual copay maximum: for infertility services

Covered Services	Per Member Copay
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
Smoking Cessation Program	No copay
Physician Medical Services	
• Office & home visits	$15/visit
• Specialists	$15/visit
• Skilled nursing facility visits	No copay
• Hospital visits	No copay
• Injectable medications in physician's office *(excluding allergy serum and immunization)*	20%/up to $150 maximum copay
• Surgeon & Surgical assistant	No copay
• Anesthesiologist or anesthetist	No copay
Acupuncture	$15/visit
Outpatient Medical Services (*Services received in a hospital, other than emergency room services, or in any facility that is affiliated with a hospital*)	
• Outpatient surgery & supplies	No copay
• Advanced Imaging	No copay
• All other X-ray & laboratory tests (*including genetic testing*)	No copay
• Radiation therapy, chemotherapy & hemodialysis treatment & Infusion therapy	No copay
• Other Outpatient Medical Services including: Rehabilitation Therapy *(Physical, Occupational, or Speech Therapy, limited to a 60-day period of care)*	No copay
General Medical Services (*when performed in non-hospital-based facility*)	
• Advanced Imaging	No copay
• All other X-ray & laboratory tests (*including genetic testing*)	No copay
• Allergy testing & treatment *(including serums)*	No copay
• Radiation therapy, chemotherapy & hemodialysis treatment & Infusion therapy	No copay
• Rehabilitation Therapy *(Physical, Occupational, or Speech Therapy or Chiropractic Care, limited to 60-days period of care)*	$15/visit
Emergency Care	
• Physician & medical services	No copay

CONTINUED ON NEXT PAGE

Covered Services	Per Member Copay
• Outpatient hospital emergency room services	$100/visit (*waived if admitted inpatient*)
Inpatient Medical Services Semi-private room or private room, medically necessary services & supplies	No copay
Urgent Care *(out of service area)*	$15/visit *(copay waived if admitted inpatient or outpatient ER. For in area, contact your PCP or medical group)*
Skilled Nursing Facility (*limited to 100 days/calendar year*) • All necessary services & supplies (*excluding take-home drugs*)	 No copay
Ambulance Services • Transportation when medically necessary	No copay
Ambulatory Surgical Center • Outpatient surgery & supplies	No copay
Pregnancy and Maternity Care Prenatal & postnatal Professional *(physician)* services *(For your Inpatient copay, see Inpatient Medical Services. For your Outpatient Services copay, see Outpatient Medical Services)* **Elective Abortions** *(including prescription drug for abortion, mifepristone)*	No copay $100
Prosthetic devices *(including Orthotics)*	No copay
Durable medical equipment • Rental and Purchase of DME *(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)*	No copay
Family Planning and Infertility Services • Infertility studies & tests, Including treatment • Female Sterilization *(including tubal ligation and counseling/consultation)* • Male Sterilization • Counseling & consultation	 $15/visit No copay $15/visit $15/visit
Mental or Nervous Disorders and Substance Abuse Benefits are administered through Avante Behavrioral Health	
Home Health Care (*limited to 100 visits/calendar year; one visit by a home health aide equals four hours or less*)	$15/visit
Hospice Care (*Inpatient or outpatient services; family bereavement services*)	No copay
Organ and Tissue Transplant • Inpatient Care • Physician office visits • Specialist office visits	 No copay $15/visit $15/visit

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).

Premier HMO - Exclusions and Limitations

Care Not Approved. Care from a health care provider without the OK of primary care doctor, except for emergency services or urgent care.

Care Not Covered. Services before the member was on the plan, or after coverage ended.

Care Not Listed. Services not listed as being covered by this plan.

Care Not Needed. Any services or supplies that are not medically necessary.

Crime or Nuclear Energy. Any health problem caused: (1) while committing or trying 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) by nuclear energy, when the government can pay for treatment.

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 ask that the denial be reviewed by an external independent medical review organization, as described in the Evidence of Coverage (EOC).

Government Treatment. Any services the member actually received that were given 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.

Services Given by Providers Who Are Not With Anthem Blue Cross HMO. We will not cover these services unless primary care doctor refers the member, except for emergencies or urgent care.

Services Not Needing Payment. Services the member is not required to pay for or are given to the member at no charge, except services the member got at a charitable research hospital (not with the government). This hospital must:1. Be known throughout the world as devoted to medical research.2. Have at least 10% of its yearly budget spent on research not directly related to patient care.3. Have 1/3 of its income from donations or grants (not gifts or payments for patient care).4. Accept patients who are not able to pay.5. Serve patients with conditions directly related to the hospital's research (at least 2/3 of their patients).

Work-Related. Care for health problems that are work-related if such health problems are or can be covered by workers' compensation, an employer's liability law, or a similar law. We will provide care for a work-related health problem, but, we have the right to be paid back for that care. See "Third Party Liability" below.

Acupressure. Acupressure, or massage to help pain, treat illness or promote health by putting pressure to one or more areas of the body.**Air Conditioners.** Air purifiers, air conditioners, or humidifiers.

Birth Control Devices. Any devices needed for birth control which can be obtained without a doctor's prescription such as condoms.

Blood. Benefits are not provided for the collection, processing and storage of self-donated blood unless it is specifically collected for a planned and covered surgical procedure.

Braces or Other Appliances or Services for straightening the teeth (orthodontic services).

Chronic Pain Treatment. Treatment of frequent recurrences of pain, over a long period of time, that is not related to an active medical condition currently being treated.

Clinical Trials. Services and supplies in connection with clinical trials, except as specified as covered in the Evidence of Coverage (EOC).

Commercial weight loss programs. Weight loss programs, whether or not they are pursued under medical or doctor supervision, except as specified as covered in the EOC. 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 for treatment of anorexia nervosa or bulimia nervosa.

Consultations given by telephone or fax.

Cosmetic Surgery. Surgery or other services done only to make the member: look beautiful; to improve appearance; or to change or reshape normal parts or tissues of the body. This does not apply to reconstructive surgery the member might need to: get back the use of a body part; have for breast reconstruction after a mastectomy; correct or repair a deformity caused by birth defects, abnormal development, injury or illness in order to improve function, symptomatology or create a normal appearance. Cosmetic surgery does not become reconstructive because of psychological or psychiatric reasons.

Custodial Care or Rest Cures. Room and board charges for a hospital stay mostly for a change of scene or to make the member feel good. Services given by a rest home, a home for the aged, or any place like that.

Dental Services or Supplies. Dentures, bridges, crowns, caps, or dental prostheses, dental implants, dental services, tooth extraction, or treatment to the teeth or gums. Cosmetic dental surgery or other dental services for beauty purposes.

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

Eye Exercises or Services and Supplies for Correcting Vision. Optometry services, eye exercises, and orthoptics, except for eye exams to find out if the member's vision needs to be corrected. Eyeglasses or contact lenses are not covered. Contact lens fitting is not covered.

Eye Surgery for Refractive Defects. Any eye surgery just for correcting vision (like nearsightedness and/or astigmatism). Contact lenses and eyeglasses needed after this surgery.

Food or Dietary Supplements. Nutritional and/or dietary supplements, except as specified as covered in the EOC 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.

Health Club Membership. 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 doctor. This exclusion also applies to health spas.

Immunizations. Immunizations needed to travel outside the USA.

Infertility Treatment. Any infertility treatment including artificial insemination or in vitro fertilization & sperm bank.

Lifestyle Programs. Programs to help member change how one lives, like fitness clubs, or dieting programs. This does not apply to cardiac rehabilitation programs approved by the medical group.

Mental or nervous disorders. Academic or educational testing, counseling. Remedying an academic or education problem, except as stated as covered in the EOC.

Non-Prescription Drugs. Non-prescription, over-the-counter drugs or medicines.

Orthopedic Shoes. Orthopedic shoes (except when joined to braces) or shoe inserts (except custom molded orthotics). This does not apply to shoes and inserts designed to prevent or treat foot complications due to diabetes.

Outpatient Drugs. Outpatient prescription drugs or medications including insulin.

Personal Care and Supplies. Services for personal care, such as: help in walking, bathing, dressing, feeding, or preparing food. Any supplies for comfort, hygiene or beauty purposes.

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

Routine Exams. Routine physical or psychological exams or tests asked for by a job or other group, such as a school, camp, or sports program.

Scalp hair prostheses. Scalp hair prostheses, including wigs or any form of hair replacement.

Sex Change. Sex change surgery or treatments.

Sexual Problems. Treatment of any sexual problems unless due to a medical problem, physical defect, or disease.

Sterilization Reversal. Surgery done to reverse a sterilization.

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).

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

Varicose Vein Treatment. Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) when services are rendered for cosmetic purposes.

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.

County of Fresno
Modified Premier PPO
(250/20/100/50) - Active

PPO Benefits

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. 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.

Benefit year deductible for all providers	$250/member maximum of two separate deductibles/family
Deductible for non-Anthem Blue Cross PPO hospital or residential treatment center	$500/admission *(waived for emergency admission)*
Deductible for non-Anthem Blue Cross PPO hospital or residential treatment center if utilization review not obtained	$500/admission *(waived for emergency admission)*
Deductible for emergency room services	$100/visit *(waived if admitted directly from ER)*
Annual Out-of-Pocket Maximums	
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 out-of-pocket maximums: deductibles listed above; dollar copays; non-covered expense. After a member reaches the out-of-pocket maximum, the member no longer pays percentage copays for the remainder of the year. However, member remains responsible for dollar copays; and 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**
Hospital Medical Services *(subject to utilization review for inpatient services; waived for emergency admissions)*		
➢ Semi-private room, meals & special diets, & ancillary services	No copay	50%[1]
➢ Outpatient medical care, surgical services & supplies *(hospital care other than emergency room care)*	No copay	50%[1]
Ambulatory Surgical Centers		
➢ Outpatient surgery, services & supplies	No copay	50% *(benefit limited to $350/day)*
Skilled Nursing Facility *(subject to utilization review)*		
➢ Semi-private room, services & supplies *(limited to 100 days/benefit year)*	No copay	50%
Hospice Care		
➢ Inpatient or outpatient services ; family bereavement services	No copay[2]	
Home Health Care *(subject to utilization review)*		
➢ Services & supplies from a home health agency *(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)*	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 *(subject to utilization review)*		
➢ Includes medication, ancillary services & supplies; caregiver training & visits by provider to monitor therapy; durable medical equipment; lab services	No copay	50% *(benefit limited to $600/day)*
Physician Medical Services		
➢ Office & home visits	$20/visit[1] *(deductible waived)*	50%
➢ Hospital & skilled nursing facility visits	No copay	50%
➢ Surgeon & surgical assistant; anesthesiologist or anesthetist	No copay	50%
Diagnostic X-ray & Lab		
➢ MRI, CT scan, PET scan & nuclear cardiac scan *(subject to utilization review)*	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.		
➢ Routine physical examinations *(birth through age six)*	No copay/exam *(deductible waived)*	50% *(benefit limited to $20/exam)*
➢ Immunizations *(birth through age six)*	No copay *(deductible waived)*	50% *(benefit limited to $12/immunization)*
➢ Routine physical exams, immunizations, diagnostic X-ray & lab for routine physical exam *(members 7 years old and older)*	No copay/exam *(deductible waived)*	50%
➢ Adult preventive services *(including mammograms, Pap smears, prostate cancer screenings & colorectal cancer screenings)*	No copay *(deductible waived)*	50% *(deductible waived)*
Physical Therapy, Physical Medicine & Occupational Therapy, including Chiropractic Services *(limited to 24 visits/benefit year; additional visits may be authorized)*	No copay	50% *(benefit limited to $25/visit)*
Speech Therapy		
➢ Outpatient speech therapy following injury or organic disease	No copay	50%
Acupuncture		
➢ Services for the treatment of disease, illness or injury *(limited to $30/visit & 12 visits/benefit year)*	No copay[2]	50%[2]
Temporomandibular Joint Disorders		
➢ Splint therapy & surgical treatment	No copay	50%
Pregnancy & Maternity Care		
➢ Physician office visits	$20/visit[1] *(deductible waived)*	50%
➢ Prescription drug for elective abortion *(mifepristone)*	No copay	50%
Normal delivery, cesarean section, complications of pregnancy & abortion		
➢ Inpatient physician services	No copay	50%
➢ Hospital & ancillary services	No copay	50%[3]
Organ & Tissue Transplants *(subject to utilization review; specified organ transplants covered only when performed at Center of Expertise [COE])*		
➢ 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(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)*	No copay *(deductible waived)*	

[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
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	No copay	
➢ Bariatric travel expense when member's home is 50 miles or more from the nearest bariatric *COE (member's transportation to & from COE limited to $130/person/trip for 3 trips [pre-surgical visit, initial surgery & one follow-up visit]; one companion's transportation to & from COE limited to $130/person/trip for 2 trips [initial surgery & one follow-up visit]; hotel for member & one companion limited to one room double occupancy & $100/day for 2 days/trip, or as medically necessary, for pre-surgical & follow-up visit; hotel for one companion limited to one room double occupancy & $100/day for duration of member's initial surgery stay for 4 days; other reasonable expenses limited to $25/day/person for 4 days/trip)*	No copay *(deductible waived)*	
Diabetes Education Programs *(requires physician supervision)*		
➢ Teach members & their families about the disease process, the daily management of diabetic therapy & self-management training	$20/visit *(deductible waived)*	50%
Prosthetic Devices		
➢ Coverage for breast prostheses; prosthetic devices to restore a method of speaking; surgical implants; artificial limbs or eyes; the first pair of contact lenses or eyeglasses when required as a result of eye surgery; & therapeutic shoes & inserts for members with diabetes	No copay	50%
Durable Medical Equipment		
➢ Rental or purchase of DME including hearing aids, dialysis equipment & supplies *(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)*	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 *(self-donated blood collection, testing, processing & storage for planned surgery)*	No copay[1]	
Specialty Pharmacy Drugs *(utilization review may be required)*		
➢ Specialty pharmacy drugs filled through the specialty pharmacy program *(limited to 30-day supply; not covered if benefits are provided through prescription drug benefits, if applicable)*	No copay	Not covered[2]
If member does not get specialty pharmacy drugs from the specialty pharmacy program, member will not receive any specialty pharmacy drug benefits under this plan, unless the member qualifies for an exception as specified in the EOC.		

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

[2] No copay if member or non-PPO physician obtains drug from Specialty Pharmacy Program; otherwise, not covered.

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay
Emergency Care		
➢ Emergency room services & supplies *($100 deductible waived if admitted)*	No copay	No copay
➢ Inpatient hospital services	No copay	No copay
➢ Physician services	No copay	No copay

Mental or Nervous Disorders and Substance Abuse
Benefits are administered through Avante Behavioral Health

[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.

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.

Nicotine Use. Smoking cessation programs or treatment of nicotine or tobacco use. Smoking cessation drugs.

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).

Sex Transformation. Procedures or treatments to change characteristics of the body to those of the opposite sex.

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 Supplies. Orthopedic supplies, orthopedic shoes (other than shoes joined to braces), or non-custom molded and cast shoe inserts, except for therapeutic shoes and inserts for the prevention and treatment of diabetes-related feet complications , except as specified as covered 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.

Chronic Pain. Treatment of chronic pain, 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.

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.

Pre-Existing Condition Exclusion — No payment will be made for services or supplies for the treatment of a pre-existing condition during a period of six months following either (a) member's effective date or (b) the first day of any waiting period required by the group, whichever is earlier. However, this limitation does not apply to a child born to or newly adopted by an enrolled subscriber or spouse/domestic partner, or to conditions of pregnancy. Also, if member was covered under creditable coverage, as outlined in the member's EOC, the time spent under the creditable coverage will be used to satisfy, or partially satisfy, the six-month period.

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

County of Fresno
Modified Lumenos®
Health Savings Account (HSA)
LHSA266 (1500/80/60)
Retirees Under 65

PPO Benefits

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

Explanation of Maximum Allowed Amount

Maximum Allowed Amount is the total reimbursement payable under the plan for covered services received from Participating and Non-Participating Providers. It is the payment towards the services billed by a provider combined with any applicable deductible, copayment or coinsurance. Participating Providers- The rate the provider has agreed to accept as reimbursement for covered services. Members are not responsible for the difference between the provider's usual charges & the maximum allowed amount.

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

When using non-participating providers, the insured person is responsible for any difference between the covered expense & actual charges, as well as any deductible & percentage copay.

When using the outpatient prescription drug benefits, the insured person is always responsible for drug expenses which are not covered under this plan, as well as any deductible, percentage or dollar copay.

Calendar year deductible for all providers *(applicable to medical care & prescription drug benefits)*	
➢ Individual insured person	$1,500/individual insured person
➢ Insured family *(includes insured employee & one or more members of the employee's family; no coverage may be paid for any member of a family unless this $3,000 deductible is met)*	$3,000/insured family
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; $5,000/insured family/year
➢ Non-Participating Providers & Non-Participating Pharmacy	$10,000/individual insured person; $15,000/insured family/year

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

Lifetime Maximum	Unlimited

Covered Services	Traditional Health Coverage Insured Person Copay In-Network	 Out-of-Network *(Insured is also responsible for charges in excess of covered expense.)*
Hospital Medical Services *(subject to utilization review for inpatient services; waived for emergency admissions)*		
➢ Semi-private room, meals & special diets, & ancillary services	20%	40%
➢ Outpatient medical care, surgical services & supplies *(hospital care other than emergency room care)*	20%	40%
Ambulatory Surgical Centers		
➢ Outpatient surgery, services & supplies	20%	40% *(benefit limited to $350/day)*
Skilled Nursing Facility *(subject to utilization review)*		
➢ Semi-private room, services & supplies *(limited to 100 days/calendar year)*	20%	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 *(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)*	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% *(benefit limited to $600/day)*
Physician Medical Services		
➢ Office & home visits	20%	40%
➢ Hospital & skilled nursing facility visits	20%	40%
➢ Surgeon & surgical assistant; anesthesiologist or anesthetist	20%	40%
Diagnostic X-ray & Lab		
➢ MRI, CT scan, PET scan & nuclear cardiac scan *(subject to utilization review)*	20%	40%
➢ Other diagnostic x-ray & lab	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. *This list is not exhaustive. This benefit includes all Preventive Care Services required by federal and state law.	No copay	40%
Physical Therapy, Physical Medicine & Occupational Therapy, including Chiropractic Services *(limited to 24 visits/calendar year)*	20%	40% *(benefit limited to $25/visit)*
Speech Therapy		
➢ Outpatient speech therapy following injury or organic disease	20%	40%
Acupuncture		
➢ Services for the treatment of disease, illness or injury *(limited to $30/visit & 12 visits/calendar year)*	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 Insured Person Copay 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 *(mifepristone)*	20%	40%
Normal delivery, cesarean section, complications of pregnancy & abortion		
➢ Inpatient physician services	20%	40%
➢ Hospital & ancillary services	20%	40%
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	20%	
➢ 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)*	20%	
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	20%	
➢ 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)*	20%	
Diabetes Education Programs *(requires physician supervision)*		
➢ 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 Insured Person Copay 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 *(hearing aids benefit available for one hearing aid per ear every three years; breast pump and supplies are covered under preventive care at no charge for in-network)*	20%	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 *(self-donated blood collection, testing, processing & storage for planned surgery)*	20%[1]	
Specialty Pharmacy Drugs *(utilization review may be required)* ➢ Specialty pharmacy drugs filled through the specialty pharmacy program *(limited to 30-day supply; not covered if benefits are provided through prescription drug benefits, if applicable)* **If insured person does not get specialty pharmacy drugs from the specialty pharmacy program, insured person will not receive any specialty pharmacy drug benefits under this plan, unless the insured person qualifies for an exception as specified in the Certificate.**	20%	Not covered[2]
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 Care		
➢ Facility-based care *(subject to utilization review; waived for emergency admissions)*	20%	40%
➢ Inpatient physician visits	20%	40%
Outpatient Care		
➢ Facility-based care *(subject to utilization review; waived for emergency admissions)*	20%	40%
➢ Outpatient physician visits *(*Behavioral Health treatment will be subject to pre-service review*)*	20%	40%

[1] These providers are not represented in the PPO network.

[2] 20% copay if insured person or non-PPO physician obtains drug from Specialty Pharmacy Program; otherwise, not covered.

Covered Services	Traditional Health Coverage Insured Person Copay In-Network	 Out-of-Network *(Insured is also responsible for charges in excess of the prescription drug maximum allowed amount)*
Outpatient Prescription Drug Benefits		
➢ Female oral contraceptives generic and single source brand	No copay	
➢ Retail pharmacy prescription drug maximum allowed amount	20%	40%[1]
➢ Mail service prescription drug maximum allowed amount	20%	Not applicable
➢ Specialty pharmacy drugs *(obtained through specialty pharmacy program)*	20%	Not applicable
Supply Limits[2]		
➢ Retail Pharmacy *(participating and non-participating)*	30-day supply; 60-day supply for federally classified Schedule II attention deficit disorder drugs that require a triplicate prescription form, but require a double copay; 6 tablets or units/30-day period for impotence and/or sexual dysfunction drugs (available only at retail pharmacies)	
➢ Mail Service	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:

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

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

Lumenos 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.

Nicotine Use. Smoking cessation programs, except as specified as covered in the Certificate, or treatment of nicotine or tobacco use. Smoking cessation drugs, 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.

Sex Transformation. Procedures or treatments to change characteristics of the body to those of the opposite sex.

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 Supplies. Orthopedic supplies, orthopedic shoes (other than shoes joined to braces), or non-custom molded and cast shoe inserts, except for therapeutic shoes and inserts for the prevention and treatment of diabetes-related feet complications as specified as covered 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.

Chronic Pain. Treatment of chronic pain, except as specified as covered in the Certificate.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Lumenos 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.**

Pre-Existing Condition Exclusion —No payment will be made for services or supplies for the treatment of a pre-existing condition during a period of six months following either: (a) the insured person's effective date or (b) the first day of any waiting period required by the group, whichever is earlier. However, this limitation does not apply to a child born to or newly adopted by an enrolled employee or spouse/domestic partner, or to conditions of pregnancy. Also if an insured person was covered under creditable coverage, as outlined in the insured person's Certificate, the time spent under the creditable coverage will be used to satisfy, or partially satisfy, the six-month period.

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.

County of Fresno
Modified Lumenos®
Health Savings Account (HSA)
LHSA 263 (3000/100/50)

PPO Benefits

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.

This Lumenos plan is an innovative type of coverage that allows an insured person to use a Health Savings Account to pay for routine medical care. The program also includes traditional health coverage, similar to a typical health plan, that protects the insured person against large medical expenses.

The insured person can spend the money in the HSA account the way the insured person wants on routine medical care, prescription drugs and other qualified medical expenses. There are no copays or deductibles to satisfy first. Unused dollars can be saved from year to year to reduce the amount the insured person may have to pay in the future. If covered expenses exceed the insured person's available HSA dollars, the traditional health coverage is available after a limited out-of-pocket amount is paid by the insured person.

Certain Covered Services have maximum visit and/or day limits per year. The number of visits and/or days allowed for these services will begin accumulating on the first visit and/or day, regardless of whether your Deductible has been met. The insured person is responsible for all costs over the plan maximums. Plan maximums and other important information appear in *italics*. Benefits are subject to all terms, conditions, limitations, and exclusions of the Policy.

Explanation of Maximum Allowed Amount

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

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

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

Participating Pharmacies & Mail Service Program-members are not responsible for any amount in excess of the prescription drug maximum allowed amount. Non-Participating Pharmacies-members are responsible for any expense not covered under this plan & any amount in excess of the prescription drug maximum allowed amount.

When using non-participating providers, the insured person is responsible for any difference between the covered expense & actual charges, as well as any deductible & percentage copay.

When using the outpatient prescription drug benefits, the insured person is always responsible for drug expenses which are not covered under this plan, as well as any deductible, percentage or dollar copay.

Calendar year deductible for all providers *(applicable to medical care & prescription drug benefits)*	
➢ Individual insured person	$3,000/individual insured person
➢ Insured family *(includes insured employee & one or more members of the employee's family; no coverage may be paid for any member of a family unless this $6,000 deductible is met)*	$6,000/insured family
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

Covered Services	Traditional Health Coverage Insured Person Copay In-Network	 Out-of-Network *(Insured is also responsible for charges in excess of covered expense.)*
Hospital Medical Services *(subject to utilization review for inpatient services; waived for emergency admissions)*		
➢ Semi-private room, meals & special diets, & ancillary services	No copay	50%
➢ Outpatient medical care, surgical services & supplies *(hospital care other than emergency room care)*	No copay	50%
Ambulatory Surgical Centers		
➢ Outpatient surgery, services & supplies	No copay	50% *(benefit limited to $350/day)*
Skilled Nursing Facility *(subject to utilization review)*		
➢ Semi-private room, services & supplies *(limited to 100 days/calendar year)*	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 *(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)*	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% *(benefit limited to $600/day)*
Physician Medical Services		
➢ Office & home visits	No copay	50%
➢ Hospital & skilled nursing facility visits	No copay	50%
➢ Surgeon & surgical assistant; anesthesiologist or anesthetist	No copay	50%
Diagnostic X-ray & Lab		
➢ MRI, CT scan, PET scan & nuclear cardiac scan *(subject to utilization review)*	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	50%
Physical Therapy, Physical Medicine & Occupational Therapy, including Chiropractic Services *(limited to 24 visits/calendar year)*	No copay	50% *(benefit limited to $25/visit)*
Speech Therapy		
➢ Outpatient speech therapy following injury or organic disease	No copay	50%
Acupuncture		
➢ Services for the treatment of disease, illness or injury *(limited to $30/visit & 12 visits/calendar year)*	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 Insured Person Copay 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 *(mifepristone)*	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 Insured Person Copay 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 *(self-donated blood collection, testing, processing & storage for planned surgery)*	No copay [1]	
Specialty Pharmacy Drugs *(utilization review may be required)*		
➢ Specialty pharmacy drugs filled through the specialty pharmacy program *(limited to 30-day supply; not covered if benefits are provided through prescription drug benefits, if applicable)*	No copay	Not covered[2]
If insured person does not get specialty pharmacy drugs from the specialty pharmacy program, insured person will not receive any specialty pharmacy drug benefits under this plan, unless the insured person qualifies for an exception as specified in the Certificate.		
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 Care		
➢ Facility-based care *(subject to utilization review; waived for emergency admissions)*	No copay	50%
➢ Inpatient physician visits	No copay	50%
Outpatient Care		
➢ Facility-based care *(subject to utilization review; waived for emergency admissions)*	No copay	50%
➢ Outpatient physician visits *(*Behavioral Health treatment will be subject to pre-service review *)*	No copay	50%

[1] These providers are not represented in the PPO network.

[2] 10% if insured person or non-PPO physician obtains drug from Specialty Pharmacy Program; otherwise, not covered.

Covered Services	Traditional Health Coverage Insured Person Copay In-Network	 Out-of-Network *(Insured is also responsible for charges in excess of the prescription drug maximum allowed amount)*
Outpatient Prescription Drug Benefits		
➢ Female oral contraceptives generic and single source brand	No copay	
➢ Retail pharmacy prescription drug maximum allowed amount	No copay	50%[1]
➢ Mail service prescription drug maximum allowed amount	No copay	Not applicable
➢ Specialty pharmacy drugs *(obtained through specialty pharmacy program)*	No copay	Not applicable
Supply Limits[2]		
➢ Retail Pharmacy *(participating and non-participating)*	30-day supply; 60-day supply for federally classified Schedule II attention deficit disorder drugs that require a triplicate prescription form, but require a double copay; 6 tablets or units/30-day period for impotence and/or sexual dysfunction drugs (available only at retail pharmacies)	
➢ Mail Service	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:

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

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

Lumenos 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.

Nicotine Use. Smoking cessation programs, except as specified as covered in the Certificate, or treatment of nicotine or tobacco use. Smoking cessation drugs, 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.

Sex Transformation. Procedures or treatments to change characteristics of the body to those of the opposite sex.

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 Supplies. Orthopedic supplies, orthopedic shoes (other than shoes joined to braces), or non-custom molded and cast shoe inserts, except for therapeutic shoes and inserts for the prevention and treatment of diabetes-related feet complications as specified as covered 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.

Chronic Pain. Treatment of chronic pain, except as specified as covered in the Certificate.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Lumenos 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.**

Pre-Existing Condition Exclusion – No payment will be made for services or supplies for the treatment of a pre-existing condition during a period of six months following either: (a) the insured person's effective date or (b) the first day of any waiting period required by the group, whichever is earlier. However, this limitation does not apply to a child born to or newly adopted by an enrolled employee or spouse/domestic partner, or to conditions of pregnancy. Also if an insured person was covered under creditable coverage, as outlined in the insured person's Certificate, the time spent under the creditable coverage will be used to satisfy, or partially satisfy, the six-month period.

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

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

SJVIA
San Joaquin Valley
Insurance Authority

USscript

Prescription Drug Copays - County of Fresno

30 Day Supply:	**Mail**
Generic = $10	Generic = $20
Formulary = $20	Formulary = $40
Non-Formulary = $35	Non-Formulary = $60
DAW 1 - No Cost Differential	DAW 1 - No Cost Differential
DAW 2 - Non-Formulary + Cost Difference	DAW 2 - Non-Formulary + Cost Difference
90 Day Supply:	**Specialty Medication copays:**
Generic = $20	Generic = $10
Formulary = $40	Formulary = $20
Non-Formulary = $60	Non-Formulary = $35
DAW 1 - No Cost Differential	*** Specialty medications are covered at a 30-day*
DAW 2 - Non-Formulary + Cost Difference	*Supply only.***

Exclusions

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

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

Plan Benefit Highlights for: COUNTY OF FRESNO

Group No: 05879

DELTA DENTAL PPO℠

BENEFIT HIGHLIGHTS

Eligibility	Primary enrollee, spouse (includes domestic partner) and eligible dependent children to age 26		
Deductibles	$50 per person / $150 per family each calendar year		
Deductibles waived for D & P?	Yes In-Network Only		
Maximums (Waived for D&P Services)	$2500 per person each calendar year		
Waiting Period(s)	Basic Benefits None	Major Benefits None	Orthodontics None

Benefits and Covered Services*	Delta Dental PPO dentists**	Non-PPO dentists**
Diagnostic & Preventive Services (D & P) Exams, cleanings, x-rays	100 %	90 %
Basic Services Fillings, sealants	90 %	90 %
Endodontics (root canals)	50 %	50 %
Periodontics (gum treatment)	50 %	50 %
Oral Surgery	50 %	50 %
Major Services Crowns, inlays, onlays and cast restorations, bridges and dentures, implants	50 %	50 %
Orthodontic Benefits adults and dependent children	100 % After co-payment	100 % After co-payment
Orthodontic Copayments 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	**Customer Service**	**Claims Address**
100 First St. San Francisco, CA 94105	800-765-6003	P.O. Box 997330 Sacramento, CA 95899-7330

deltadentalins.com

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

SCHEDULE A

Description of Benefits and Copayments

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

Text that appears in italics below is specifically intended to clarify the delivery of benefits under the DeltaCare® USA program and is not to be interpreted as CDT-2011 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 COPAYMENTS
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
D0180	Comprehensive periodontal evaluation - new or established patient	No Cost
D0210	Intraoral *radiographs* - complete series (including bitewings) - *limited to 1 series every 24 months*	No Cost
D0220	Intraoral - periapical first film	No Cost
D0230	Intraoral - periapical each additional film	No Cost
D0240	Intraoral - occlusal film	No Cost
D0250	Extraoral - first film	No Cost
D0260	Extraoral - each additional film	No Cost
D0270	Bitewing *radiograph* - single film	No Cost
D0272	Bitewings *radiographs* - two films	No Cost
D0273	Bitewings *radiographs* - three films	No Cost
D0274	Bitewings *radiographs* - four films - *limited to 1 series every 6 months*	No Cost
D0277	Vertical bitewings - 7 to 8 films	No Cost
D0330	Panoramic film	No Cost
D0415	Collection of microorganisms for culture and sensitivity	No Cost
D0425	Caries susceptibility tests	No Cost
D0460	Pulp vitality tests	No Cost
D0470	Diagnostic casts	No Cost
D0472	Accession of tissue, gross examination, preparation and transmission of written report - *available only when performed in conjunction with a covered biopsy*	No Cost
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report - *available only when performed in conjunction with a covered biopsy*	No Cost
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report - *available only when performed in conjunction with a covered biopsy*	No Cost
D0999	Unspecified diagnostic procedure, by report - *includes office visit, per visit (in addition to other services)*	No Cost
D1000-D1999	**II. PREVENTIVE**	
D1110	Prophylaxis *cleaning* - adult - *1 per 6 month period*	No Cost
D1110	*Additional prophylaxis cleaning - adult (within the 6 month period)*	$45.00
D1120	Prophylaxis *cleaning* - child - *1 per 6 month period*	No Cost
D1120	*Additional prophylaxis cleaning - child (within the 6 month period)*	$35.00
D1203	Topical application of fluoride - child - *to age 19; 1 per 6 month period*	No Cost
D1204	Topical application of fluoride - adult - *1 per 6 month period*	No Cost
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients - *1 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
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-cementation of 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	Recement inlay, onlay or partial coverage restoration	No Cost
D2915	Recement cast or prefabricated post and core	No Cost
D2920	Recement crown	No Cost
D2930	Prefabricated stainless steel crown - primary tooth	No Cost
D2931	Prefabricated stainless steel crown - permanent tooth	No Cost
D2932	Prefabricated resin crown - *anterior primary tooth*	No Cost
D2933	Prefabricated stainless steel crown with resin window - *anterior primary tooth*	No Cost
D2940	Protective restoration	No Cost
D2950	Core buildup, including any pins	No Cost
D2951	Pin retention - per tooth, in addition to restoration	No Cost
D2952	Post and core in addition to crown, indirectly fabricated - *includes canal preparation*	No Cost
D2953	Each additional indirectly fabricated post - same tooth - *includes canal preparation*	No Cost
D2954	Prefabricated post and core in addition to crown - *base metal post; includes canal preparation*	No Cost
D2955	Post removal (not in conjunction with endodontic therapy)	No Cost
D2957	Each additional prefabricated post - same tooth - *base metal post; includes canal preparation*	No Cost
D2960	Labial veneer (resin laminate) - chairside - *limited to replacement of significant tooth structure loss due to caries or fracture*	$245.00
D2961	Labial veneer (resin laminate) - laboratory - *limited to replacement of significant tooth structure loss due to caries or fracture*	$295.00
D2962	Labial veneer (porcelain laminate) - laboratory - *limited to replacement of significant tooth structure loss due to caries or fracture*	$345.00
D2970	Temporary crown (fractured tooth) - *palliative treatment only*	No Cost
D2971	Additional procedures to construct new crown under existing partial denture framework	$14.00
D2980	Crown repair, by report	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/pulpal regeneration - initial visit (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)	$55.00
D3352	Apexification/recalcification/pulpal regeneration - 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/periradicular surgery - anterior	No Cost
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	No Cost

D3425	Apicoectomy/periradicular surgery - molar (first root)	No Cost
D3426	Apicoectomy/periradicular surgery (each additional root)	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 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
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 flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	$75.00
D4261	Osseous surgery (including flap entry 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
D4271	Free soft tissue graft procedure (including donor site surgery)	$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
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, by report - *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, by report - 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

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	Recement fixed partial denture	No Cost
D6940	Stress breaker	No Cost
D6970	Post and core in addition to fixed partial denture retainer, indirectly fabricated - *includes canal preparation*	No Cost
D6972	Prefabricated post and core in addition to fixed partial denture retainer - *base metal post; includes canal preparation*	No Cost
D6973	Core buildup for retainer, including any pins	No Cost
D6976	Each additional indirectly fabricated post - same tooth - *includes canal preparation*	No Cost
D6977	Each additional prefabricated post - same tooth - *base metal post; includes canal preparation*	No Cost
D6980	Fixed partial denture repair, by report	No Cost

D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY

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

D7111	Extraction, coronal remnants - deciduous tooth	No Cost
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	No Cost
D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$10.00
D7220	Removal of impacted tooth - soft tissue	$15.00
D7230	Removal of impacted tooth - partially bony	$25.00
D7240	Removal of impacted tooth - completely bony	$35.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$50.00
D7250	Surgical removal of residual tooth roots (cutting procedure)	No Cost
D7251	Coronectomy - intentional partial tooth removal	$50.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$35.00
D7280	Surgical access of an unerupted tooth	$25.00

D7282	Mobilization of erupted or malpositioned tooth to aid eruption	$25.00
D7283	Placement of device to facilitate eruption of impacted tooth	No Cost
D7286	Biopsy of oral tissue - soft - *does not include pathology laboratory procedures*	No Cost
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	No Cost
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	No Cost
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	No Cost
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	No Cost
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	No Cost
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	No Cost
D7471	Removal of lateral exostosis (maxilla or mandible)	No Cost
D7472	Removal of torus palatinus	No Cost
D7473	Removal of torus mandibularis	No Cost
D7510	Incision and drainage of abscess - intraoral soft tissue	No Cost
D7960	Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure	No Cost
D7970	Excision of hyperplastic tissue - per arch	No Cost
D7971	Excision of pericoronal gingiva	No Cost

D8000-D8999 XI. ORTHODONTICS

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

Pre and post orthodontic records include:

	The benefit for pre-treatment records and diagnostic services includes:	$200.00
D0210	Intraoral - complete series (including bitewings)	
D0322	Tomographic survey	
D0330	Panoramic film	
D0340	Cephalometric film	
D0350	Oral/facial photographic images	
D0470	Diagnostic casts	
	The benefit for post-treatment records includes:	$70.00
D0210	Intraoral - complete series (including bitewings)	
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 visit	$25.00
D8670	Periodic orthodontic treatment visit (as part of contract)- *included in comprehensive case fee*	No Cost
D8680	Orthodontic retention (removal of appliances, construction and placement of *removable* retainers)	$275.00
D8693	Rebonding or recementing; and/or repair, as required, of fixed retainers -*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
D9220	Deep sedation/general anesthesia - first 30 minutes	$165.00
D9221	Deep sedation/general anesthesia - each additional 15 minutes	$80.00
D9241	Intravenous conscious sedation/analgesia - first 30 minutes	$165.00
D9242	Intravenous 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
D9940	Occlusal guard, by report - *limited to 1 in 3 years*	$75.00
D9951	Occlusal adjustment, limited	No Cost
D9952	Occlusal adjustment, complete	No Cost
D9972	External bleaching - per arch - *limited to one bleaching tray and gel for two weeks of self treatment*	$125.00
D9999	Unspecified adjunctive procedure, by report - *includes failed appointment without 24 hour notice - per 15 minutes of appointment time - up to an overall maximum of $40.00*	$10.00

If services for a listed procedure are performed by the assigned Contract Dentist, the Enrollee pays the specified Copayment. Listed procedures which require a Dentist to provide Specialist Services, and are referred by the assigned Contract Dentist, must be preauthorized in writing 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.

VSP
Vision care for life

Your Vision Benefit Summary

Keep your eyes healthy with
County of Fresno and VSP® Vision Care.

Using your VSP benefit is easy.

- **Find an eyecare provider who's right for you.** You can choose to see any eyecare provider—your local VSP doctor, a retail chain affiliate, or any other provider. To find a VSP doctor or retail chain affiliate, visit **vsp.com** or call **800.877.7195**.
- **Review your benefit information.** Visit **vsp.com** to review your plan coverage before your appointment.
- **At your appointment, tell them you have VSP.** There's no ID card necessary.

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

Primary EyeCare

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.

Choice in Eyewear

From classic styles to the latest designer frames, you'll find hundreds of options for you and your family. You'll have access to great brands, like bebe®, Calvin Klein, Disney, FENDI, Nike, and Tommy Bahama®.

Plan Information

VSP Coverage Effective Date: 12/10/2012
VSP Doctor Network: VSP Choice

Primary EyeCare Copay: $20

Benefit	Description	Copay
Your Coverage with VSP Doctors and Affiliate Providers*		
WellVision Exam	• Focuses on your eyes and overall wellness • Every 12 months	$10
Prescription Glasses		$0
Frame	• $150 allowance for a wide selection of frames • $80 allowance at Costco • 20% off amount over your allowance at a VSP Doctor • Every 24 months	Included in Prescription Glasses
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children • Every 12 months	Included in Prescription Glasses
Lens Options	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average 20-25% off other lens options • Every 12 months	$55 $95 - $105 $150 - $175
Contacts (instead of glasses)	• $130 allowance for contacts and contact lens exam (fitting and evaluation) • 15% off contact lens exam (fitting and evaluation) • Every 12 months	$0
Additional Coverage	• Primary Eyecare	
Extra Savings and Discounts	**Glasses and Sunglasses** • 20% off additional glasses and sunglasses, including lens options, from any VSP doctor within 12 months of your last WellVision Exam. **Laser Vision Correction** • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities	

Your Coverage with Other Providers

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

Exam.....up to $45	Lined Trifocal Lenses.....up to $65
Frame.....up to $70	Progressive Lenses.....up to $50
Single Vision Lenses.....up to $30	Contacts.....up to $105
Lined Bifocal Lenses.....up to $50	

***Coverage with a retail chain affiliate may be different. Once your benefit is effective, visit vsp.com for details.**
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.

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

County of Fresno

EXHIBIT B

Active Employees SJVIA Health Plan Rates

Effective Date: December 10, 2012

	Anthem HMO	Anthem PPO	Anthem HDPPO
	In-Network	In-Network	In-Network
DEDUCTIBLE			
Per Individual	$0	$250	$3,000
Per Family	$0	$500	$6,000
OUT OF POCKET MAX			
Per Individual	$1,000	$3,000	$3,000
Per Family	$2,000	$5,000	$6,000
PHYSICIAN SERVICES			
Office Visits	$15	$20	N/C after ded.
Lab and X-Rays	No charge	No charge	N/C after ded.
OUTPATIENT SERVICES			
Surgery	No charge	No charge	N/C after ded.
HOSPITALIZATION SERVICES			
Inpatient Services	No charge	No charge	N/C after ded.
EMERGENCY ROOM	$100/visit	$100 deductible	N/C after ded.
CHIROPRACTIC SERVICES	$15 (60 days)	No charge 24/Visits	N/C after ded. 24/Visits
PRESCRIPTON DRUG			
Generic	$10	$10	N/C after ded.
Preferred	$20	$20	N/C after ded.
Non-preferred	$35	$35	N/C after ded.

Active Renewal *Bi-Weekly* Rates (Illustrative)				All Cost Including Rx & MN	All Cost Including Rx & MN	All Cost Including Rx & MN
	HMO	**PPO**	**HDPPO**			
Employee	1993	232	229	$262.02	$369.94	$203.43
Employee +Spouse	616	33	16	$463.39	$776.58	$430.91
Employee + Child(ren)	1337	15	16	$408.97	$703.56	$386.32
Employee + Family	603	7	10	$609.78	$1,072.83	$588.70
Total Enrollment	4549	287	271			

County of Fresno
Pre 65 Retirees SJVIA Health Plan Rates
Proposed Effective Date: January 1, 2013

	Anthem HDPPO
	In-Network
DEDUCTIBLE	
Per Individual	$1,500
Per Family	$3,000
OUT OF POCKET MAX	
Per Individual	$3,000
Per Family	$5,000
PHYSICIAN SERVICES	
Physician & Specialist Office Visits	20% after Ded
Laboratory and X-Rays	20% after Ded
OUTPATIENT SERVICES	
Surgery	20% after Ded
HOSPITALIZATION SERVICES	
Inpatient Services	20% after Ded
EMERGENCY ROOM	20% after Ded
CHIROPRACTIC SERVICES	20% after Ded (24 max)
PRESCRIPTION DRUGS	
Generic	20% after deductible
Brand Name	20% after deductible

Pre-65 Renewal Monthly Rates (Illustrative)		All Cost Including Rx & MN
	HDPPO	
Employee	218	$617.01
Employee +Spouse	46	$1,092.31
Employee + Child(ren)	6	$963.86
Employee + Family	2	$1,437.99
Total Enrollment	272	

County of Fresno
SJVIA PPO Dental Plan Rates
Effective Date: December 10, 2012 (Actives), January 1, 2013 (Retirees)

		SJVIA Delta Dental DPPO		
		PPO	**Premier**	**Out-of Network**
Deductible				
Individual			$50	
Family			$150	
Waived for Preventive		Yes	No	No
Annual Maximum			$2,500	
Preventive Services		100%	90%	90%
Basic Services		90%	90%	90%
Major Services		50%	50%	50%
Dental Implants		Yes	Yes	Yes
Orthodontia*				
Adult			$1,880 Copay	
Child			$1,660 Copay	
Lifetime Maximum			n/a	
UCR Percentile			80th	
Rate Guarantee			**2 Years****	
Monthly Rates				
Employee	2177		$51.47	
Employee +Spouse	679		$82.08	
Employee + Child(ren)	888		$71.52	
Employee + Family	391		$105.00	
Total Enrollment	4135			

*Ortho plan pays 100% after the member's co-payment. Maximum of 24 mo of active ortho treatment. Ortho's reimbursement is at the CA's 80th percentile for non-PPO and non-Delta dentists only.

**SJVIA/Delta Dental 2nd Year Guarantee is a not to

County of Fresno
SJVIA DHMO Dental Plan Rates
Effective Date: December 10, 2012 (Actives), January 1, 2013 (Retirees)

			SJVIA Delta Dental Custom Plan
Employee co-pays			
D0230	Intraoral - periapical each additional film		$0
D1110	Prophylaxis - adult		$0
D2392	Resin-based composite - two surfaces, posterior		$30
D3330	Molar (excluding final restoration)		$60
D4341	Periodontal scaling and root planing		$0
D5214	Mandibular partial denture		$95
D6750	Crown - porcelain fused to high noble metal		$70
D7210	Surgical removal of erupted tooth		$10
D9220	Deep sedation/general anesthesia - first 30 minutes		$165
D9972	External Bleaching - 1 tray & gel for 2 weeks		$125
D8080	Child Ortho		$1,700
D8090	Adult Ortho		$1,900
Rate Guarantee			**2 Years***
Monthly Rates		**Enrollment**	
Employee		1294	$21.69
Employee +Spouse		333	$37.22
Employee + Child(ren)		553	$37.48
Employee + Family		255	$54.01
Total Enrollment		2435	

*SJVIA/Delta Dental 2nd Year Guarantee is a not to exceed 10% increase.

County of Fresno
SJVIA Vision Plan Rates
Effective Date: December 10, 2012 (Actives), January 1, 2013 (Retirees)

		VSP Vision Plan	
		In-Network	**Out-of Network**
Frequency		12 / 12 / 24	
Copays			
Exams		$10	Up to $45
Materials - Standard Lenses		$0	Scheduled
Lenses		$0	$30
Single Vision		$0	$50
Lined Bifocal		$0	$65
Lined Trifocal			
Frames		$150	Up to $70
Contacts			
Medically Necessary		$0	Up to $210
Cosmetic - Elective		$130	Up to $105
Rate Guarantee		**2 Years**	
Monthly Rates	**Enrollment**		
Single	2930	$7.34	
Employee +spouse	843	$13.19	
Employee +child(ren)	1370	$12.93	
Family	614	$18.93	
Total Enrollment	5757		

SJVIA PARTICIPATION AGREEMENT

THIS AGREEMENT ("Agreement") is made and entered into this 1st day of January, 2013, by and between **COUNTY OF TULARE**, a political subdivision of the State of California, hereinafter referred to as "**COUNTY OF TULARE**", and the SAN JOAQUIN VALLEY INSURANCE AUTHORITY, a joint powers agency, hereinafter referred to as "SJVIA".

W I T N E S S E T H:

WHEREAS, the purpose of the SJVIA is to develop and provide various health insurance programs, 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 Health Benefits"), for the benefit of participating entities; and

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

WHEREAS, the COUNTY OF TULARE elects to participate in the SJVIA health insurance program (Anthem Blue Cross HMO, PPO, HDPPO), pharmacy program (US Script), dental program (Delta Dental DHMO, DPPO) and vision program (VSP); 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 Health Benefits to be provided under the Insurance Contract and by the SJVIA and its agents and consultants, as provided herein.

WHEREAS, a true and correct copy of a summary of applicable SJVIA 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 Health Benefits under the terms and conditions of a written contract between the SJVIA and the Insurance Provider (the "Insurance Contract") for each of COUNTY OF TULARE's participating employees; and

WHEREAS, the SJVIA represents that the rates for the health benefits 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 health 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, hereinafter set forth, the sufficiency of which is acknowledged, the Parties agree as follows:

1. **COUNTY OF TULARE'S OBLIGATIONS:** 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. COUNTY OF TULARE acknowledges that this agreement requires a commitment to participate in said SJVIA health benefits effective December 10, 2012 through December 8, 2013 for employees and January 1, 2013 through December 31, 2013 for retirees.

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 business hours, and as often as the COUNTY OF TULARE may deem necessary, make available to the COUNTY OF TULARE for examination all of its records and data with respect to the matters covered by this Agreement. The SJVIA shall, upon request by the COUNTY OF TULARE, permit the COUNTY OF TULARE to audit and inspect all such records and data necessary to ensure SJVIA's compliance with the terms of this Agreement. SJVIA shall be subject to the examination and audit of the State Auditor General for a period of three (3) years after final payment under contract (Government Code section 8546.7).

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

COUNTY OF TULARE	SJVIA
Jeffrey Cardell Human Resource Director 2900 West Burrel Visalia, CA 93291 JCardell@co.tulare.ca.us	Paul Nerland SJVIA Manager 2220 Tulare St, 14th Floor Fresno, CA 93721 Pnerland@co.fresno.ca.us

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

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

8. TERM: This Agreement shall become effective on January 1, 2013 and shall terminate on December 31, 2013.

9. TERMINATION:

a. The terms of this Agreement, and the health benefits, 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.

9. 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.

10. 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.

11. 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.

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

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(Go to next page for signatures)

AGREEMENT BETWEEN COUNTY OF TULARE AND THE

SAN JOAQUIN VALLEY INSURANCE AUTHORITY

SAN JOAQUIN VALLEY INSURANCE AUTHORITY:

By _____
Pete Vander Poel
SJVIA Board President

Date: _____

REVIEWED & RECOMMENDED FOR APPROVAL

By _____
Paul Nerland
SJVIA Manager

COUNTY OF TULARE

By _____
Allen Ishida
Chairman, Board of Supervisors

Date: _____

ATTEST:

By _____
Jean Rousseau, County Administrative Officer/Clerk Of The Board Of Supervisors

APPROVED AS TO LEGAL FORM:

By _____
Deanne Peterson, County Counsel

Anthem Blue Cross

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

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

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

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

Explanation of Covered Expense

Plan payments are based on covered expense, which is the lesser of the charges billed by the provider or the following:

PPO Providers—PPO negotiated rates. Members are not responsible for the difference between the provider's usual charges & the negotiated amount.

Non-PPO Providers—For non-emergency services, the scheduled amount. For emergency services, same as other health care providers

Other Health Care Providers *(includes those not represented in the PPO provider network)*—The customary & reasonable charge for professional services or the reasonable charge for institutional services.

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	
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: deductibles listed above; dollar copays; non-covered expense. After a member reaches the out-of-pocket maximum, the member remains responsible for deductibles listed above; dollar copays & for non-PPO providers & other health care providers, costs in excess of the covered expense.

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

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

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

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay[1]
Home Health Care *(subject to utilization review)*		
➢ Services & supplies from a home health agency *(limited to combined 100 prior authorized visits/calendar year, one visit by a home health aide equals four hours or less; not covered while member receives hospice care)*	10%	10% with authorization
Home Infusion Therapy *(subject to utilization review)*		
➢ Includes medication, ancillary services & supplies; caregiver training & visits by provider to monitor therapy; durable medical equipment; lab services	10%	10%
Physician Medical Services		
➢ Office & home visits	$20/visit[2]	30%
➢ Hospital & skilled nursing facility visits	10%	30%
➢ Surgeon & surgical assistant; anesthesiologist or anesthetist	10%	30%
Diagnostic X-ray & Lab		
➢ MRI, CT scan, PET scan & nuclear cardiac scan *(subject to utilization review)*	10%	30%
➢ Other diagnostic x-ray & lab	No copay	30%
Well Baby & Well-Child Care for Dependent Children		
➢ Routine physical examinations, eye/ear screenings *(birth through age six)*	$20/visit	Not covered
➢ Immunizations, vaccinations *(birth through age six)*	No copay	Not covered
Physical Exams for Members Ages Seven & Older		
➢ Routine physical exams	$20/exam	Not covered
➢ Immunizations, diagnostic x-ray & lab for routine physical exam	No copay	Not covered
Adult Preventive Services *(including mammograms, Pap smears, prostate cancer screenings & colorectal cancer screenings, or other FDA-approved cervical cancer screening tests)*	No copay	Not covered
Physical Therapy, Physical Medicine & Occupational Therapy	$25/visit	30%
Chiropractic Services *(up to 12 visits/calendar year; additional visits may be approved, if medically necessary)*	$25/visit	30%
Speech Therapy		
➢ Outpatient speech therapy following injury or organic disease	$20/visit	30%
Acupuncture		
➢ Services for the treatment of disease, illness or injury *(limited to 20 visits/calendar year)*	$25/visit[3]	$25/visit[3]
Temporomandibular Joint Disorders		
➢ Splint therapy & surgical treatment	10%	30%
Pregnancy & Maternity Care		
➢ Physician office visits	$20/visit[2]	30%
➢ Prescription drug for elective abortion *(mifepristone)*	10%	Not covered
Normal delivery, cesarean section, complications of pregnancy & abortion *(newborn routine nursery care covered when natural mother is subscriber or spouse/domestic partner)*		
➢ Inpatient physician services	10%	30%
➢ Hospital & ancillary services	10%	30% *(benefit limited to $600/day)*
➢ Family planning counseling	$20/visit	Not covered

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

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

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

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

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

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

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay[1]
Specialty Pharmacy Drugs *(utilization review may be required)*		
➢ Specialty pharmacy drugs filled through the specialty pharmacy program *(limited to 30-day supply; not covered if benefits are provided through prescription drug benefits, if applicable)*	10%	Not covered[2]
If member does not get specialty pharmacy drugs from the specialty pharmacy program, member will not receive any specialty pharmacy drug benefits under this plan, unless the member qualifies for an exception as specified in the EOC.		
Emergency Care		
➢ Emergency room services & supplies *($100 deductible waived if admitted)*	10%	10%
➢ Inpatient hospital services & supplies	10%	10%
➢ Physician services	10%	10%
Mental or Nervous Disorders and Substance Abuse		
Inpatient Care		
➢ Facility-based care *(subject to utilization review; waived for emergency admissions)*	10%	30% *(benefit limited to $600/day)*
➢ Inpatient physician visits	10%	30%
Outpatient Care		
➢ Facility-based care *(subject to utilization review; waived for emergency admissions)*	10%	30% *(benefit limited to $600/day)*
➢ Outpatient physician visits *(pre-service review required after the 12th visit)*	$20/visit[3]	30%

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

[2] 10% copay if member or non-PPO physician obtains drug from Specialty Pharmacy Program; otherwise, not covered.

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

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

Classic PPO Exclusions and Limitations

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Nicotine Use. Smoking cessation programs or treatment of nicotine or tobacco use. Smoking cessation drugs

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).

Sex Transformation. Procedures or treatments to change characteristics of the body to those of the opposite sex.

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 Supplies. Orthopedic supplies, orthopedic shoes (other than shoes joined to braces), or non-custom molded and cast shoe inserts, except as specified as covered 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.

Chronic Pain. Treatment of chronic pain, except as specified as covered in the EOC.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Wigs.

Pre-Existing Condition Exclusion — No payment will be made for services or supplies for the treatment of a pre-existing condition during a period of six months following either: (a) the member's effective date or (b) the first day of any waiting period required by the group, whichever is earlier. However, this limitation does not apply to a child born to or newly adopted by an enrolled subscriber or spouse/domestic partner, or to conditions of pregnancy. Also if a member was covered under creditable coverage, as outlined in the member's EOC, the time spent under the creditable coverage will be used to satisfy, or partially satisfy, the six-month period.

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.

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

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

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

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

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

Explanation of Covered Expense

Plan payments are based on covered expense, which is the lesser of the charges billed by the provider or the following:

PPO Providers—PPO negotiated rates. Members are not responsible for the difference between the provider's usual charges & the negotiated amount.

Non-PPO Providers—For non-emergency services, the scheduled amount. For emergency services, same as other health care providers

Other Health Care Providers *(includes those not represented in the PPO provider network)*—The customary & reasonable charge for professional services or the reasonable charge for institutional services.

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		
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: deductibles listed above; dollar copays; non-covered expense. After a member reaches the out-of-pocket maximum, the member remains responsible for deductibles listed above; dollar copays & for non-PPO providers & other health care providers, costs in excess of the covered expense		
Lifetime Maximum	Unlimited	
Covered Services	**PPO: Per Member Copay**	**Non-PPO: Per Member Copay[1]**
Hospital Medical Services ***(subject to utilization review*** *for inpatient services; waived for emergency admissions)*		
➢ Semi-private room, meals & special diets, & ancillary services	$250/admission + 20%	40% *(benefit limited to $600/day)*
➢ Outpatient medical care, surgical services & supplies *(hospital care other than emergency room care)*	20%	40% *(benefit limited to $600/day)*
Ambulatory Surgical Centers		
➢ Outpatient surgery, services & supplies	$125/surgery + 20%	40% *(benefit limited to $350/day)*
Skilled Nursing Facility *(subject to utilization review)*		
➢ Semi-private room, services & supplies *(limited to 100 days/calendar year)*	20%	20%
Hospice Care *(subject to utilization review)*		
➢ Inpatient or outpatient services for members with up to one year life expectancy; family bereavement services	No copay[2]	

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

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

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay[1]
Home Health Care *(subject to utilization review)*		
➢ Services & supplies from a home health agency *(limited to combined 100 prior authorized visits/calendar year, one visit by a home health aide equals four hours or less; not covered while member receives hospice care)*	20%	20% with authorization
Home Infusion Therapy *(subject to utilization review)*		
➢ Includes medication, ancillary services & supplies; caregiver training & visits by provider to monitor therapy; durable medical equipment; lab services	20%	20%
Physician Medical Services		
➢ Office & home visits	$35/visit[2] *(deductible waived)*	40%
➢ Hospital & skilled nursing facility visits	20%	40%
➢ Surgeon & surgical assistant; anesthesiologist or anesthetist	20%	40%
Diagnostic X-ray & Lab		
➢ MRI, CT scan, PET scan & nuclear cardiac scan *(subject to utilization review)*	20%	40%
➢ Other diagnostic x-ray & lab	No copay	40%
Well Baby & Well-Child Care for Dependent Children		
➢ Routine physical examinations *(birth through age six)*	$35/exam *(deductible waived)*	Not covered
➢ Immunizations, vaccinations *(birth through age six)*	No copay *(deductible waived)*	Not covered
Physical Exams for Members Ages Seven & Older		
➢ Routine physical exams	$20/exam	Not covered
Immunizations, diagnostic x-ray & lab for routine physical exam	No copay	Not covered
Adult Preventive Services *(including mammograms, Pap smears, prostate cancer screenings & colorectal cancer screenings, or other FDA-approved cervical cancer screening tests)*	No copay	Not covered
Physical Therapy, Physical Medicine & Occupational Therapy	$25/visit *(deductible waived)*	40%
Chiropractic Services *(up to 12 visits/calendar year; additional visits may be approved, if medically necessary)*	$25/visit *(deductible waived)*	40%
Speech Therapy		
➢ Outpatient speech therapy following injury or organic disease	$35/visit *(deductible waived)*	40%
Acupuncture		
➢ Services for the treatment of disease, illness or injury *(limited to 20 visits/calendar year)*	20%[3]	40%[3]
Temporomandibular Joint Disorders		
➢ Splint therapy & surgical treatment	20%	40%
Pregnancy & Maternity Care		
➢ Physician office visits	$35/visit[2] *(deductible waived)*	40%
➢ Prescription drug for elective abortion *(mifepristone)*	20%	Not covered
Normal delivery, cesarean section, complications of pregnancy & abortion *(newborn routine nursery care covered when natural mother is subscriber or spouse/domestic partner)*		
➢ Inpatient physician services	20%	40%
➢ Hospital & ancillary services	$250/admission + 20%	40% *(benefit limited to $600/day)*
➢ Tubal ligation and vasectomy	20%	Not covered
➢ Family Planning counseling	$35/visit *(deductible waived)*	Not covered

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

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

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

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

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

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

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay[1]
Specialty Pharmacy Drugs *(utilization review may be required)*		
➢ Specialty pharmacy drugs filled through the specialty pharmacy program *(limited to 30-day supply; not covered if benefits are provided through prescription drug benefits, if applicable)*	20%	Not covered[2]
If member does not get specialty pharmacy drugs from the specialty pharmacy program, member will not receive any specialty pharmacy drug benefits under this plan, unless the member qualifies for an exception as specified in the EOC.		
Emergency Care		
➢ Emergency room services & supplies *($100 deductible waived if admitted)*	20%	20%
➢ Inpatient hospital services & supplies	$250/admission + 20%	$250/admission + 20%
➢ Physician services	20%	20%
Mental or Nervous Disorders and Substance Abuse		
Inpatient Care		
➢ Facility-based care *(subject to utilization review; waived for emergency admissions)*	$250/admission + 20%	40% *(benefit limited to $600/day)*
➢ Inpatient physician visits	20%	40%
Outpatient Care		
➢ Facility-based care *(subject to utilization review; waived for emergency admissions)*	20%	40% *(benefit limited to $600/day)*
➢ Outpatient physician visits *(pre-service review required after the 12th visit)*	$35/visit[3] *(deductible waived)*	40%

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

[2] 20% copay if member or non-PPO physician obtains drug from Specialty Pharmacy Program; otherwise, not covered.

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

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

Classic PPO Plan Exclusions and Limitations

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Nicotine Use. Smoking cessation programs or treatment of nicotine or tobacco use. Smoking cessation drugs

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).

Sex Transformation. Procedures or treatments to change characteristics of the body to those of the opposite sex.

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 Supplies. Orthopedic supplies, orthopedic shoes (other than shoes joined to braces), or non-custom molded and cast shoe inserts, except as specified as covered 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.

Chronic Pain. Treatment of chronic pain, except as specified as covered in the EOC.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Wigs.

Pre-Existing Condition Exclusion — No payment will be made for services or supplies for the treatment of a pre-existing condition during a period of six months following either: (a) the member's effective date or (b) the first day of any waiting period required by the group, whichever is earlier. However, this limitation does not apply to a child born to or newly adopted by an enrolled subscriber or spouse/domestic partner, or to conditions of pregnancy. Also if a member was covered under creditable coverage, as outlined in the member's EOC, the time spent under the creditable coverage will be used to satisfy, or partially satisfy, the six-month period.

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.

County of Tulare
Custom Classic PPO
(1000/45/80/50)

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

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

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

Explanation of Covered Expense

Plan payments are based on covered expense, which is the lesser of the charges billed by the provider or the following:

PPO Providers—PPO negotiated rates. Members are not responsible for the difference between the provider's usual charges & the negotiated amount.

Non-PPO Providers—For non-emergency services, the scheduled amount. For emergency services, same as other health care providers

Other Health Care Providers *(includes those not represented in the PPO provider network)*—The customary & reasonable charge for professional services or the reasonable charge for institutional services.

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	
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: deductibles listed above; dollar copays; non-covered expense. After a member reaches the out-of-pocket maximum, the member remains responsible for deductibles listed above; dollar copays & for non-PPO providers & other health care providers, costs in excess of the covered expense.

Lifetime Maximum	Unlimited	
Covered Services	**PPO: Per Member Copay**	**Non-PPO: Per Member Copay[1]**
Hospital Medical Services ***(subject to utilization review*** *for inpatient services; waived for emergency admissions)*		
➢ Semi-private room, meals & special diets, & ancillary services	$1,000/year[2] + 20%	50% *(benefit limited to $600/day)*
➢ Outpatient medical care, surgical services & supplies *(hospital care other than emergency room care)*	20%	50% *(benefit limited to $600/day)*
Ambulatory Surgical Centers		
➢ Outpatient surgery, services & supplies	$250/surgery + 20%	50% *(benefit limited to $350/visit)*
Skilled Nursing Facility *(subject to utilization review)*		
➢ Semi-private room, services & supplies *(limited to 100 days/calendar year)*	20%	20%
Hospice Care *(subject to utilization review)*		
➢ Inpatient or outpatient services; for members with up to one year life expectancy; family Bereavement services	No copay	

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

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

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay[1]
Home Health Care *(subject to utilization review)*		
➢ Services & supplies from a home health agency *(limited to 100 prior authorized visits/calendar year, one visit by a home health aide equals four hours or less; not covered while member receives hospice care)*	20%	20% with authorization
Home Infusion Therapy *(subject to utilization review)*		
➢ Includes medication, ancillary services & supplies;*)* caregiver training & visits by provider to monitor therapy; durable medical equipment; lab services	20%	20%
Physician Medical Services		
➢ Office & home visits	$45/visit[2] *(deductible waived)*	50%
➢ Hospital & skilled nursing facility visits	20%	50%
➢ Surgeon & surgical assistant; anesthesiologist or anesthetist	20%	50%
Diagnostic X-ray & Lab		
➢ MRI, CT scan, PET scan & nuclear cardiac scan *(subject to utilization review)*	20%	50%
➢ Other diagnostic x-ray & lab	No copay	50%
Well Baby & Well-Child Care for Dependent Children		
➢ Routine physical examinations *(birth through age six)*	$45/exam *(deductible waived)*	Not covered
➢ Immunizations, vaccinations *(birth through age six)*	No copay *(deductible waived)*	Not covered
Physical Exams for Members Ages Seven & Older		
➢ Routine physical exams	$20/exam	Not covered
➢ Immunizations, diagnostic X-ray & lab for routine physical exam	No copay	Not covered
Adult Preventive Services *(including mammograms, Pap smears, prostate cancer screenings & colorectal cancer screenings or other FDA-approved cervical cancer screening tests)*	No copay	Not covered
Physical Therapy, Physical Medicine & Occupational Therapy	$25/visit *(deductible waived)*	50%
Chiropractic Services *(up to 12 visits/calendar year; additional visits may be approved, if medically necessary)*	$25/visit *(deductible waived)*	50%
Speech Therapy		
➢ Outpatient speech therapy following injury or organic disease	$45/visit *(deductible waived)*	50%
Acupuncture		
➢ Services for the treatment of disease, illness or injury *(limited to 20 visits/calendar year)*	20%[3]	50%[3]
Temporomandibular Joint Disorders		
➢ Splint therapy & surgical treatment	20%	50%
Pregnancy & Maternity Care		
➢ Physician office visits	$45/visit[2] *(deductible waived)*	50%
➢ Prescription drug for elective abortion *(mifepristone*)	20%	Not covered
Normal delivery, cesarean section, complications of pregnancy & abortion *(newborn routine nursery care covered when natural mother is subscriber or spouse/domestic partner)*		
➢ Inpatient physician services	20%	50%
➢ Hospital & ancillary services	$1,000/year[4] + 20%	50% *(benefit limited to $600/day)*
➢ Tubal ligation and vasectomy	20%	Not covered
➢ Family planning counseling	$45/visit *(deductible waived)*	Not covered

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[2]The dollar copay applies only to the visit itself. An additional 20% copay applies for any services performed in office (i.e., X-ray, lab, surgery), after any applicable deductible.
[3]Acupuncture services can be performed by a certified acupuncturist (C.A.), a doctor of medicine (M.D.), a doctor of osteopathy (D.O.), a podiatrist (D.P.M.), or a dentist (D.D.S.).
[4] Applicable to the Annual Out-of-Pocket maximums

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

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[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]
Specialty Pharmacy Drugs *(utilization review may be required)*		
➢ Specialty pharmacy drugs filled through the specialty pharmacy program *(limited to 30-day supply; not covered if benefits are provided through prescription drug benefits, if applicable)*	20%	Not covered[2]
If member does not get specialty pharmacy drugs from the specialty pharmacy program, member will not receive any specialty pharmacy drug benefits under this plan, unless the member qualifies for an exception as specified in the EOC.		
Emergency Care		
➢ Emergency room services & supplies *($100 deductible waived if admitted)*	20%	20%
➢ Inpatient hospital services & supplies	$1,000/year[4] + 20%	20%
➢ Physician services	20%	20%
Mental or Nervous Disorders and Substance Abuse		
Inpatient Care		
➢ Facility-based care *(subject to utilization review; waived for emergency admissions)*	$1,000/year[4] + 20%	50% *(benefit limited to $600/day)*
➢ Inpatient physician visits	20%	50%
Outpatient Care		
➢ Facility-based care *(subject to utilization review; waived for emergency admissions)*	20%	50% *(benefit limited to $600/day)*
➢ Outpatient physician visits *(pre-service review required after the 12th visit)*	$45/visit[3] *(deductible waived)*	50%

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[2] 20% copay if member or non-PPO physician obtains drug from Specialty Pharmacy Program; otherwise, not covered.

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

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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.

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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.

Nicotine Use. Smoking cessation programs or treatment of nicotine or tobacco use. Smoking cessation drugs

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.

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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).

Sex Transformation. Procedures or treatments to change characteristics of the body to those of the opposite sex.

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 Supplies. Orthopedic supplies, orthopedic shoes (other than shoes joined to braces), or non-custom molded and cast shoe inserts, except as specified as covered 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.

Chronic Pain. Treatment of chronic pain, except as specified as covered in the EOC.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Wigs.

Pre-Existing Condition Exclusion — No payment will be made for services or supplies for the treatment of a pre-existing condition during a period of six months following either: (a) the member's effective date or (b) the first day of any waiting period required by the group, whichever is earlier. However, this limitation does not apply to a child born to or newly adopted by an enrolled subscriber or spouse/domestic partner, or to conditions of pregnancy. Also if a member was covered under creditable coverage, as outlined in the member's EOC, the time spent under the creditable coverage will be used to satisfy, or partially satisfy, the six-month period.

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

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

PPO Benefits

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

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

This Lumenos plan is an innovative type of coverage that allows an insured person to use a Health Savings Account to pay for routine medical care. The program also includes traditional health coverage, similar to a typical health plan, that protects the insured person against large medical expenses.

The insured person can spend the money in the HSA account the way the insured person wants on routine medical care, prescription drugs and other qualified medical expenses. There are no copays or deductibles to satisfy first. Unused dollars can be saved from year to year to reduce the amount the insured person may have to pay in the future. If covered expenses exceed the insured person's available HSA dollars, the traditional health coverage is available after a limited out-of-pocket amount is paid by the insured person.

Certain Covered Services have maximum visit and/or day limits per year. The number of visits and/or days allowed for these services will begin accumulating on the first visit and/or day, regardless of whether your Deductible has been met.

The insured person is responsible for all costs over the plan maximums. Plan maximums and other important information appear in *italics*. Benefits are subject to all terms, conditions, limitations, and exclusions of the Policy.

Explanation of Covered Expense

Plan payments are based on covered expense, which is the lesser of the charges billed by the provider or the following:

Participating Providers—Negotiated rates. Insured persons are not responsible for the difference between the provider's usual charges & the negotiated amount.

Non-Participating Providers & Other Health Care Providers *(includes those not represented in the PPO provider network)—*The customary & reasonable charge for professional services or the reasonable charge for institutional services.

Participating Pharmacies & Mail Service Program—Prescription drug negotiated rates. Insured persons are not responsible for any amount in excess of the prescription drug negotiated rate.

Non-Participating Pharmacies—Drug limited fee schedule amount. Insured persons are responsible for any expense not covered under this plan & any amount in excess of drug limited fee schedule amount.

When using non-participating providers, the insured person is responsible for any difference between the covered expense & actual charges, as well as any deductible & percentage copay.
When using the outpatient prescription drug benefits, the insured person is always responsible for drug expenses which are not covered under this plan, as well as any deductible, percentage or dollar copay.

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

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

Lifetime Maximum	Unlimited

Covered Services	Traditional Health Coverage Insured Person Copay In-Network	 Out-of-Network *(Insured is also responsible for charges in excess of covered expense.)*
Hospital Medical Services *(subject to utilization review for inpatient services; waived for emergency admissions)*		
➢ Semi-private room, meals & special diets, & ancillary services	10%	50% up to $580 plan payment per day
➢ Outpatient medical care, surgical services & supplies *(hospital care other than emergency room care)*	10%	50% *(benefit limited to $350/day)*
Ambulatory Surgical Centers		
➢ Outpatient surgery, services & supplies	10%	50% *(benefit limited to $350/day)*
Skilled Nursing Facility *(subject to utilization review)*		
➢ Semi-private room, services & supplies *(limited to 100 days/calendar year)*	10%	10%
Hospice Care *(subject to utilization review) ($10,000 combined maximum per member per lifetime)*		
➢ Inpatient or outpatient services for insured persons with up to one year life expectancy; family bereavement services	10%	10%
Home Health Care *(subject to utilization review)*		
➢ Services & supplies from a home health agency *(limited to 100 visits/calendar year, one visit by a home health aide equals four hours or less; not covered while insured person receives hospice care)*	10%	10%
Home Infusion Therapy		
➢ Includes medication, ancillary services & supplies; caregiver training & visits by provider to monitor therapy; durable medical equipment; lab services	10%	10%
Physician Medical Services		
➢ Office & home visits	10%	50%
➢ Hospital & skilled nursing facility visits	10%	50%
➢ Surgeon & surgical assistant; anesthesiologist or anesthetist	10%	50%
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%
Well Baby & Well-Child Care for Dependent Children		
➢ Routine physical examinations *(birth through age six)*	$25/visit *(deductible waived)*	50%
➢ Immunizations *(birth through age six)*	No copay *(deductible waived)*	50%
Physical Exams for Insured Persons Ages Seven & Older		
➢ Routine physical exams	$25/visit	Not covered
➢ Immunizations, diagnostic X-ray & lab for routine physical exam	No copay	Not covered
Adult Preventive Services *(including mammograms, Pap smears, prostate cancer screenings & colorectal cancer screenings)*	10% *(deductible waived)*	50%
Physical Therapy, Physical Medicine & Occupational Therapy, including Chiropractic Services *(limited to 12 visits/calendar year; up to $25/visit; 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 $30/visit & 20 visits/calendar year)*	10%[1]	50%[1]
Temporomandibular Joint Disorders		
➢ Splint therapy & surgical treatment	10%	50%
Pregnancy & Maternity Care		
➢ Physician office visits	10%	50%
➢ Prescription drug for elective abortion *(mifepristone*)	10%	50%
Normal delivery, cesarean section, complications of pregnancy & abortion *(newborn routine nursery care covered when natural mother is insured employee or spouse/domestic partner)*		
➢ Inpatient physician services	10%	50%
➢ Hospital & ancillary services	10%	50% *(benefit limited to $580/day)*
Organ & Tissue Transplants *(subject to utilization review; specified organ transplants covered only when performed at a Center of Expertise [COE])*		
➢ Inpatient services provided in connection with non-investigative organ or tissue transplants	10%	
➢ Transplant travel expense for an authorized, specified transplant at a *COE (recipient & companion transportation limited to 6 trips/episode & $250/person/trip for round-trip coach airfare hotel limited to 1 room double occupancy & $100/day for 21 days/trip, other expenses limited to $25/day/person for 21 days/trip; donor transportation limited to 1 trip/episode & $250 for round-trip coach airfare, hotel limited to $100/day for 7 days, other expenses limited to $25/day for 7 days)*	No copay	
Bariatric Surgery *(subject to utilization review; medically necessary surgery for weight loss, only for morbid obesity, covered only when performed at a Center of Expertise [COE])*		
➢ Inpatient services provided in connection with medically necessary surgery for weight loss, only for morbid obesity	10%	
➢ Bariatric travel expense when insured person's home is 50 miles or more from the nearest bariatric *COE (insured person's transportation to & from COE limited to $130/person/trip for 3 trips [pre-surgical visit, initial surgery & one follow-up visit]; one companion's transportation to & from COE limited to $130/person/trip for 2 trips [initial surgery & one follow-up visit]; hotel for insured person & one companion limited to one room double occupancy & $100/day for 2 days/trip, or as medically necessary, for pre-surgical & follow-up visit; hotel for one companion limited to one room double occupancy & $100/day for duration of insured person's initial surgery stay for 4 days; other reasonable expenses limited to $25/day/person for 4 days/trip)*	No copay	
Diabetes Education Programs *(requires physician supervision)*		
➢ Teach insured persons & their families about the disease process, the daily management of diabetic therapy & self-management training	10%	50%

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

Covered Services	Traditional Health Coverage Insured Person Copay In-Network	Out-of-Network *(Insured is also responsible for charges in excess of covered expense.)*
Prosthetic Devices		
➢ Coverage for breast prostheses; prosthetic devices to restore a method of speaking; surgical implants; artificial limbs or eyes; the first pair of contact lenses or eyeglasses when required as a result of eye surgery; wigs for alopecia resulting from chemotherapy or radiation therapy; & therapeutic shoes & inserts for insured persons with diabetes	10%	10%
Durable Medical Equipment		
➢ Rental or purchase of DME including dialysis equipment & supplies, home medical equipment, prosthetics/orthotics *(hearing aids benefit available for one hearing aid per ear every three years)*	10%	10%
Related Outpatient Medical Services & Supplies		
➢ Ground or air ambulance transportation, services & disposable supplies	10%[1]	
➢ Blood transfusions, blood processing & the cost of unreplaced blood & blood products	10%[1]	
➢ Autologous blood *(self-donated blood collection, testing, processing & storage for planned surgery)*	10%[1]	
Specialty Pharmacy Drugs *(utilization review may be required)*		
➢ Specialty pharmacy drugs filled through the specialty pharmacy program *(limited to 30-day supply; not covered if benefits are provided through prescription drug benefits, if applicable)*	10%	Not covered[2]
If insured person does not get specialty pharmacy drugs from the specialty pharmacy program, insured person will not receive any specialty pharmacy drug benefits under this plan, unless the insured person qualifies for an exception as specified in the Certificate.		
Emergency Care		
➢ Emergency room services & supplies	10%	10%
➢ Inpatient hospital services & supplies	10%	10%
➢ Physician services	10%	10%
Mental or Nervous Disorders and Substance Abuse		
Inpatient Care		
➢ Facility-based care *(subject to utilization review; waived for emergency admissions)*	10%	50% *(benefit limited to $580/day)*
➢ Inpatient physician visits	10%	50%
Outpatient Care		
➢ Facility-based care *(subject to utilization review; waived for emergency admissions)*	10%	50% *(benefit limited to $350/day)*
➢ Outpatient physician visits *(pre-service review required after the 12th visit)*	10%	50%

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

[2] 10% copay if insured person or non-PPO physician obtains drug from Specialty Pharmacy Program; otherwise, not covered.

Covered Services (For Outpatient Prescription Drugs)	Traditional Health Coverage Per Insured Person Copay for Each Prescription or Refill
Outpatient Prescription Drug Benefits *(Until the calendar year deductible is satisfied, the insured person pays the prescription drug ,maximum allowed amount and not the copays listed below.)*	
Retail Pharmacy	
➢ Generic drugs	$7
➢ Brand name formulary drugs[1,2]	$25
➢ Self-administered injectable drugs, except insulin	$25
Mail Service	
➢ Generic drugs	$14
➢ Brand name formulary drugs[1,2]	$50
➢ Self-administered injectable drugs, except insulin	$25
Specialty pharmacy drugs *(may only be obtained through the specialty pharmacy program)*	
➢ Generic drugs	$7
➢ Brand name formulary drugs[1]	$25
➢ Self-administered injectable drugs, except insulin	$25
Non-participating Pharmacies *(compound drugs & specialty pharmacy drugs not covered at retail participating pharmacies)*	*Insured person pays the above retail pharmacy copay plus:* 30% of the remaining prescription drug maximum allowed amount & costs in excess of the maximum amount allowed
Supply Limits[3]	
➢ Retail Pharmacy *(participating and non-participating)*	30-day supply; 60-day supply for federally classified Schedule II attention deficit disorder drugs that require a triplicate prescription form, but require a double copay; 6 tablets or units/30-day period for impotence and/or sexual dysfunction drugs (available only at retail pharmacies)
➢ Mail Service	90-day supply
➢ Specialty Pharmacy	30-day supply

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

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

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

The Outpatient Prescription Drug Benefit covers the following:

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

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

Lumenos HSA Plan — Exclusions and Limitations

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Nicotine Use. Smoking cessation programs, except as specified as covered in the Certificate, or treatment of nicotine or tobacco use. Smoking cessation drugs, 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.

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.

Sex Transformation. Procedures or treatments to change characteristics of the body to those of the opposite sex.

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 Supplies. Orthopedic supplies, orthopedic shoes (other than shoes joined to braces), or non-custom molded and cast shoe inserts, except as specified as covered 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.

Chronic Pain. Treatment of chronic pain, except as specified as covered in the Certificate.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Professional charges in connection with administering, injecting or dispensing drugs

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

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

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

Services or supplies for which the insured person is not charged

Oxygen

Cosmetics & health or beauty aids.

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

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

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

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

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

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

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

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

Allergy desensitization products or allergy serum

Infusion drugs, except drugs that are self-administered subcutaneously

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

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

Compound medications unless:

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

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

Pre-Existing Condition Exclusion – No payment will be made for services or supplies for the treatment of a pre-existing condition during a period of six months following either: (a) the insured person's effective date or (b) the first day of any waiting period required by the group, whichever is earlier. However, this limitation does not apply to a child born to or newly adopted by an enrolled employee or spouse/domestic partner, or to conditions of pregnancy. Also if an insured person was covered under creditable coverage, as outlined in the insured person's Certificate, the time spent under the creditable coverage will be used to satisfy, or partially satisfy, the six-month period.

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.

Your Summary of Benefits
County of Tulare

Anthem Blue Cross

Custom Premier HMO 15

This Summary of Benefits is a brief overview of your plan's benefits only. For more detailed information about the benefits in your plan, please refer to your Certificate of Insurance or Evidence of Coverage (EOC), which explains the full range of covered services, as well as any exclusions and limitations for your plan.

Anthem Blue Cross HMO benefits are covered only when services are provided or coordinated by the primary care physician and authorized by the participating medical group or independent practice association (IPA), except services provided under the "ReadyAccess" program, OB/GYN services received within the member's medical group/IPA, and services for all mental and nervous disorders and substance abuse. Benefits are subject to all terms, conditions, limitations, and exclusions of the Policy.

Annual copay maximum: Individual $1,000; Family $2,000

The following copay does not apply to the annual copay maximum: for infertility services

Covered Services	Per Member Copay
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
Smoking Cessation Program	No copay
Physician Medical Services	
• Office & home visits	$15/visit
• Specialists	$15/visit
• Skilled nursing facility visits	No copay
• Hospital visits	No copay
• Injectable medications in physician's office *(excluding allergy serum and immunization)*	20%/up to $150 maximum copay
• Surgeon & Surgical assistant	No copay
• Anesthesiologist or anesthetist	No copay
Acupuncture	$15/visit
Outpatient Medical Services (*Services received in a hospital, other than emergency room services, or in any facility that is affiliated with a hospital***)**	
• Outpatient surgery & supplies	No copay
• Advanced Imaging	No copay
• All other X-ray & laboratory tests (*including genetic testing*)	No copay
• Radiation therapy, chemotherapy & hemodialysis treatment & Infusion therapy	No copay
• Other Outpatient Medical Services including: Rehabilitation Therapy *(Physical, Occupational, or Speech Therapy, limited to a 60-day period of care)*	No copay
General Medical Services (*when performed in non-hospital-based facility***)**	
• Advanced Imaging	No copay
• All other X-ray & laboratory tests (*including genetic testing*)	No copay
• Allergy testing & treatment *(including serums)*	No copay
• Radiation therapy, chemotherapy & hemodialysis treatment & Infusion therapy	No copay
• Rehabilitation Therapy *(Physical, Occupational, or Speech Therapy or Chiropractic Care, limited to 60-days period of care)*	$15/visit
Emergency Care	
• Physician & medical services	No copay

CONTINUED ON NEXT PAGE

Covered Services	Per Member Copay
• Outpatient hospital emergency room services	$100/visit (*waived if admitted inpatient*)
Inpatient Medical Services Semi-private room or private room, medically necessary services & supplies	No copay
Urgent Care *(out of service area)*	$15/visit *(copay waived if admitted inpatient or outpatient ER. For in area, contact your PCP or medical group)*
Skilled Nursing Facility (*limited to 100 days/calendar year*) • All necessary services & supplies (*excluding take-home drugs*)	 No copay
Ambulance Services • Transportation when medically necessary	No copay
Ambulatory Surgical Center • Outpatient surgery & supplies	No copay
Pregnancy and Maternity Care Prenatal & postnatal Professional *(physician)* services *(For your Inpatient copay, see Inpatient Medical Services. For your Outpatient Services copay, see Outpatient Medical Services)* **Elective Abortions** *(including prescription drug for abortion, mifepristone)*	No copay $100
Prosthetic devices *(including Orthotics)*	No copay
Durable medical equipment • Rental and Purchase of DME *(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)*	No copay
Family Planning and Infertility Services • Infertility studies & tests, Including treatment • Female Sterilization *(including tubal ligation and counseling/consultation)* • Male Sterilization • Counseling & consultation	 $15/visit No copay $15/visit $15/visit
Mental or Nervous Disorders and Substance Abuse **Inpatient Care** • Facility-based care (*pre-authorization required*) • Physician hospital visits **Outpatient Care** • Facility-based care (*pre-authorization required*) • Outpatient physician visits *(Behavioral Health treatment will be subject to pre-service review)*	 No copay No copay No copay $15/visit
Home Health Care (*limited to 100 visits/calendar year; one visit by a home health aide equals four hours or less*)	$15/visit
Hospice Care (*Inpatient or outpatient services; family bereavement services*)	No copay
Organ and Tissue Transplant • Inpatient Care • Physician office visits • Specialist office visits	 No copay $15/visit $15/visit

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).

Premier HMO - Exclusions and Limitations

Care Not Approved. Care from a health care provider without the OK of primary care doctor, except for emergency services or urgent care.

Care Not Covered. Services before the member was on the plan, or after coverage ended.

Care Not Listed. Services not listed as being covered by this plan.

Care Not Needed. Any services or supplies that are not medically necessary.

Crime or Nuclear Energy. Any health problem caused: (1) while committing or trying 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) by nuclear energy, when the government can pay for treatment.

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 ask that the denial be reviewed by an external independent medical review organization, as described in the Evidence of Coverage (EOC).

Government Treatment. Any services the member actually received that were given 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.

Services Given by Providers Who Are Not With Anthem Blue Cross HMO. We will not cover these services unless primary care doctor refers the member, except for emergencies or urgent care.

Services Not Needing Payment. Services the member is not required to pay for or are given to the member at no charge, except services the member got at a charitable research hospital (not with the government). This hospital must:1. Be known throughout the world as devoted to medical research.2. Have at least 10% of its yearly budget spent on research not directly related to patient care.3. Have 1/3 of its income from donations or grants (not gifts or payments for patient care).4. Accept patients who are not able to pay.5. Serve patients with conditions directly related to the hospital's research (at least 2/3 of their patients).

Work-Related. Care for health problems that are work-related if such health problems are or can be covered by workers' compensation, an employer's liability law, or a similar law. We will provide care for a work-related health problem, but, we have the right to be paid back for that care. See "Third Party Liability" below.

Acupressure. Acupressure, or massage to help pain, treat illness or promote health by putting pressure to one or more areas of the body.**Air Conditioners.** Air purifiers, air conditioners, or humidifiers.

Birth Control Devices. Any devices needed for birth control which can be obtained without a doctor's prescription such as condoms.

Blood. Benefits are not provided for the collection, processing and storage of self-donated blood unless it is specifically collected for a planned and covered surgical procedure.

Braces or Other Appliances or Services for straightening the teeth (orthodontic services).

Chronic Pain Treatment. Treatment of frequent recurrences of pain, over a long period of time, that is not related to an active medical condition currently being treated.

Clinical Trials. Services and supplies in connection with clinical trials, except as specified as covered in the Evidence of Coverage (EOC).

Commercial weight loss programs. Weight loss programs, whether or not they are pursued under medical or doctor supervision, except as specified as covered in the EOC. 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 for treatment of anorexia nervosa or bulimia nervosa.

Consultations given by telephone or fax.

Cosmetic Surgery. Surgery or other services done only to make the member: look beautiful; to improve appearance; or to change or reshape normal parts or tissues of the body. This does not apply to reconstructive surgery the member might need to: get back the use of a body part; have for breast reconstruction after a mastectomy; correct or repair a deformity caused by birth defects, abnormal development, injury or illness in order to improve function, symptomatology or create a normal appearance. Cosmetic surgery does not become reconstructive because of psychological or psychiatric reasons.

Custodial Care or Rest Cures. Room and board charges for a hospital stay mostly for a change of scene or to make the member feel good. Services given by a rest home, a home for the aged, or any place like that.

Dental Services or Supplies. Dentures, bridges, crowns, caps, or dental prostheses, dental implants, dental services, tooth extraction, or treatment to the teeth or gums. Cosmetic dental surgery or other dental services for beauty purposes.

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

Eye Exercises or Services and Supplies for Correcting Vision. Optometry services, eye exercises, and orthoptics, except for eye exams to find out if the member's vision needs to be corrected. Eyeglasses or contact lenses are not covered. Contact lens fitting is not covered.

Eye Surgery for Refractive Defects. Any eye surgery just for correcting vision (like nearsightedness and/or astigmatism). Contact lenses and eyeglasses needed after this surgery.

Food or Dietary Supplements. Nutritional and/or dietary supplements, except as specified as covered in the EOC 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.

Health Club Membership. 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 doctor. This exclusion also applies to health spas.

Immunizations. Immunizations needed to travel outside the USA.

Infertility Treatment. Any infertility treatment including artificial insemination or in vitro fertilization & sperm bank.

Lifestyle Programs. Programs to help member change how one lives, like fitness clubs, or dieting programs. This does not apply to cardiac rehabilitation programs approved by the medical group.

Mental or nervous disorders. Academic or educational testing, counseling. Remedying an academic or education problem, except as stated as covered in the EOC.

Non-Prescription Drugs. Non-prescription, over-the-counter drugs or medicines.

Orthopedic Shoes. Orthopedic shoes (except when joined to braces) or shoe inserts (except custom molded orthotics). This does not apply to shoes and inserts designed to prevent or treat foot complications due to diabetes.

Outpatient Drugs. Outpatient prescription drugs or medications including insulin.

Personal Care and Supplies. Services for personal care, such as: help in walking, bathing, dressing, feeding, or preparing food. Any supplies for comfort, hygiene or beauty purposes.

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

Routine Exams. Routine physical or psychological exams or tests asked for by a job or other group, such as a school, camp, or sports program.

Scalp hair prostheses. Scalp hair prostheses, including wigs or any form of hair replacement.

Sex Change. Sex change surgery or treatments.

Sexual Problems. Treatment of any sexual problems unless due to a medical problem, physical defect, or disease.

Sterilization Reversal. Surgery done to reverse a sterilization.

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).

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

Varicose Vein Treatment. Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) when services are rendered for cosmetic purposes.

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

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

SJVIA
Modified Chiropractic Care and Acupuncture 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 and/or ASH Plans Acupuncturist. These benefits are provided in addition to the benefits described in the Anthem Blue Cross HMO Evidence of Coverage (EOC) document. However, when expenses are incurred for treatment received from an ASH Plans Chiropractor or ASH Plans Acupuncturist, 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
Office Visit to an Acupuncturist	$10/visit
Maximum Benefits	
Office visits to a Chiropractor or Acupuncturist	40 visits per calendar year (chiropractic and acupuncture visits combined)
Chiropractic appliances	$50 per calendar year

Covered Services

Chiropractor Services: Member has up to 30 visits, combined with visits for acupuncture services, 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 or ASH Plans acupuncturist 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.

Acupuncture Services. Member has up to 30 visits, combined with visits for chiropractic care, in a calendar year for acupuncture services that are determined by ASH Plans to be medically/clinically necessary. All visits to an ASH Plans chiropractor or ASH Plans acupuncturist will be applied towards the maximum number of visits in a calendar year. The ASH Plans acupuncturist 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 acupuncturist to determine the appropriateness of acupuncture services.
- Follow-up office visits as set forth in a treatment plan approved by ASH Plans and provided by an ASH Plans acupuncturist
- An established patient exam performed by an ASH Plans acupuncturist 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 acupuncturist.

Chiropractic Care and Acupuncture Rider Exclusions & Limitations

Care Not Approved: Any services provided by an ASH Plans chiropractor or an ASH Plans acupuncturist that are not approved by ASH Plans except as specified as covered in the Evidence of Coverage (EOC). An ASH Plans chiropractor or ASH Plans acupuncturist 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 or acupuncture services or supplies in connection with:

- Diagnostic scanning, such as magnetic resonance imaging (MRI) or computerized axial tomography (CAT) scans. Diagnostic services for acupuncture.
- Thermography.
- Hypnotherapy.
- Behavior training.
- Sleep therapy.
- Weight programs.
- Any non-medical program or service.
- Pre-employment examinations, any chiropractic or acupuncture 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.
- Acupuncture performed with reusable needles.
- Acupuncture services benefits are not provided for magnets used for diagnostic or therapeutic use, ion cord devices, manipulation or adjustments of the joints, physical therapy services, iridology, hormone replacement products, acupuncture point or trigger-point injections (including injectable substances), laser/laser biostim, colorpuncture, NAET diagnosis and/or treatment, and direct moxibustion.
- Any service or supply for the exam and/or treatment by an ASH chiropractor for conditions other than those related to neuromusculoskeletal disorders.
- Services from an ASH Plans acupuncturist for exam and/or treatment for conditions not related to neuromusculoskeletal disorders, nausea or pain, incluing, without limitation, asthma or addictions such as nicotine addiction.
- 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 or non-ASH Plans Acupuncturists: Services and supplies provided by a chiropractor or an acupuncturists 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 and Acupuncture Care benefit, except for emergency services. The member should follow the procedures specified by their Anthem Blue Cross HMO 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.

SJVIA
San Joaquin Valley Insurance Authority

USscript

Prescription Drug Copays: County of Tulare

30 Day Supply:
Generic = $10
Formulary = $20
Non-Formulary = $35
DAW 1 - No Cost Differential
DAW 2 - Non-Formulary + Cost Difference

90 Day Supply:
Generic = $20
Formulary = $40
Non-Formulary = $60
DAW 1 - No Cost Differential
DAW 2 - Non-Formulary + Cost Difference

Mail
Generic = $20
Formulary = $40
Non-Formulary = $60
DAW 1 - No Cost Differential
DAW 2 - Non-Formulary + Cost Difference

Specialty Medication copays:
30% ($100.00 max.)

** Specialty medications are covered at a 30-day Supply only.**

Exclusions

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

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

Plan Benefit Highlights

Effective Date: 1/1/2013

DELTA DENTAL PPO℠

BENEFIT HIGHLIGHTS

Eligibility	Primary enrollee, spouse and eligible dependent children to age 26		
Deductibles	In-network: None Out-of-network: $25 per person / $75 per family each calendar year		
Deductibles waived for D & P?	In-network: N/A Out-of-network: Yes		
Maximums	$1,000 per person each calendar year		
Waiting Period(s)	Basic Benefits None	Major Benefits None	Orthodontics None

Benefits and Covered Services*	**Delta Dental PPO dentists**** **In-PPO Network**	**Non-PPO dentists**** **Out-of-PPO Network**
Diagnostic & Preventive Services (D & P) Exams, cleanings, x-rays	100 %	100 %
Basic Services Fillings, simple tooth extractions	80 %	80 %
Endodontics (root canals) Covered Under Basic Services	80 %	80 %
Periodontics (gum treatment) Covered Under Basic Services	80 %	80 %
Oral Surgery Covered Under Basic Services	80 %	80 %
Major Services Crowns, inlays, onlays and cast restorations, bridges and dentures, implants	50 %	50 %
Orthodontic Benefits Adults and eligible dependent children	50 %	50 %
Dental Accidents	100 %	100 %
Dental Accidents Maximums	$1,000 per calendar year	
Orthodontic Maximums	$ 1,500 Lifetime	$ 1,500 Lifetime

* 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.

DeltaCare® USA – provided by Delta Dental of California

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 you can:

Visit our website at **deltadentalins.com/enrollees**

- Click on "Find a Dentist" on our home page
- Select "DeltaCare USA" as your plan network

Or call Customer Service at **800-422-4234** 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 DENTAL®

Administered by Delta Dental Insurance Company

What if I have questions about my DeltaCare USA Program?

Eligibility for you and your family

If you meet your group's eligibility requirements for dental coverage, you can enroll in the DeltaCare USA program. You may also enroll eligible dependents. Contact your benefits administrator if you have any questions.

Easy enrollment

Simply complete the enrollment process as directed by your benefits administrator. Be sure to indicate a dentist (from the list of contract dental facilities) for both yourself and your eligible dependents. Include the name of your group.

How your DeltaCare USA program works

Your selected contract dentist will take care of your dental care needs. If you require treatment from a specialist, your contract dentist will handle the referral for you.

After you have enrolled, you will receive a Delta Dental membership packet that includes an identification card and an Evidence of Coverage booklet that fully describes the benefits of your dental program. Also included in this packet are the name, address and phone number of your contract dentist. Simply call the dental facility to make an appointment.

Under the DeltaCare USA program, many services are covered at no cost, while others have copayments (amount you pay your contract dentist) for certain benefits. See the "Description of Benefits and Copayments" for a list of your benefits.

Please note: Dental services that are not performed by your selected contract dentist, or are not covered under provisions for emergency care below, must be preauthorized by Delta Dental to be covered by your DeltaCare USA program.

Provisions for emergency care

Under your DeltaCare USA program, you and your eligible dependents are covered for out-of-network dental emergencies. Your program pays up to $100 for out-of-network emergency dental expenses per emergency for each enrollee.

My dentist is a Delta Dental dentist but is not on the list of DeltaCare USA dentists. Can I still receive treatment from this dentist?

You must receive treatment from your selected DeltaCare USA contract dentist. Please note that Delta Dental dentists are not necessarily DeltaCare USA dentists. With more than 3,800 general and specialist dentists, the DeltaCare USA network is one of the largest dental networks in California.

Do my family members receive treatment from the same DeltaCare USA contract dentist?

You and your eligible dependents may receive care from the same contract dentist, or if you prefer, you may collectively select up to a maximum of three individual contract dental facilities.

Can I change my contract dentist?

You may change contract dentists by notifying us either by phone or in writing, or by visiting our website (deltadentalins.com). If you contact us by the 21st of the month, the change will become effective the first of the following month.

Can I have my teeth whitened under the DeltaCare USA program?

External bleaching is a benefit under your program. See the "Description of Benefits and Copayments" and talk to your contract dentist about your options.

Highlights of your DeltaCare USA Program

Does my DeltaCare USA program cover tooth-colored fillings and crowns?

Porcelain and other tooth-colored materials are included as a benefit under your program. The copayment shows you what your out of pocket cost will be.

How long does it take to get an appointment with a DeltaCare USA dentist?

Two to four weeks is a reasonable amount of time to wait for a routine, non-urgent appointment. If you require a specific time, you may have to wait longer. Most DeltaCare USA dentists are in private group practices, which means greater appointment availability and extended office hours.

Are pre-existing dental conditions and work in progress covered?

Treatment for pre-existing conditions, such as extracted teeth, is covered under the DeltaCare USA program. However, benefits are not provided for any dental treatment started before joining the program (that is, work in progress, such as preparations for crowns, root canals and impressions for dentures). Orthodontic treatment in progress may be covered for new DeltaCare USA enrollees. See the "Limitations and Exclusions of Benefits."

How does the DeltaCare USA program encourage preventive care?

Your DeltaCare USA program is designed to encourage regular visits to the dentist by having no copayments (fees you pay to the contract dentist) on most diagnostic and preventive benefits. See the enclosed "Description of Benefits and Copayments."

Does my DeltaCare USA program cover specialists' services?

Your contract dentist will coordinate your specialty care needs for oral surgery, endodontics, periodontics or pediatric dentistry with an approved contract specialist. If there is no contract specialist within your service area, a referral to an out-of-network specialist will be authorized at no extra cost, other than the applicable copayment. If you or your dependent is assigned to a dental school clinic for specialty services, those services may be provided by a dentist, a dental student, a clinician or a dental instructor.

What if I have questions about my DeltaCare USA program?

Call Delta Dental Customer Service at 800-422-4234. We have multilingual representatives available from 5 a.m. to 6 p.m. Pacific time, Monday through Friday. Our Customer Service representatives have worked in dental facilities and can answer benefits questions, as well as arrange facility transfers and urgent care referrals.

Our Customer Service representatives have worked in dental facilities and can answer benefits questions, as well as arrange facility transfers and urgent care referrals.

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-2011 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 COPAYMENTS
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
D0180	Comprehensive periodontal evaluation - new or established patient	No Cost
D0210	Intraoral *radiographs* - complete series (including bitewings) - *limited to 1 series every 24 months*	No Cost
D0220	Intraoral - periapical first film	No Cost
D0230	Intraoral - periapical each additional film	No Cost
D0240	Intraoral - occlusal film	No Cost
D0250	Extraoral - first film	No Cost
D0260	Extraoral - each additional film	No Cost
D0270	Bitewing *radiograph* - single film	No Cost
D0272	Bitewings *radiographs* - two films	No Cost
D0273	Bitewings *radiographs* - three films	No Cost
D0274	Bitewings *radiographs* - four films - *limited to 1 series every 6 months*	No Cost
D0277	Vertical bitewings - 7 to 8 films	No Cost
D0330	Panoramic film	No Cost
D0415	Collection of microorganisms for culture and sensitivity	No Cost
D0425	Caries susceptibility tests	No Cost
D0460	Pulp vitality tests	No Cost
D0470	Diagnostic casts	No Cost
D0472	Accession of tissue, gross examination, preparation and transmission of written report - *available only when performed in conjunction with a covered biopsy*	No Cost
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report - *available only when performed in conjunction with a covered biopsy*	No Cost
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report - *available only when performed in conjunction with a covered biopsy*	No Cost
D0999	Unspecified diagnostic procedure, by report - *includes office visit, per visit (in addition to other services)*	No Cost
D1000-D1999	**II. PREVENTIVE**	
D1110	Prophylaxis *cleaning* - adult - *1 per 6 month period*	No Cost
D1110	*Additional prophylaxis cleaning - adult (within the 6 month period)*	$45.00
D1120	Prophylaxis *cleaning* - child - *1 per 6 month period*	No Cost
D1120	*Additional prophylaxis cleaning - child (within the 6 month period)*	$35.00
D1203	Topical application of fluoride - child - *to age 19; 1 per 6 month period*	No Cost
D1204	Topical application of fluoride - adult - *1 per 6 month period*	No Cost
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients - *1 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
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-cementation of 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	Recement inlay, onlay or partial coverage restoration	No Cost
D2915	Recement cast or prefabricated post and core	No Cost
D2920	Recement crown	No Cost
D2930	Prefabricated stainless steel crown - primary tooth	No Cost
D2931	Prefabricated stainless steel crown - permanent tooth	No Cost
D2932	Prefabricated resin crown - *anterior primary tooth*	No Cost
D2933	Prefabricated stainless steel crown with resin window - *anterior primary tooth*	No Cost
D2940	Protective restoration	No Cost
D2950	Core buildup, including any pins	No Cost
D2951	Pin retention - per tooth, in addition to restoration	No Cost
D2952	Post and core in addition to crown, indirectly fabricated - *includes canal preparation*	No Cost
D2953	Each additional indirectly fabricated post - same tooth - *includes canal preparation*	No Cost
D2954	Prefabricated post and core in addition to crown - *base metal post; includes canal preparation*	No Cost
D2955	Post removal (not in conjunction with endodontic therapy)	No Cost
D2957	Each additional prefabricated post - same tooth - *base metal post; includes canal preparation*	No Cost
D2960	Labial veneer (resin laminate) - chairside - *limited to replacement of significant tooth structure loss due to caries or fracture*	$245.00
D2961	Labial veneer (resin laminate) - laboratory - *limited to replacement of significant tooth structure loss due to caries or fracture*	$295.00
D2962	Labial veneer (porcelain laminate) - laboratory - *limited to replacement of significant tooth structure loss due to caries or fracture*	$345.00
D2970	Temporary crown (fractured tooth) - *palliative treatment only*	No Cost
D2971	Additional procedures to construct new crown under existing partial denture framework	$14.00
D2980	Crown repair, by report	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/pulpal regeneration - initial visit (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)	$55.00
D3352	Apexification/recalcification/pulpal regeneration - 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/periradicular surgery - anterior	No Cost
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	No Cost

D3425	Apicoectomy/periradicular surgery - molar (first root)	No Cost
D3426	Apicoectomy/periradicular surgery (each additional root)	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 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
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 flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	$75.00
D4261	Osseous surgery (including flap entry 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
D4271	Free soft tissue graft procedure (including donor site surgery)	$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
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, by report - *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, by report - 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

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	Recement fixed partial denture	No Cost
D6940	Stress breaker	No Cost
D6970	Post and core in addition to fixed partial denture retainer, indirectly fabricated - *includes canal preparation*	No Cost
D6972	Prefabricated post and core in addition to fixed partial denture retainer - *base metal post; includes canal preparation*	No Cost
D6973	Core buildup for retainer, including any pins	No Cost
D6976	Each additional indirectly fabricated post - same tooth - *includes canal preparation*	No Cost
D6977	Each additional prefabricated post - same tooth - *base metal post; includes canal preparation*	No Cost
D6980	Fixed partial denture repair, by report	No Cost

D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY

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

D7111	Extraction, coronal remnants - deciduous tooth	No Cost
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	No Cost
D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$10.00
D7220	Removal of impacted tooth - soft tissue	$15.00
D7230	Removal of impacted tooth - partially bony	$25.00
D7240	Removal of impacted tooth - completely bony	$35.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$50.00
D7250	Surgical removal of residual tooth roots (cutting procedure)	No Cost
D7251	Coronectomy - intentional partial tooth removal	$50.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$35.00
D7280	Surgical access of an unerupted tooth	$25.00

D7282	Mobilization of erupted or malpositioned tooth to aid eruption	$25.00
D7283	Placement of device to facilitate eruption of impacted tooth	No Cost
D7286	Biopsy of oral tissue - soft - *does not include pathology laboratory procedures*	No Cost
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	No Cost
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	No Cost
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	No Cost
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	No Cost
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	No Cost
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	No Cost
D7471	Removal of lateral exostosis (maxilla or mandible)	No Cost
D7472	Removal of torus palatinus	No Cost
D7473	Removal of torus mandibularis	No Cost
D7510	Incision and drainage of abscess - intraoral soft tissue	No Cost
D7960	Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure	No Cost
D7970	Excision of hyperplastic tissue - per arch	No Cost
D7971	Excision of pericoronal gingiva	No Cost

D8000-D8999 XI. ORTHODONTICS

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

Pre and post orthodontic records include:

	The benefit for pre-treatment records and diagnostic services includes:	$200.00
D0210	Intraoral - complete series (including bitewings)	
D0322	Tomographic survey	
D0330	Panoramic film	
D0340	Cephalometric film	
D0350	Oral/facial photographic images	
D0470	Diagnostic casts	
	The benefit for post-treatment records includes:	$70.00
D0210	Intraoral - complete series (including bitewings)	
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 visit	$25.00
D8670	Periodic orthodontic treatment visit (as part of contract)- *included in comprehensive case fee*	No Cost
D8680	Orthodontic retention (removal of appliances, construction and placement of *removable* retainers)	$275.00
D8693	Rebonding or recementing; and/or repair, as required, of fixed retainers -*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
D9220	Deep sedation/general anesthesia - first 30 minutes	$165.00
D9221	Deep sedation/general anesthesia - each additional 15 minutes	$80.00
D9241	Intravenous conscious sedation/analgesia - first 30 minutes	$165.00
D9242	Intravenous 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
D9940	Occlusal guard, by report - *limited to 1 in 3 years*	$75.00
D9951	Occlusal adjustment, limited	No Cost
D9952	Occlusal adjustment, complete	No Cost
D9972	External bleaching - per arch - *limited to one bleaching tray and gel for two weeks of self treatment*	$125.00
D9999	Unspecified adjunctive procedure, by report - *includes failed appointment without 24 hour notice - per 15 minutes of appointment time - up to an overall maximum of $40.00*	$10.00

If services for a listed procedure are performed by the assigned Contract Dentist, the Enrollee pays the specified Copayment. Listed procedures which require a Dentist to provide Specialist Services, and are referred by the assigned Contract Dentist, must be preauthorized in writing 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 D9972, External bleaching, 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.

SmileWay® Wellness Program

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

Connect with us!

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

DeltaCare USA Customer Service

800-422-4234

NOTE: THIS IS ONLY A BRIEF SUMMARY OF THE PLAN.

The Group Dental Service Contract must be consulted to determine the exact terms and conditions of coverage. An Evidence of Coverage will be sent to you upon enrollment. **If you wish to review an Evidence of Coverage prior to enrollment, you may request a copy by calling the Customer Service department at 800-422-4234.**

In California, DeltaCare USA is underwritten by Delta Dental of California and administered by Delta Dental Insurance Company. These companies are financially responsible for their own products.

Customer Service
800-422-4234
Monday through Friday
5 a.m. to 6 p.m., Pacific time

Provided by:
Delta Dental of California
17871 Park Plaza Drive, Suite 200
Cerritos, CA 90703

Administered by:
Delta Dental Insurance Company
P.O. Box 1803
Alpharetta, GA 30023

DELTA DENTAL®

deltadentalins.com/enrollees

Your VSP Vision Benefits Summary

Welcome to VSP® Vision Care. Your VSP vision benefit offers you the best in eyecare and eyewear.

Personalized Care. A VSP doctor provides personalized care that focuses on keeping you and your eyes healthy year after year. Plus, when you see a VSP doctor, you'll get the most out of your benefit, have lower out-of-pocket costs, and your satisfaction is guaranteed.

Eyewear. Choose the eyewear that's right for you and your budget. From classic styles to the latest designer frames, you'll find the eyewear that's right for you and your family.

Choice of Providers. With open access to see any eyecare provider, you can see the one who's right for you. Choose a VSP doctor or any other provider.

Using your VSP benefit is easy.

- **Find the right eyecare provider for you.** To find a VSP doctor, visit **vsp.com** or call **800.877.7195**.
- **Review your benefit information.** Visit **vsp.com** to review your plan coverage before your appointment.
- **At your appointment, tell them you have VSP.** There's no ID card required.

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

For your complete benefit description, visit **vsp.com** or call **800.877.7195**.

County of Tulare and VSP provide you an affordable eyecare plan.

Doctor Network.....VSP Choice

Your Coverage with a VSP Doctor

WellVision Exam® focuses on your eye health and overall wellness

- $10 copay.....***every 12 months***

Prescription Glasses

- $25 copay

Lenses.....***every 12 months***

- *Single vision, lined bifocal, and lined trifocal lenses*
- *Polycarbonate lenses for dependent children*

Frame.....***every 24 months***

- *$130.00 allowance for a wide selection of frames*
- *20% off the amount over your allowance*

~OR~

Contact Lens Care

- **No copay .....*every 12 months***

$120.00 allowance for contacts and the contact lens exam (fitting and evaluation). If you choose contact lenses you will be eligible for a frame 24 months from the date the contact lenses were obtained.

Current soft contact lens wearers may qualify for a special program that includes a contact lens exam and initial supply of replacement lenses.

Primary EyeCare.....$20 copay
For treatment and diagnosis of eye conditions like pink eye, loss of vision, and monitoring of cataracts, glaucoma and diabetic retinopathy.

Extra Discounts and Savings

Glasses and Sunglasses

- *Average 20-25% savings on all non-covered lens options*
- *20% off additional glasses and sunglasses, including lens options, from any VSP doctor within 12 months of your last WellVision Exam*

Contacts

- *15% off cost of contact lens exam (fitting and evaluation)*

Laser Vision Correction

- *Average 15% off the regular price or 5% off the promotional price. Discounts only available from contracted facilities.*

Your Coverage with Other Providers

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

Exam	*Up to $45.00*
Single vision lenses	*Up to $30.00*
Lined bifocal lenses	*Up to $50.00*
Lined trifocal lenses	*Up to $65.00*
Frame	*Up to $70.00*
Contacts	*Up to $105.00*

VSP guarantees service from VSP doctors only. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail.

VSP® Vision care for life

CAT#00611 JOB#3755CM 6/10

Exhibit B

County of Tulare

2013 Anthem SJVIA Plan Rates

Effective January 1, 2013

Anthem Medical:	**Single**	**EE + Sp**	**EE +Ch**	**Family**
Anthem $0 Deductible	$703.26	$1,405.77	$1,283.25	$2,131.30
Anthem $500 Deductible	$529.57	$1,059.65	$970.54	$1,671.34
Anthem $1,000 Deductilbe	$465.20	$929.71	$853.08	$1,417.27
Anthem $2,500 Deductible HSA	$440.88	$881.07	$808.43	$1,343.16
Anthem HMO	$567.78	$1,004.12	$886.20	$1,321.34
Delta Dental:				
Dental PPO	$36.66	$63.55	$72.01	$106.91
Dental HMO	$21.69	$37.22	$37.48	$54.01
VSP Vision:				
Vision	$4.28	$7.28	$7.70	$11.56

SJVIA
San Joaquin Valley Insurance Authority

Meeting Location:
Tulare County Employee Retirement Association Board Chambers
136 N. Akers Street
Visalia, CA 93291
November 9, 2012
9:00 AM

AGENDA DATE: November 9, 2012

ITEM NUMBER: 5h

SUBJECT: Approval and Execution of SJVIA Participation Agreements with the County of Fresno and Tulare for Plan Year 2013

REQUEST(S): Authorize Board President to execute the SJVIA Participation Agreement with the County of Fresno effective December 10, 2012 and Participation Agreement with the County of Tulare effective January 1, 2013.

DESCRIPTION: On August 24, 2012, your Board approved several action items relating to health benefits for the County of Fresno and Tulare in 2013. Your Board approved actions that offered the County of Fresno and Tulare health plans administered by Anthem Blue Cross, prescription coverage administered by US Script, dental coverage administered by Delta Dental and vision coverage administered by VSP. On September 18, the County of Tulare Board of Supervisors approved said SJVIA benefits and on September 25th, the County of Fresno approved said SJVIA benefits. The attached Participation Agreements for the County of Fresno (December 10, 2012 to December 31, 2013) and County of Tulare (January 1, 2013 to December 31, 2013) reflect the rates and benefits approved by your Board and both participating entities. Approval of this item will authorize the Board President to execute both Participation Agreements. Pending your approval, the County of Fresno and Tulare will execute the agreements. The agreements were reviewed by Gallagher Benefit Services, SJVIA staff, SJVIA Counsel and each County Counsel.

FISCAL IMPACT/FINANCING:

AGENDA: San Joaquin Valley Insurance Authority

DATE: November 9, 2012

The rates in the attached Participation Agreement are included in the revised FY 12/13 SJVIA Budget (also on today's agenda for your approval). Based on current enrollment at the County of Fresno and Tulare, the agreements represent a potential cost of $77.5 million in Plan Year 2013.

ADMINISTRATIVE SIGN-OFF:

Paul Nerland
SJVIA Manager

Jeffrey Cardell
Assistant SJVIA Manager

BEFORE THE BOARD OF DIRECTORS
SAN JOAQUIN VALLEY INSURANCE AUTHORITY

IN THE MATTER OF Approval and Execution of SJVIA Participation Agreements with the County of Fresno and Tulare for Plan Year 2013

RESOLUTION NO. _____
AGREEMENT NO. _____

UPON MOTION OF DIRECTOR _____, SECONDED BY DIRECTOR _____, THE FOLLOWING WAS ADOPTED BY THE BOARD OF DIRECTORS, AT AN OFFICIAL MEETING HELD _____ _____, BY THE FOLLOWING VOTE:

AYES:
NOES:
ABSTAIN:
ABSENT:

ATTEST:

BY: _____

* * * * * * * * * * * * * * * * * * *

That the Board authorized the Board President to execute the SJVIA Participation Agreement with the County of Fresno effective December 10, 2012 and Participation Agreement with the County of Tulare effective January 1, 2013.

PRICE PAIGE & COMPANY
ACCOUNTANCY CORPORATION

September 11, 2012

Ms. Vicki Crow, CPA
Auditor-Controller/
Treasurer-Tax Collector
County of Fresno
2200 Fresno Street
Fresno, California 93721

Dear Ms. Crow:

It is our pleasure to present our proposal to continue to provide independent auditing services to the San Joaquin Valley Insurance Authority (the Authority).

We will perform the annual financial statement audit of the San Joaquin Valley Insurance Authority financial statements for the year ended June 30, 2012. Our audit will be conducted in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in Government Auditing Standards issued by the Comptroller General of the United States.

It is our understanding that there has been a significant change in the nature of the Authority's operations for the 2012 fiscal year. In prior years, the Authority did not 'retain risk' as that concept is defined in GASB 10; instead the Authority simply acted as a claims servicer and not an insurer. However, for the 2012 fiscal year, the participants in the pool have transferred risk to the Authority and accordingly the accounting and financial reporting requirements are significantly different. As a result of this change in the nature of operations, our fee for the audit of the financial statements for the fiscal year ended June 30, 2012 is $17,500.

Our audit professionals are highly qualified and have extensive experience in governmental audit and accounting and we can assure you that we fully understand the work to be performed. Additionally, we wish to emphasize our commitment to meeting or exceeding all of your expectations. Additional information about our firm's audit department and the services we offer may be found on our website at **www.ppcpas.com**.

We appreciate the opportunity to submit this proposal to serve you and would be pleased to furnish any additional information regarding our Firm or answer any other specific questions or concerns you may have. I am the audit principal for our firm and I am authorized to make representations for the firm with regard to this proposal. I may be reached at **(559) 299-9540** or via e-mail at **fausto@ppcpas.com**.

Sincerely,

Fausto Hinojosa, CPA, CFE
Audit Principal
Price, Paige & Company

677 Scott Avenue, Clovis, California 93612
Telephone (559) 299-9540 • *Fax* (559) 299-2344 • *E-mail* ppc@ppcpas.com • www.ppcpas.com

SJVIA
San Joaquin Valley Insurance Authority

Meeting Location:
Tulare County Employee Retirement Association Board Chambers
136 N Akers St
Visalia, CA 93921
November 9, 2012
9:00 AM

AGENDA DATE: November 9, 2012

ITEM NUMBER: 5i

SUBJECT: Approve the proposal from Price, Paige and Company to audit the financial statements for the fiscal year ended June 30, 2012

REQUEST(S): That the Board approve the proposal from Price, Paige and Company to audit the financial statements for the fiscal year ended June 30, 2012

DISCUSSION:

The San Joaquin Valley Insurance Authority (SJVIA) is required to have an annual audit of its financial statements under California Government Code 6505. The financial statement audit for the 2011-12 fiscal year is going to be particularly complex due to the unique accounting and reporting requirements resulting from the transfer of risk from the participants to the SJVIA. This change, resulted in the need to prepare and have audited two (2) financial statements; one financial statement covers the period under the old accounting and reporting framework, July 1, 2011 to December 31, 2011, and a second under the "Full Risk" model covering the period of January 1, 2012 to June 30, 3012.

Due to these unique circumstances and given Price, Paige and Company's experience in auditing the SJVIA from its inception, the SJVIA Auditor-Treasurer recommends that the SJVIA Board accept Price, Paige and Company's proposal to perform the audit of the San Joaquin Valley Insurance Authority for the fiscal year ended June 30, 2012.

AGENDA: San Joaquin Valley Insurance Authority

DATE: November 9, 2012

For the fiscal year ended June 30, 2013, the audit of the San Joaquin Valley Insurance Authority audit will be included with the contract for external auditor services between the County of Fresno and Brown, Armstrong, Accountancy Corporation. Brown Armstrong was recently selected, via an RFP process, to perform the County of Fresno's Comprehensive Annual Financial Statement Audit, for the fiscal year ended June 30, 2012, based on their expertise, location, and price.

FISCAL IMPACT/FINANCING:

The quote for this audit from Price, Paige and Company is $17,500.00

ADMINISTRATIVE SIGN-OFF:

Vicki Crow

Vicki Crow

BEFORE THE BOARD OF DIRECTORS
SAN JOAQUIN VALLEY INSURANCE AUTHORITY

IN THE MATTER OF approving the proposal from Price, Paige and Company to audit the financial statements for the fiscal year ended June 30, 2012

RESOLUTION NO. _____
AGREEMENT NO. _____

UPON MOTION OF DIRECTOR _____, SECONDED BY DIRECTOR _____, THE FOLLOWING WAS ADOPTED BY THE BOARD OF DIRECTORS, AT AN OFFICIAL MEETING HELD _____ _____, BY THE FOLLOWING VOTE:

AYES:
NOES:
ABSTAIN:
ABSENT:

ATTEST:

BY: _____

* * * * * * * * * * * * * * * * * * *

That the Board approved the proposal from Price, Paige and Company to audit the financial statements for the fiscal year ended June 30, 2012.

SJVIA
San Joaquin Valley Insurance Authority

Meeting Location:
Tulare County Employee Retirement Association Board Chambers
136 N Akers St
Visalia, CA 93921
November 9, 2012
9:00 AM

AGENDA DATE: November 9, 2012

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AGENDA: San Joaquin Valley Insurance Authority

DATE: November 9, 2012

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FISCAL IMPACT/FINANCING:

The quote for this audit from Price, Paige and Company is $17,500.00

ADMINISTRATIVE SIGN-OFF:

Paul Nerland
SJVIA Manager

Jeffrey Cardell
Assistant SJVIA Manager

BEFORE THE BOARD OF DIRECTORS
SAN JOAQUIN VALLEY INSURANCE AUTHORITY

IN THE MATTER OF approving the proposal from Price, Paige and Company to audit the financial statements for the fiscal year ended June 30, 2012

RESOLUTION NO. _____
AGREEMENT NO. _____

UPON MOTION OF DIRECTOR _____, SECONDED BY DIRECTOR _____, THE FOLLOWING WAS ADOPTED BY THE BOARD OF DIRECTORS, AT AN OFFICIAL MEETING HELD _____ _____, BY THE FOLLOWING VOTE:

AYES:
NOES:
ABSTAIN:
ABSENT:

ATTEST:

BY: _____

* * * * * * * * * * * * * * * * * * *

That the Board approved the proposal from Price, Paige and Company to audit the financial statements for the fiscal year ended June 30, 2012.

SJVIA
San Joaquin Valley Insurance Authority

Meeting Location:
Tulare County Employee Retirement Association Board Chambers
136 N. Akers Street
Visalia, CA 93291
November 9, 2012
9:00 AM

AGENDA DATE: November 9, 2012

ITEM NUMBER 6

SUBJECT Proposed 2013 Board Meeting Calendar

REQUEST(S): That the Board Approve the Proposed 2013 Board Meeting Calendar

DESCRIPTION:

The attached proposed schedule recommends five meetings of your Board in 2013 and maintains the tradition of alternating meeting locations between the County of Fresno and County of Tulare with meeting times scheduled from 9:00am to 12:00pm. Your Board may elect to adopt other dates and times or add meetings based on SJVIA business and your availability. Adopting dates today will allow staff to reserve locations and publish the 2013 SJVIA Board Calendar.

FISCAL IMPACT/FINANCING:

None.

AGENDA: San Joaquin Valley Insurance Authority

DATE: November 9, 2012

ADMINISTRATIVE SIGN-OFF:

Paul Nerland
SJVIA Manager

Jeffrey Cardell
Assistant SJVIA Manager

BEFORE THE BOARD OF DIRECTORS
SAN JOAQUIN VALLEY INSURANCE AUTHORITY

IN THE MATTER OF Proposed 2013 Board Meeting Calendar

RESOLUTION NO. _____
AGREEMENT NO. _____

UPON MOTION OF DIRECTOR _____, SECONDED BY DIRECTOR _____, THE FOLLOWING WAS ADOPTED BY THE BOARD OF DIRECTORS, AT AN OFFICIAL MEETING HELD _____ _____, BY THE FOLLOWING VOTE:

AYES:
NOES:
ABSTAIN:
ABSENT:

ATTEST:

BY: _____

* * * * * * * * * * * * * * * * * * *

That the Board Approved the Proposed 2013 Board Meeting Calendar

SJVIA
San Joaquin Valley Insurance Authority

Board of Directors Meetings - 2013

PROPOSED SCHEDULE

Date	Time	City	Location
January 25, 2013 (Friday)	9:00-12:00	Fresno	FCERA Board Chambers-Fresno County Employee Retirement Assn
April 26, 2013 (Friday)	9:00-12:00	Visalia	TCERA Board Chambers-Tulare County Employee Retirement Assn
July 26, 2013 (Friday)	9:00-12:00	Fresno	FCERA Board Chambers-Fresno County Employee Retirement Assn
August 23, 2013 (Friday)	9:00-12:00	Visalia	TCERA Board Chambers-Tulare County Employee Retirement Assn
November 1, 2013 (Friday)	9:00-12:00	Fresno	FCERA Board Chambers-Fresno County Employee Retirement Assn

LOCATIONS:

FCERA-Fresno County Employee Retirement Association
1111 H Street
Fresno, CA 93721

TCERA-Tulare County Employee Retirement Association
136 N. Akers Street
Visalia, Ca 93291

SJVIA
San Joaquin Valley Insurance Authority

Meeting Location:
Tulare County Employee Retirement Association Board Chambers
136 N. Akers Street
Visalia, CA 93291
November 9, 2012
9:00 AM

AGENDA DATE: November 9, 2012

ITEM NUMBER 7

SUBJECT Results of SJVIA External Audit

REQUEST(S): That the Board receive and file the 2010-11 Audited Financial Statements with Independent Auditor's Reports

DESCRIPTION:

The audited financial statements will be presented by Vicki Crow, C.P.A., County of Fresno, Auditor-Controller/Treasurer-Tax Collector.

FISCAL IMPACT/FINANCING:

See Attachment – Audit Report

AGENDA: San Joaquin Valley Insurance Authority

DATE: November 9, 2012

ADMINISTRATIVE SIGN-OFF:

Vicki Crow

Vicki Crow

BEFORE THE BOARD OF DIRECTORS
SAN JOAQUIN VALLEY INSURANCE AUTHORITY

IN THE MATTER OF Results of SJVIA External Audit

RESOLUTION NO. _____
AGREEMENT NO. _____

UPON MOTION OF DIRECTOR _____, SECONDED BY DIRECTOR _____, THE FOLLOWING WAS ADOPTED BY THE BOARD OF DIRECTORS, AT AN OFFICIAL MEETING HELD _____ _____, BY THE FOLLOWING VOTE:

AYES:
NOES:
ABSTAIN:
ABSENT:

ATTEST:

BY: _____

* * * * * * * * * * * * * * * * * * *

That the Board received and filed the 2010-11 Audited Financial Statements with Independent Auditor's Reports

SAN JOAQUIN VALLEY INSURANCE AUTHORITY

FINANCIAL STATEMENTS WITH INDEPENDENT AUDITOR'S REPORTS

FOR THE YEAR ENDED JUNE 30, 2011

SAN JOAQUIN VALLEY INSURANCE AUTHORITY
FRESNO, CALIFORNIA

JUNE 30, 2011

TABLE OF CONTENTS

PRICE PAIGE & COMPANY
ACCOUNTANCY CORPORATION

INDEPENDENT AUDITOR'S REPORT

To the Board of Directors
San Joaquin Valley Insurance Authority
Fresno, California

We have audited the accompanying financial statements of San Joaquin Valley Insurance Authority (the Authority), as of and for the year ended June 30, 2011, as listed in the table of contents. These financial statements are the responsibility of the Authority's management. Our responsibility is to express an opinion on these financial statements based on our audit.

We conducted our audit in accordance with auditing standards generally accepted in the United States of America and the standards for financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatements. An audit includes consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Authority's internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and the significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audit provides a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of San Joaquin Valley Insurance Authority, as of June 30, 2011, and the respective changes in financial position, and cash flows, thereof, for the year then ended in conformity with accounting principles generally accepted in the United States of America.

In accordance with *Government Auditing Standards*, we have also issued our report dated October 26, 2012, on our consideration of the Authority's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* and should be considered in assessing the results of our audit.

Accounting principles generally accepted in the United States of America require that the management's discussion and analysis on pages 5 through 7 be presented to supplement the basic financial statements. Such information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board, who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have

677 Scott Avenue, Clovis, California 93612
Telephone (559) 299-9540 • *Fax* (559) 299-2344 • *E-mail* ppc@ppcpas.com • www.ppcpas.com

applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Price Paige & Company

Clovis, California
October 26, 2012

MANAGEMENT'S DISCUSSION AND ANALYSIS

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OVERVIEW OF THE FINANCIAL STATEMENTS

The following is a narrative overview and analysis of the financial performance of San Joaquin Valley Insurance Authority (the Authority) financial activities for the year ended June 30, 2011. Please read it in conjunction with the Authority's basic financial statements which follow this section.

FINANCIAL HIGHLIGHTS

- At the close of the fiscal year June 30, 2011, assets of the Authority exceeded it liabilities by $704,303 (net assets). This entire amount is unrestricted and may be used to meet the Authority's ongoing obligations.

- The Authority's total net assets increased by $417,223.

OVERVIEW OF THE FINANCIAL STATEMENTS

This discussion and analysis is intended to serve as an introduction to the Authority's basic financial statements. The annual financial report for the Authority includes this management's discussion and analysis (MD&A), the basic financial statements and notes to the basic financial statements.

The Authority reported as an *enterprise fund*. Enterprise funds are a type of proprietary fund that is used to report information in a manner similar to a private-sector business. An enterprise fund is used to account for functions that are intended to recover all or a significant portion of their costs through user users and charges.

The basic financial statements include the Statement of Net Assets; Statement of Revenues, Expenses, and Changes in Fund Net Assets; and Statement of Cash Flows. Following is a brief explanation of the use of each of the statements.

The *Statement of Net Assets* presents information on all of the Authority's assets and liabilities with the difference between the two reported as net assets. Over time, increases or decreases in net assets may serve as a useful indicator of whether the financial position of the Authority is improving or deteriorating.

The *Statement of Revenue, Expenses and Changes in Fund Net Assets* presents information showing how the Authority's net assets changed during the most recent fiscal year. All changes in net assets are reported as soon as the underlying event giving rise to the change occurs, regardless of the timing of the related cash flows.

The *Statement of Cash Flows* presents the cash inflows and outflows and the resulting cash position at fiscal year-end.

Notes to the Basic Financial Statements. The notes to the basic financial statements provide additional information that is essential to a full understanding of the data provided in the basic financial statements. The notes to the basic financial statements can be found on pages 14-20 of this report.

Financial Statement Analysis

As noted earlier, net assets may serve over time as a useful indicator of a government's financial position. In case of the Authority, assets exceed liabilities by $704,303 at the close of the most recent fiscal year.

Authority's Net Assets

	6/30/2011	6/30/2010
Assets:		
Current and other assets	$ 817,528	$ 414,265
Total Assets	817,528	414,265
Liabilities:		
Current and other liabilities	113,225	127,185
Total Liabilities	113,225	127,185
Net Assets:		
Unrestricted	704,303	287,080
Total Net Assets	$ 704,303	$ 287,080

The entire net assets balance is unrestricted as of June 30, 2011, and may be used to meet the Authority's ongoing obligations to creditors.

Authority's Change in Net Assets

	6/30/2011	6/30/2010
Operating Revenues:		
Claims servicing revenue	$ 1,604,505	$ 815,807
Total Revenues	1,604,505	815,807
Operating Expenses:		
Eligibility administration - Chimenti	697,081	291,036
Consulting fees - Gallagher	404,377	233,348
Claim mitigation fees	10,000	-
Administrative costs	75,824	4,343
Total Expenses	1,187,282	528,727
Change in Net Assets	417,223	287,080
Net Assets, Beginning of Year	287,080	-
Net Assets, End of Year	$ 704,303	$ 287,080

The Authority's net assets increased by $417,223 during the current fiscal year. This increase represents the degree to which increases in ongoing revenues have outstripped similar increases in ongoing expenses. Fiscal year 2010 was the Authority's first year operation and it operated for a nine-month period.

Economic Factors and Next Year's Budget

Although the Authority currently includes County entities that are suffering the effects of the recession, revenues are projected to remain stable for next year with a slight increase due to an overall increase in health insurance costs consistent with industry projections.

Personnel costs are also expected to increase slightly resulting in additional usage of the administrative reserve funds.

These factors were considered in preparing the Authority's budget for fiscal year 2011-12. The Authority will make adjustments to its budget as necessary to deal with further expected changes in County entities' actions that impact benefit packages, and related costs.

As of January 1, 2012, the Authority moved from a claims servicing entity to a full risk self-insurance model. The member entities transferred their funding for Incurred But Not Reported (IBNR) claims to the Authority. As of January 1, 2012, the Authority has assumed all risk for incurred claims.

Requests for Information

The financial report is designed to provide a general overview of the Authority's finances for all those with an interest in the government's finances. Questions concerning any of the information provided in this report or requests for additional financial information should be addressed to the Office of the Auditor-Controller/Treasurer-Tax Collector, 2281 Tulare Street, Fresno, CA 93721.

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BASIC FINANCIAL STATEMENTS

SAN JOAQUIN VALLEY INSURANCE AUTHORITY
FRESNO, CALIFORNIA

STATEMENT OF NET ASSETS
JUNE 30, 2011

Assets:		
Cash and cash equivalents	$	577,545
Due from other governmental units		142,019
Other receivables		1,027
Amount due from pool participants		96,937
Total assets	$	817,528
Liabilities:		
Accounts payable	$	113,225
Total liabilities		113,225
Net Assets:		
Unrestricted		704,303
Total net assets	$	704,303

The notes to the financial statements are an integral part of this statement.

SAN JOAQUIN VALLEY INSURANCE AUTHORITY
FRESNO, CALIFORNIA

STATEMENT OF REVENUES, EXPENSES, AND CHANGES IN FUND NET ASSETS
FOR THE YEAR ENDED JUNE 30, 2011

Operating Revenues:	
Claims servicing revenue	$ 1,604,505
Total revenues	1,604,505
Operating Expenses:	
Eligibility administration - Chimenti	697,081
Consulting fees - Gallagher	404,377
Claim mitigation fees	10,000
Administrative costs	75,824
Total expenses	1,187,282
Change in net assets	417,223
Net assets, beginning of year	287,080
Net assets, end of year	$ 704,303

The notes to the financial statements are an integral part of this statement.

SAN JOAQUIN VALLEY INSURANCE AUTHORITY
FRESNO, CALIFORNIA

STATEMENT OF CASH FLOWS
FOR THE YEAR ENDED JUNE 30, 2011

Cash flows from operating activities:	
Cash received from users	$ 26,159,322
Cash paid to suppliers	(1,201,242)
Claims paid	(24,494,168)
Net cash provided by (used in) operating activities	463,912
Cash and cash equivalents - beginning	113,633
Cash and cash equivalents - ending	$ 577,545

Reconciliation of Operating Income (Loss) to Net Cash Provided by (Used in) Operating Activities:

Operating income (loss)	$ 417,223
Adjustments to reconcile operating income (loss) to net cash provided by (used in) operating activities:	
(Increase) decrease in due from other governmental units	40,900
(Increase) decrease in other receivables	(1,027)
(Increase) decrease in amount due from pool participants	20,776
Increase (decrease) in accounts payable	(13,960)
Total adjustments	46,689
Net cash provided by (used in) operating activities	$ 463,912

The notes to the financial statements are an integral part of this statement.

NOTES TO THE BASIC FINANCIAL STATEMENTS

NOTE 1 – SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

The accompanying financial statements are presented in conformity with accounting principles generally accepted in the United States of America for governmental units as prescribed by the Governmental Accounting Standards Board (GASB) and other authoritative sources.

In November 1989, GASB issued Statement No. 10, *Accounting and Financial Reporting for Risk Financing and Related Insurance Issues*. GASB Statement No. 10 establishes accounting and financial reporting standards for risk financing and insurance-related activities for state and local governmental entities, including public entity risk pools. These financial statements have been prepared in accordance with GASB Statement No. 10, as amended by GASB Statement No. 30, *Risk Financing Omnibus*.

A. Reporting Entity

On October 6, 2009, County of Fresno and County of Tulare entered into an agreement creating the San Joaquin Valley Insurance Authority (the Authority) to negotiate, purchase or otherwise fund health, vision, dental, and life insurance for the employees of County of Fresno and certain employees of County of Tulare, in all instances subject to obtaining a financial commitment by the County of Fresno and County of Tulare to pay for their respective costs. Both counties desire to secure such coverage for the purpose of obtaining other coverage and/or insurance policies at more favorable rates, and administering such insurance programs with greater efficiency, than they could obtain by their individual efforts.

The Authority's Board of Directors is governed by the Board of Directors which is composed of seven directors. Four of the directors are appointed by the County of Fresno Board of Supervisors and three of the directors are appointed by the County of Tulare Board of Supervisors. The Board of Directors elects from its membership a President and Vice President to serve two-year terms.

The Authority is legally separate and financially independent and is not a component unit of the County of Fresno or County of Tulare. Therefore, these financial statements represent solely the activities, transactions and status of the Authority.

The Authority itself does not employ any personnel. The County of Fresno staff provides the necessary services such as maintenance and accounting to the Authority on a reimbursement basis.

B. Basis of Accounting

Pursuant to Governmental Accounting Standards Board (GASB) Standard No. 20, *Accounting and Financial Reporting for Proprietary Funds and Other Governmental Entities That Use Proprietary Fund Accounting*, all Financial Accounting Standards Board (FASB) statements and authoritative pronouncements issued before November 30, 1989, are applied to proprietary operations unless they conflict with GASB pronouncements. The Authority has elected not to apply FASB statements issued subsequent to November 30, 1989.

NOTE 1 – SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

B. Basis of Accounting (Continued)

The Authority is a proprietary entity; it uses an enterprise fund format to report its activities for financial statement purposes. Proprietary Fund Financial Statements include a Statement of Net Assets, a Statement of Revenues, Expenses, and Changes in Fund Net Assets, and a Statement of Cash Flows.

Proprietary funds are accounted for using the "economic resources" measurement focus and the accrual basis of accounting. Accordingly, all assets and liabilities (whether current or noncurrent) are included on the Statement of Net Assets. The Statement of Revenues, Expenses and Changes in Fund Net Assets presents increases (revenues) and decreases (expenses) in total net assets. Under the accrual basis of accounting, revenues are recognized in the period in which they are earned while expenses are recognized in the period in which the liability is incurred.

Operating revenues in the proprietary funds are those revenues that are generated from the primary operations of the fund. All other revenues are reported as non-operating revenues. Operating expenses are those expenses that are essential to the primary operations of the fund. All other expenses are reported as non-operating expenses.

When both restricted and unrestricted resources are available for use, it is the Authority's policy to use restricted resources first, then unrestricted resources as they are needed.

C. Basis of Presentation

GASB Statement No. 10 states that public entity risk pools that do not transfer or pool risk among participants are acting as claims servicers and not insurers. Accordingly, operating statements of these pools should report claims servicing revenue and administrative costs. Amounts collected or due from pool participants and paid to settle claims should be reported as a net asset or liability on an accrual basis.

D. New Pronouncements

Governmental Accounting Standards Board Statement No. 54

In March 2009, GASB issued Statement No. 54, *Fund Balance Reporting and Governmental Fund-Type Definitions.* The objective of this Statement is to enhance the usefulness of fund balance information by providing clearer fund balance classifications that can be more consistently applied by clarifying the existing governmental fund-type definitions. This Statement establishes fund balance classifications that comprise a hierarchy based primarily on the extent to which a government is bound to observe constraints imposed upon the use of the resources reported in governmental funds. This Statement is effective for financial statements with reporting periods beginning after June 15, 2010. This Statement did not have an impact on the Authority's financial statements.

NOTE 1 – SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

D. New Pronouncements (Continued)

The Authority is currently analyzing its accounting practices to determine the potential impact on the financial statements for the following GASB Statements:

Governmental Accounting Standards Board Statement No. 60

In November 2010, GASB issued Statement No. 60, *Accounting and Financial Reporting for Service Concession Arrangements*. The objective of this Statement is to improve financial reporting by addressing issues related to service concession arrangements ("SCAs"), which are a type of public-private or public-public partnership. This Statement requires disclosures about an SCA including a general description of the arrangement and information about the associated assets, liabilities, and deferred inflows, the rights granted and retained, and guarantees and commitments. Application of this Statement is effective for the Authority's fiscal year ending June 30, 2013.

Governmental Accounting Standards Board Statement No. 62

In December 2010, GASB issued Statement No. 62, *Codification of Accounting and Financial Reporting Guidance Contained in Pre-November 30, 1989 FASB and AICPA Pronouncements.* The objective of this Statement is to incorporate into the GASB's authoritative literature certain accounting and financial reporting guidance that is included in the following pronouncements issued on or before November 30, 1989, which does not conflict with or contradict GASB pronouncements:

1. Financial Accounting Standards Board ("FASB") Statements and Interpretations
2. Accounting Principles Board Opinions
3. Accounting Research Bulletins of the American Institute of Certified Public Accountants' ("AICPA") Committee on Accounting Procedure

Governmental Accounting Standards Board Statement No. 63

In June 2011, GASB issued Statement No. 63, *Financial Reporting of Deferred Outflows of Resources, Deferred Inflows of Resources, and Net Position*. This Statement provides financial reporting guidance for deferred outflows of resources and deferred inflows of resources. This Statement also amends the net asset reporting requirements in Statement No. 34, *Basic Financial Statements—and Management's Discussion and Analysis—for State and Local Governments*, and other pronouncements by incorporating deferred outflows of resources and deferred inflows of resources into the definitions of the required components of the residual measure and by renaming that measure as net position, rather than net assets. The requirements of this Statement are effective for the City's fiscal year ending June 30, 2013.

NOTE 1 – SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

D. New Pronouncements (Continued)

Governmental Accounting Standards Board Statement No. 64

In June 2011, GASB issued Statement No. 64, *Derivative Instruments: Application of Hedge Accounting Termination Provisions.* This Statement sets forth criteria to establish when the effective hedging relationship continues and hedge accounting should continue to be applied. The requirements of this Statement enhance comparability and improve financial reporting by clarifying the circumstances in which hedge accounting should continue when a swap counterparty, or a swap counterparty's credit support provider, is replaced. The requirements of this Statement are effective for the Authority's fiscal year ending June 30, 2012. This statement did not have an impact on the Authority's financial statements.

Governmental Accounting Standards Board Statement No. 65

In March 2012, GASB issued Statement No. 65, *Items Previously Reported as Assets and Liabilities.* This Statement establishes accounting and financial reporting standards that reclassify, as deferred outflows of resources or deferred inflows of resources, certain items that were previously reported as assets and liabilities and recognizes, as outflows of resources or inflows of resources, certain items that were previously reported as assets and liabilities. The requirements of this Statement are effective for the Authority's fiscal year ending June 30, 2014.

Governmental Accounting Standards Board Statement No. 66

In March 2012, GASB issued Statement No. 66, *Technical Corrections – 2012 – An Amendment of GASB Statements No. 10 and No. 62.* The objective of this Statement is to improve accounting and financial reporting for a governmental financial reporting entity by resolving conflicting guidance that resulted from the issuance of two pronouncements, Statements No. 54, *Fund Balance Reporting and Governmental Fund Type Definitions,* and No. 62, *Codification of Accounting and Financial Reporting Guidance Contained in Pre-November 30, 1989 FASB and AICPA Pronouncements.* The requirements of this Statement are effective for the Authority's fiscal year ending June 30, 2014.

Hereinafter, these pronouncements collectively are referred to as the "FASB and AICPA pronouncements." This Statement will improve financial reporting by contributing to the GASB's efforts to codify all sources of generally accepted accounting principles for state and local governments so that they derive from a single source. Application of this Statement is effective for the Authority's fiscal year ending June 30, 2013.

NOTE 1 – SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

D. New Pronouncements (Continued)

Governmental Accounting Standards Board Statement No. 67

In June 2012, GASB issued No. 67, Financial Reporting for Pension Plans—an amendment of GASB Statement No. 25. The objective of this Statement is to improve financial reporting by state and local governmental pension plans. This Statement results from a comprehensive review of the effectiveness of existing standards of accounting and financial reporting for pensions with regard to providing decision-useful information, supporting assessments of accountability and interperiod equity, and creating additional transparency. This Statement replaces the requirements of Statements No. 25, *Financial Reporting for Defined Benefit Pension Plans and Note Disclosures for Defined Contribution Plans*, and No. 50, *Pension Disclosures,* as they relate to pension plans that are administered through trusts or equivalent arrangements (hereafter jointly referred to as trusts) that meet certain criteria. The requirements of Statement No.'s 25 and 50 remain applicable to pension plans that are not administered through trusts covered by the scope of this Statement and to defined contribution plans that provide postemployment benefits other than pensions. The requirements of this Statement are effective for the Authority's fiscal year ending June 30, 2014.

Governmental Accounting Standards Board Statement No. 68

In June 2012, GASB issued No. 68, *Accounting and Financial Reporting for Pensions—an amendment of GASB Statement No. 27*. The primary objective of this Statement is to improve accounting and financial reporting by state and local governments for pensions. It also improves information provided by state and local governmental employers about financial support for pensions that is provided by other entities. This Statement results from a comprehensive review of the effectiveness of existing standards of accounting and financial reporting for pensions with regard to providing decision-useful information, supporting assessments of accountability and interperiod equity, and creating additional transparency. This Statement replaces the requirements of Statement No. 27, *Accounting for Pensions by State and Local Governmental Employers,* as well as the requirements of Statement No. 50, *Pension Disclosures,* as they relate to pensions that are provided through pension plans administered as trusts or equivalent arrangements (hereafter jointly referred to as trusts) that meet certain criteria. The requirements of Statement No.'s 27 and 50 remain applicable for pensions that are not covered by the scope of this Statement. The requirements of this Statement are effective for the Authority's fiscal year ending June 30, 2015.

E. Assets, Liabilities and Net Assets

1. Cash and Cash Equivalents

For purposes of the Statement of Cash Flows, the Authority considered all highly liquid investments with a maturity of three months or less when purchased to be cash equivalents.

NOTE 1 – SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

E. Assets, Liabilities and Net Assets (Continued)

2. Due from Other Governmental Units

Certain revenues are earned by the Authority during the current reporting period but are not received until after the beginning of the next fiscal period. These revenues are reported as due from other governmental units in the financial statements. The Authority's current due from other governmental units' balance of $142,019, as of June 30, 2011, is related to eligibility administration service fees, consulting fees and other administrative fees.

3. Amount Due from Pool Participants

The Authority has made claim payments to the health care providers on behalf of the County of Fresno and County of Tulare during the fiscal year but has not been reimbursed by the counties as of year-end. The amount due from pool participants as of June 30, 2011 is $96,937.

4. Accounts Payable

Certain costs are incurred by the Authority during the current reporting period but are not paid until after the beginning of the next fiscal period. These costs are reported as payables in the financial statements. The Authority's current accounts payable balance of $113,225 as of June 30, 2011, is related to certain contract services and payments for eligibility administration and consulting fees.

5. Net Assets

Net assets are reported in three categories as follows:

Invested in capital assets, net of related debt – This amount consists of capital assets net of accumulated depreciation and reduced by outstanding debt that attributed to the acquisition.

Restricted – This amount is restricted by external creditors, grantors, contributors, or laws or regulations of other governments.

Unrestricted – This amount is all net assets that do not meet the definition of "invested in capital assets, net of related debt" or "restricted net assets."

6. Use of Estimates

The preparation of financial statements in conformity with generally accepted accounting principles requires management to make estimates and assumptions that affect certain reported amounts and disclosures. Accordingly, actual results could differ from those estimates.

NOTE 2 – CASH AND CASH EQUIVALENTS

Summary of Deposits

Cash and cash equivalents as of June 30, 2011, are classified in the accompanying financial statements as follows:

Statement of net assets:

Cash and cash equivalents	$ 577,545
Total cash and cash equivalents	$ 577,545

Cash and cash equivalents as of June 30, 2011, consist of the following:

Deposits with financial institutions	$ 577,545
Total cash and cash equivalents	$ 577,545

Custodial Credit Risk

Custodial credit risk for *deposits* is the risk that, in the event of the failure of a depository financial institution, a government will not be able to recover its deposits or will not be able to recover collateral securities that are in the possession of an outside party. The California Government Code and the Authority's investment policy do not contain legal or policy requirements that would limit the exposure to custodial credit risk for deposits, other than the following provision for deposits: The California Government Code requires that a financial institution secure deposits made by state or local governmental units by pledging securities in an undivided collateral pool held by a depository regulated under state law (unless so waived by the governmental unit). The market value of the pledged securities in the collateral pool must equal at least 110% of the total amount deposited by the public agencies. California law also allows financial institutions to secure Authority deposits by pledging first trust deed mortgage notes having a value of 150% of the secured public deposits.

As of June 30, 2011, the Authority's deposits with financial institutions in excess of federal depository insurance limits were held in fully collateralized accounts, as permitted by the California Government Code.

NOTE 3 – COMMITMENTS AND CONTINGENCIES

Commitments and contingencies, undeterminable in amount, include normal recurring pending claims and litigation. In the opinion of management, based upon discussion with legal counsel, there is no pending litigation which is likely to have a material adverse affect on the financial position of the Authority.

NOTE 4 – SUBSEQUENT EVENTS

As of January 1, 2012, the Authority moved from a claims servicing entity to a full risk self-insurance model. The member entities transferred their funding for Incurred But Not Reported (IBNR) claims to the Authority. As of January 1, 2012, the Authority has assumed all risk for incurred claims.

OTHER INDEPENDENT AUDITOR’S REPORT

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PRICE PAIGE & COMPANY
ACCOUNTANCY CORPORATION

REPORT ON INTERNAL CONTROL OVER FINANCIAL
REPORTING AND ON COMPLIANCE AND OTHER MATTERS
BASED ON AN AUDIT OF FINANCIAL STATEMENTS PERFORMED
IN ACCORDANCE WITH *GOVERNMENT AUDITING STANDARDS*

To the Board of Directors
San Joaquin Valley Insurance Authority
Fresno, California

We have audited the financial statements of the San Joaquin Valley Insurance Authority (the Authority), Fresno, California, as of and for the year ended June 30, 2011, which collectively comprise the Authority's basic financial statements and have issued our report thereon dated October 26, 2012. We conducted our audit in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States.

Internal Control Over Financial Reporting

Management of the Authority is responsible for establishing and maintaining effective internal control over financial reporting. In planning and performing our audit, we considered the Authority's internal control over financial reporting as a basis for designing our auditing procedures for the purpose of expressing our opinions on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of the Authority's internal control over financial reporting. Accordingly, we do not express an opinion on the effectiveness of the Authority's internal control over financial reporting.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct misstatements on a timely basis. A *material weakness* is a deficiency, or a combination of deficiencies, in internal control such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected on a timely basis.

Our consideration of internal control over financial reporting was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control over financial reporting that might be deficiencies, significant deficiencies, or material weaknesses. We did not identify any deficiencies in internal control over financial reporting that we consider to be material weaknesses, as defined above.

Compliance and Other Matters

As part of obtaining reasonable assurance about whether the Authority's financial statements are free of material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the determination of financial statement amounts. However, providing an opinion on compliance with

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those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards*.

This report is intended solely for the information and use of management and the Board of Directors of the Authority, and is not intended to be and should not be used by anyone other than these specified parties.

Price Paige & Company

Clovis, California
October 26, 2012

SAN JOAQUIN VALLEY INSURANCE AUTHORITY
FRESNO, CALIFORNIA

SCHEDULE OF FINDINGS AND RESPONSES
FOR THE YEAR ENDED JUNE 30, 2011

SECTION I – SUMMARY OF AUDITOR'S RESULTS

Financial Statements

Type of auditor's report issued	Unqualified		
Internal control over financial reporting:			
Material weakness(es) identified?	_____ yes	X no	
Significant deficiencies identified that are not considered to be material weaknesses?	_____ yes	X	none reported
Noncompliance material to financial statement noted?	_____ yes	X no	

SECTION II – FINANCIAL STATEMENT FINDINGS

None reported.

SAN JOAQUIN VALLEY INSURANCE AUTHORITY
FRESNO, CALIFORNIA

STATUS OF PRIOR YEAR FINDINGS
FOR THE YEAR ENDED JUNE 30, 2011

SECTION II – FINANCIAL STATEMENT FINDINGS

Finding 2010-01 **Insurance Premiums and Claim Expenses**

Condition: During our testing, we noted several insurance premium and claim expense transactions were not recorded or were improperly recorded in the accounting records. Material adjusting journal entries were proposed to correct insurance premium and claim expense balances.

Criteria: Audit adjustments not identified by an entity's accounting control activities are a strong indicator of a material weakness in internal controls. Internal control policies and procedures should be established and monitored to ensure account balances are accurately recorded in a timely manner.

Effect: Material weaknesses in internal controls raise the risk of misstatements in the financial statements. Inaccurate recording of insurance premium and claim expense transactions may result in a material misstatement in the financial statements and may not accurately reflect the insurance premium and claim activities for the fiscal year.

Cause: Internal controls were not properly designed and/or operating effectively to ensure the insurance premium and claim expense transactions were initiated, recorded and reported appropriately.

Recommendation: A review of insurance premium and claim expense transactions should be performed by a person other than the preparer.

Management Response: The accounting unit has implemented additional review procedures along with tracking procedures of claims documentation to assure all claim expense transactions are recorded in the accounting system and reviewed by the financial reporting unit. This additional set of internal controls will ensure all claim expenses are reported properly and in a timely manner.

Status: Implemented

SAN JOAQUIN VALLEY INSURANCE AUTHORITY
FRESNO, CALIFORNIA

STATUS OF PRIOR YEAR FINDINGS
FOR THE YEAR ENDED JUNE 30, 2011

SECTION II – FINANCIAL STATEMENT FINDINGS (Continued)

Finding 2010-02	**Bank Reconciliation Adjustments**
Condition:	As a result of our audit procedures, a material adjustment was proposed to correct the Authority's cash balance.
Criteria:	Audit adjustments not identified by an entity's accounting control activities are a strong indicator of a material weakness in internal controls. Internal control policies and procedures should be established and monitored to ensure account balances are accurately recorded in a timely manner.
Effect:	Material weaknesses in internal controls raise the risk of misstatements in the financial statements. Inaccurate recording of cash transactions may result in a material misstatement in the financial statements.
Cause:	Internal controls were not properly designed and/or operating effectively to ensure the cash balance was reconciled accurately.
Recommendation:	A thorough review of bank reconciliations should be performed by a person other than the preparer.
Management Response:	The accounting unit receives monthly bank reconciliations from the insurance vendor which details all bank expenses. The reconciliations will be verified against claims expenditures by the financial reporting unit and compared to accounting transactions to ensure appropriate internal controls are in place.
Status:	Implemented

SJVIA 2012 - 2013 FISCAL BUDGET

	County of Fresno 2012-13 Budget	County of Tulare 2012-13 Budget	City of Tulare 2012-13 Budget	SJVIA 2012-13 Budget
REVENUE				
Counties of Fresno & Tulare, City of Tulare Health Plan Revenue				
Medical & Rx	$ 50,311,551	$ 19,152,633	$ 3,166,446	$ 72,630,630
Dental	$ 2,083,844	$ 684,973	n/a	$ 2,768,817
Vision	$ 371,775	$ 73,560	n/a	$ 445,335
TOTAL REVENUE	**$ 52,767,170**	**$ 19,911,166**	**$ 3,166,446**	**$ 75,844,782**
EXPENSES: Fixed				
1 Specific & Aggregate Stop Loss Insurance (PPO)	$ 124,798	$ 393,054	$ 47,035	$ 564,887
2 Anthem ASO Administration & Network Fees (PPO)	$ 272,068	$ 856,884	$ 145,718	$ 1,274,669
3 Chimienti Associates/Hourglass Administration (PPO & Anthem HMO)	$ 419,562	$ 205,374	$ 27,768	$ 652,704
4 GBS Consulting	$ 258,192	$ 126,384	$ 17,088	$ 401,664
5 SJVIA Association Fee	$ 129,096	$ 63,192	$ 8,544	$ 200,832
6 SJVIA Non-Founding Member Fee	$ -	$ -	$ 8,544	$ 8,544
7 Wellness/Communications	$ 193,644	$ 94,788	$ 12,816	$ 301,248
8 Anthem HMO Pooling	$ 1,311,928	$ -	$ -	$ 1,311,928
9 Anthem HMO Administration/Retention	$ 2,013,276	$ -	$ -	$ 2,013,276
TOTAL FIXED EXPENSES	**$ 4,722,563**	**$ 1,739,676**	**$ 267,513**	**$ 6,729,752**
EXPENSES: Claims				
10 Projected Paid Claims PPO & Non-Cap HMO	$ 33,255,862	$ 17,567,462	$ 2,654,825	$ 53,478,149
11 Anthem MMP HMO Capitation (Fixed Claims Cost)	$ 13,786,551	$ -	$ -	$ 13,786,551
TOTAL CLAIMS EXPENSES	**$ 47,042,413**	**$ 17,567,462**	**$ 2,654,825**	**$ 67,264,701**
12 Delta Dental (6 months beginning 1/1/2013)	$ 2,083,844	$ 684,973	$ -	$ 2,768,817
13 VSP (6 months beginning 1/1/2013)	$ 371,775	$ 73,560	$ -	$ 445,335
	$ 2,455,619	**$ 758,533**	**$ -**	**$ 3,214,152**
TOTAL PROJECTED EXPENSES	**$ 54,220,596**	**$ 20,065,671**	**$ 2,922,338**	**$ 77,208,605**
Beginning IBNR Reserves				$ 9,878,296
14 Rate Stabilization				$ (1,473,160)
Ending IBNR Reserves				**$ 8,405,136**
COMBINED EXPENSES				**$ 75,735,445**

Glossary of Terms:

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 **Anthem ASO Administration & Network Fees (PPO):**

ASO is "Administrative Services Only". This definition includes Anthem Blue Cross administration fees and includes access fees to use the Blue Cross network of providers. This is the administration fee for the PPO plan(s), not the HMO plan.

3 **Chimienti Associates/Hourglass Administration (PPO & Anthem HMO)**

Chimienti &Associates is an independent vendor providing consolidated billing, eligibility, automated enrollment and Section 125 administrative services. Hourglass and ASI are subcontractors to Chimienti Associates that assist in these administrative processes. This line is for non-Kaiser business.

4 **GBS Consulting**

Gallagher Benefit Services (GBS) is a national 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. GBS played a significant role in the formation and establishment of SJVIA.

5 **SJVIA Association Fee**

The association fee 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.

6 **SJVIA Non-Founding Member Fee**

This additional fee will be assessed to non-founding member entities and be used to offset administrative, management, legal, accounting and other services needed to effectively establish and maintain proper functioning of the Joint Powers Authority.

7 **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**

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

10 **Projected Paid Claims PPO & Non-Cap HMO**

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

11 **Anthem MMP 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

12 **Delta Dental**

This amount represents a fixed claim (premium) paid to Delta Dental for the dental program at both the County of Fresno and the County of Tulare. Because dental coverage came under the SJVIA effective 1/1/2013, this amount represents premium from 1/1/2013 through 6/30/2013.

13 **VSP**

This amount represents a fixed claim (premium) paid to VSP for the vision program at both the County of Fresno and the County of Tulare. Because vision coverage came under the SJVIA effective 1/1/2013, this amount represents premium from 1/1/2013 through 6/30/2013.

14 **Rate Stabilization**

When adopting the 2013 premiums, the Board of Director of the SJVIA elected to use a portion of the excess reserves to "buy down" the impact of the rate increase. This Rate Stabilization amount reflects this adjustment to reserves for the 2013 period of this budget year.

SJVIA 2012 - 2013 FISCAL BUDGET

	County of Fresno 2012-13 Budget	County of Tulare 2012-13 Budget	City of Tulare 2012-13 Budget	SJVIA 2012-13 Budget
REVENUE				
Counties of Fresno & Tulare, City of Tulare Health Plan Revenue				
Medical & Rx	$ 50,311,551	$ 19,152,633	$ 3,166,446	$ 72,630,630
Dental	$ 2,083,844	$ 684,973	n/a	$ 2,768,817
Vision	$ 371,775	$ 73,560	n/a	$ 445,335
TOTAL REVENUE	**$ 52,767,170**	**$ 19,911,166**	**$ 3,166,446**	**$ 75,844,782**
EXPENSES: Fixed				
1 Specific & Aggregate Stop Loss Insurance (PPO)	$ 124,798	$ 393,054	$ 47,035	$ 564,887
2 Anthem ASO Administration & Network Fees (PPO)	$ 272,068	$ 856,884	$ 145,718	$ 1,274,669
3 Chimienti Associates/Hourglass Administration (PPO & Anthem HMO)	$ 419,562	$ 205,374	$ 27,768	$ 652,704
4 GBS Consulting	$ 258,192	$ 126,384	$ 17,088	$ 401,664
5 SJVIA Association Fee	$ 129,096	$ 63,192	$ 8,544	$ 200,832
6 SJVIA Non-Founding Member Fee	$ -	$ -	$ 8,544	$ 8,544
7 Claims Management/Communications	$ 193,644	$ 94,788	$ 12,816	$ 301,248
8 Anthem HMO Pooling	$ 1,311,928	$ -	$ -	$ 1,311,928
9 Anthem HMO Administration/Retention	$ 2,013,276	$ -	$ -	$ 2,013,276
TOTAL FIXED EXPENSES	**$ 4,722,563**	**$ 1,739,676**	**$ 267,513**	**$ 6,729,752**
EXPENSES: Claims				
10 Projected Paid Claims PPO & Non-Cap HMO	$ 33,255,862	$ 17,567,462	$ 2,654,825	$ 53,478,149
11 Anthem MMP HMO Capitation (Fixed Claims Cost)	$ 13,786,551	$ -	$ -	$ 13,786,551
TOTAL CLAIMS EXPENSES	**$ 47,042,413**	**$ 17,567,462**	**$ 2,654,825**	**$ 67,264,701**
12 Delta Dental (6 months beginning 1/1/2013)	$ 2,083,844	$ 684,973	$ -	$ 2,768,817
13 VSP (6 months beginning 1/1/2013)	$ 371,775	$ 73,560	$ -	$ 445,335
	$ 2,455,619	**$ 758,533**	**$ -**	**$ 3,214,152**
TOTAL PROJECTED EXPENSES	**$ 54,220,596**	**$ 20,065,671**	**$ 2,922,338**	**$ 77,208,605**
Beginning IBNR Reserves				$ 9,878,296
14 Rate Stabilization				$ (1,473,160)
Ending IBNR Reserves				**$ 8,405,136**
COMBINED EXPENSES				**$ 75,735,445**

Glossary of Terms:

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6 **SJVIA Non-Founding Member Fee**

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7 **Claims Mitigation**

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.

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SJVIA
San Joaquin Valley Insurance Authority

Meeting Location:
Tulare County Employee Retirement Association Board Chambers
136 N. Akers Street
Visalia, CA 93291
November 9, 2012
9:00 AM

AGENDA DATE: November 9, 2012

ITEM NUMBER 8

SUBJECT Adopt Fiscal Year Budget 2012-2013

REQUEST(S): That the Board adopt the 2012-2013 Fiscal Year Budget

DESCRIPTION:

Beginning with calendar year 2013, several components have been added under the purview of the SJVIA. At the Board's direction, Delta Dental, VSP Vision and Prescription Drug coverage for the County of Fresno has all been included in the SJVIA. Additionally, The City of Tulare joined the SJVIA effective July 1, 2012.

Accordingly, the attached budget reflects the projected costs and revenue for fiscal year 2012-2013 given the above.

FISCAL IMPACT/FINANCING:

None

AGENDA: San Joaquin Valley Insurance Authority

DATE: November 9, 2012

ADMINISTRATIVE SIGN-OFF:

Paul Nerland
SJVIA Manager

Jeffrey Cardell
Assistant SJVIA Manager

BEFORE THE BOARD OF DIRECTORS
SAN JOAQUIN VALLEY INSURANCE AUTHORITY

IN THE MATTER OF Adopt Fiscal Year Budget 2012-2013

RESOLUTION NO. _____
AGREEMENT NO. _____

UPON MOTION OF DIRECTOR _____, SECONDED BY DIRECTOR _____, THE FOLLOWING WAS ADOPTED BY THE BOARD OF DIRECTORS, AT AN OFFICIAL MEETING HELD _____ _____, BY THE FOLLOWING VOTE:

AYES:
NOES:
ABSTAIN:
ABSENT:

ATTEST:

BY: _____

* * * * * * * * * * * * * * * * * * *

That the Board adopted the 2012-2013 Fiscal Year Budget

SJVIA
San Joaquin Valley Insurance Authority

Meeting Location:
Tulare County Employee Retirement Association Board Chambers
136 N. Akers Street
Visalia, CA 93291
November 9, 2012
9:00 AM

AGENDA DATE: November 9, 2012

ITEM NUMBER 9

SUBJECT Investment Options for SJVIA cash reserves

REQUEST(S): That Board receive verbal discussion on the investment options available to the SJVIA

DESCRIPTION:

The SJVIA adopted an investment policy on January 20, 2012. The Policy outlines the primary objectives of the investment pool, as well as provides investment options.

Effective January 1, 2012, the Authority moved from a claims servicing entity to a full risk self-insurance model. Up until that time, the SJVIA did not have reserves sufficient to invest outside of the primary bank accounts and maintain the necessary liquidity to pay claims. Additionally, the balances maintained in the bank accounts were generating interest credits at a level that eliminated or minimized the banking costs.

With the change to the full risk self-insurance model, reserves have been maintained in the SJVIA bank accounts and cash flow reports have been monitored to measure cash flow needs for claims payment and payment of other expenses. Liquidity is one of the primary objectives of the policy, as is return on investment.

AGENDA: San Joaquin Valley Insurance Authority

DATE: November 9, 2012

The attached summary identifies the most viable investment options for excess reserves that maximize investment earnings, while allowing flexibility to move the funds back to the claims bank account for liquidity purposes, if cash flow demands are higher than expected.

FISCAL IMPACT/FINANCING:

ADMINISTRATIVE SIGN-OFF:

_____

Vicki Crow

BEFORE THE BOARD OF DIRECTORS
SAN JOAQUIN VALLEY INSURANCE AUTHORITY

IN THE MATTER OF

RESOLUTION NO. _____
AGREEMENT NO. _____

UPON MOTION OF DIRECTOR _____, SECONDED BY DIRECTOR _____, THE FOLLOWING WAS ADOPTED BY THE BOARD OF DIRECTORS, AT AN OFFICIAL MEETING HELD _____ _____, BY THE FOLLOWING VOTE:

AYES:
NOES:
ABSTAIN:
ABSENT:

ATTEST:

BY: _____

* * * * * * * * * * * * * * * * * * *

SJVIA
San Joaquin Valley Insurance Authority

Meeting Location:
Tulare County Employee Retirement Association Board Chambers
136 N. Akers Street
Visalia, CA 93291
November 9, 2012
9:00 AM

AGENDA DATE: November 9, 2012

ITEM NUMBER 10

SUBJECT Extension of the Consulting Agreement with Gallagher Benefit Services

REQUEST(S): That the Board direct staff to amend the Agreement with Gallagher Benefit Services extending the term one additional year and authorize Board President to execute the amendment effective January 1 through December 31, 2013.

DESCRIPTION:

The SJVIA entered into an agreement with Gallagher Benefit Services (GBS) effective January 1, 2010 through December 31, 2012. The agreement provides that GBS provide services related to strategic planning, financial monitoring and reporting, renewal services, renewal underwriting and rate setting, vendor management, compliance services, member agency support services and program marketing and promotion. Based on the implementation of several new benefit programs (prescription, dental and vision), the status of SJVIA growth and marketing, compliance requirements related to the Patient Protection & Affordable Care Act (PPACA), staff recommends that the Agreement be extended one year. It is also recommended that staff conduct a competitive bidding process in 2013 and return to your Board with recommendations for a new Agreement. Approval of this item will ensure seamless transition of new benefit plans, continuing marketing efforts and compliance with PPACA.

AGENDA: San Joaquin Valley Insurance Authority

DATE: November 9, 2012

FISCAL IMPACT/FINANCING:

GBS's fee to the SJVIA for services amounts to $4.00 per employee per month (PEPM). Based on current enrollment at member entities, GBS would receive approximately $400,000 in 2013. The expense is included as part of the FY 12/13 SJVIA budget and incorporated as part of the Plan Year 2013 health insurance rates.

ADMINISTRATIVE SIGN-OFF:

Paul Nerland
SJVIA Manager

Jeffrey Cardell
Assistant SJVIA Manager

BEFORE THE BOARD OF DIRECTORS
SAN JOAQUIN VALLEY INSURANCE AUTHORITY

IN THE MATTER OF Extension of the Consulting Agreement with Gallagher Benefit Services

RESOLUTION NO. _____
AGREEMENT NO. _____

UPON MOTION OF DIRECTOR _____, SECONDED BY DIRECTOR _____, THE FOLLOWING WAS ADOPTED BY THE BOARD OF DIRECTORS, AT AN OFFICIAL MEETING HELD _____ _____, BY THE FOLLOWING VOTE:

AYES:
NOES:
ABSTAIN:
ABSENT:

ATTEST:

BY: _____

* * * * * * * * * * * * * * * * * * *

That the Board directed staff to amend the Agreement with Gallagher Benefit Services extending the term one additional year and authorized the Board President to execute the amendment effective January 1 through December 31, 2013.

SJVIA
San Joaquin Valley Insurance Authority

Meeting Location:
Tulare County Employee Retirement Association Board Chambers
136 N. Akers Street
Visalia, CA 93291
November 9, 2012
9:00 AM

AGENDA DATE: November 9, 2012

ITEM NUMBER 11

SUBJECT Health Care Reform Impact on SJVIA Health Plans

REQUEST(S): That the Board receive the attached Health Care Reform Report.

DESCRIPTION:
Health Care Reform, also referred to as the Patient Protection and Affordable Care Act (PPACA), continues to be a focus for SJVIA staff and Gallagher Benefit Services as new regulations continue to be issued as this new law is interpreted. Below is a summary of the items attracting the most interest based on impact to the SJVIA. Further, attached is additional information explaining this legislation and the impact on health plans, employers, and individuals.

Minimum Loss Ratio Rebates

This provision of the Act requires that insurance carriers with health plans sold to individuals and small employers have a minimum loss ratio ("MLR") of 80% and that health plans sold to large employers (plans with 101 or more employees) have a MLR of 85%. This essentially means that carriers must pay out 80% or 85% of premium, depending on the size of plan, in the form of health care benefits. If an insurance carrier fails to meet the required MLR, that carrier must rebate any excess premium back to enrollees under the plans. The SJVIA operates at an equivalent MLR of greater than 90%. Further,

these new requirements only affect fully insured health coverage and therefore, the SJVIA plans are exempt.

W2 Reporting

Large Employers, including all current SJVIA member entities, are required, as of the 2012 tax year, to report the aggregate cost of applicable employer sponsored coverage on the 2012 W-2s. This reporting is informational only and does not create additional taxable income at this time. The purpose of the reporting is to provide useful and comparable consumer information to employees on the cost of their health care coverage.

Clinical Effectiveness Research Fee (CER Fee)

The Act established the Patient-Centered Outcomes Research Institute. Funded by the Patient-Centered Outcomes Research Trust Fund, the institute will assist patients, clinicians, purchasers and policy-makers in making informed health decisions through the dissemination of comparative clinical effectiveness research findings. The trust fund will be funded in part by CER fees paid by health insurers and plan sponsors. The fee is imposed on the SJVIA for each plan year beginning with the current 2012 plan year and is scheduled to continue through 2018. The fee for 2012 plan year is $1 multiplied by the average number of lives covered under the plan for the plan year. For plan year 2013 the fee increases to $2. The fee amount will be indexed annually starting in 2014. These fees which are to be paid in July of each year will have minimal impact on the overall cost of the SJVIA and will not significantly impact rates.

Medicare Payroll Tax

Starting in 2013, employees with income in excess of $200,000 and couples filing jointly with incomes in excess of $250,000 will see an increase of 0.9% in their Medicare tax. However, employers will only be required to withhold the additional FICA taxes on amounts exceeding these thresholds for employees to whom with pay in excess of $200,000. The Medicare tax (a total of 3.8%) will also be applied to net investment income for individuals or couples meeting the above income thresholds.

Required Notices- Health Exchange

Employers are required to notify employees by March 1, 2013 of the existence of Health Insurance Exchanges. These Exchanges are intended for individuals to purchase coverage beginning in 2014 when the individual coverage mandate takes effect. Additional legislative guidance is pending and more detail will be communicated when available.

Reinsurance Fee

A transitional reinsurance program will be established in each State to help stabilize premiums for coverage in the individual market during the benefit years 2014 through 2016. Under this provision, the SJVIA must make contributions for each individual covered to support reinsurance payments to individual market insurers that cover high-cost individuals. The SJVIA must submit these contributions to HHS on a quarterly basis beginning January 15, 2014. Guidance on the amount of the fee is not yet available but HHS has indicated it should be released by the fall of this year. For the first year of the program, estimates have ranged from $60 per person to as high as $100 per person annually. SJVIA cost estimates will be developed when this information is available and will be incorporated into future budget projections. Using 2013 plan rates, it is estimated this Reinsurance Fee will result in a premium increase ranging from 0.6 to 3.1 %

Cadillac Tax

In 2018 the "Cadillac Plan" tax will take effect. It is determined based on the cost of the coverage provided. The cost of a plan with single coverage that exceeds $10,200 annually, or family coverage that exceeds $27,500 annually, will be considered a "Cadillac Plan" beginning in 2018. At that time, coverage with a cost that exceeds those amounts will be subject to a 40% excise tax on the value of coverage that exceeds the above amounts. The tax is imposed on insurers for insured plans. Generally, for self-funded plans, the tax will be paid by the sponsoring employer. Much more guidance is expected on this provision.

Part-Time and Temporary Employee Impact

In 2014 the Employer Mandate to offer coverage or pay a penalty takes effect. This is applicable to employers with at least 50 full time employees. The annual penalty is $2,000 for each full-time equivalent employee not covered. Special consideration for part-time and temporary employees will need to be

given for purposes of determining full-time employees. They are defined as those employees who work on average 30 hours per week. Analysis for each member entity of the impact of this provision will be developed in 2013.

Women's Preventative Services

Beginning with Plan Year 2013 the SJVIA will cover women's preventative services at no cost on non-grandfathered plans, most notably including oral contraceptives. Following is the list of required women's preventive services to be provided without cost sharing by the covered member:

(1) Well-woman visits;

(2) Gestational diabetes screening for women 24 to 28 weeks pregnant;

(3) High-risk human papilloma virus ("HPV") DNA testing for women who are 30 or older;

(4) Sexually transmitted infection ("STI") counseling;

(5) Contraception and contraceptive counseling (including all FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling);

(6) Breastfeeding support, supplies, and counseling; and7) Domestic violence screening.

Gallagher Benefit Services will continue to work with SJVIA staff to monitor and provide clear guidance to ensure timely compliance with Health Care Reform legislation. Developments and findings will be reported to the SJVIA Board on a regular and ongoing basis.

FISCAL IMPACT/FINANCING:

The legislation and regulation implementing the Patient Protection and Affordable Care Act will result in increased expenses for the SJVIA that will be factored into the development rates for each coverage option.

ADMINISTRATIVE SIGN-OFF:

Paul Nerland
SJVIA Manager

Jeffrey Cardell
Assistant SJVIA Manager

BEFORE THE BOARD OF DIRECTORS
SAN JOAQUIN VALLEY INSURANCE AUTHORITY

IN THE MATTER OF Health Care Reform Impact on SJVIA Health Plans

RESOLUTION NO. _____
AGREEMENT NO. _____

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AYES:
NOES:
ABSTAIN:
ABSENT:

ATTEST:

BY: _____

* * * * * * * * * * * * * * * * * * *

That the Board received the attached Health Care Reform report.

Gallagher Benefit Services, Inc.
thinking ahead

Healthcare Reform Update for:

SJVIA

www.gallagherbenefits.com

November 9, 2012

Healthcare Reform - What's Happened

- Adult children coverage to age 26
- No lifetime or annual limits
- No pre-existing condition for dependents under 19
- Preventive care coverage
- Slight dip in cost trend

Post Supreme Court Ruling

Business as usual:

- Summary of Benefits and Coverage (SBC)
  - **New Hires & Next Open Enrollment**
- W-2 Reporting on value of health coverage
  - **Report aggregate cost of employer sponsored coverage in 2012**
- New Fees & Taxes - CER Fee & Medicare Tax on High Earners
  - **CER paid by carriers / Medicare tax increase on earners over $200,000 single and $250,000 joint filers**
- $2,500 FSA Limit
  - **Maximum for unreimbursed health expenses beginning in 2013**
- Exchange Notification
  - **Notice still being developed to be sent by Member Entity in March 2013**
- Minimum Loss Ratio Rebates
  - **Claims to premium ratios – 85% large group; 80% small group**
- Women's Preventive Services
  - **Impacts Plans beginning on 1/1/2013**

2014: The Year of Big Changes (Maybe?)

- Early retiree reinsurance
- High-risk pools

- OTC drug reimbursements
- HSA penalties
- Employee notification requirements

- Comparative Effectiveness Research Fee
- FSA limits to $2,500
- Itemized medical expense deduction changes
- Medicare tax increase
- Part D drug subsidy deduction eliminated
- Employee Exchange notification

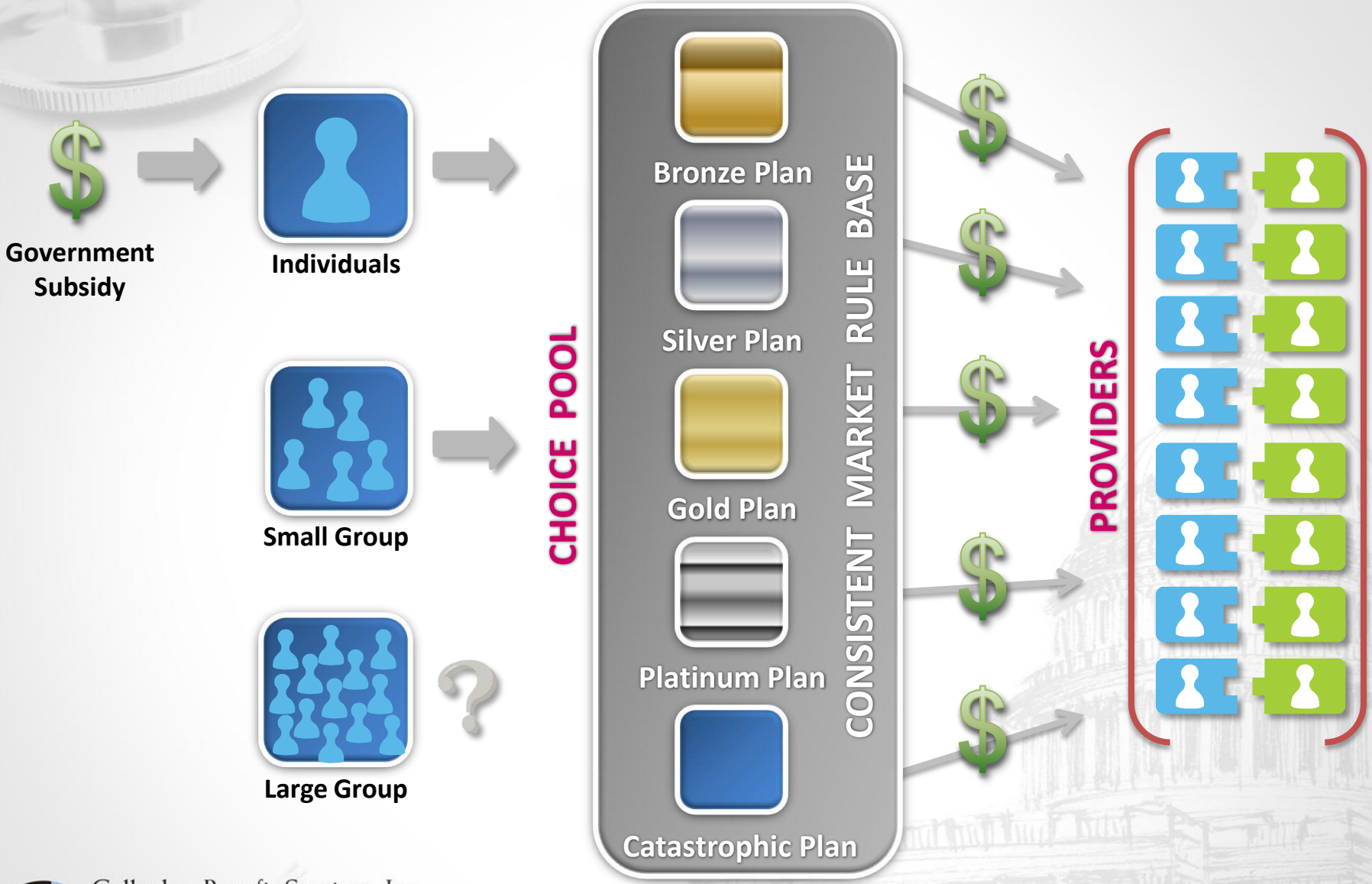
6/23/10	9/23/10	1/1/11	1/1/12	1/1/13	1/1/14+

- Coverage expansion mandates
- Patient protections

- W-2 Reporting
- "CLASS" LTC program (Suspended)
- Summary of Benefits & Coverage

- Employer and individual mandates
- Insurance exchanges
- Patient protections
- "Cadillac" excise tax (2018)
- Reinsurance & insurer fees

Exchanges - 2014



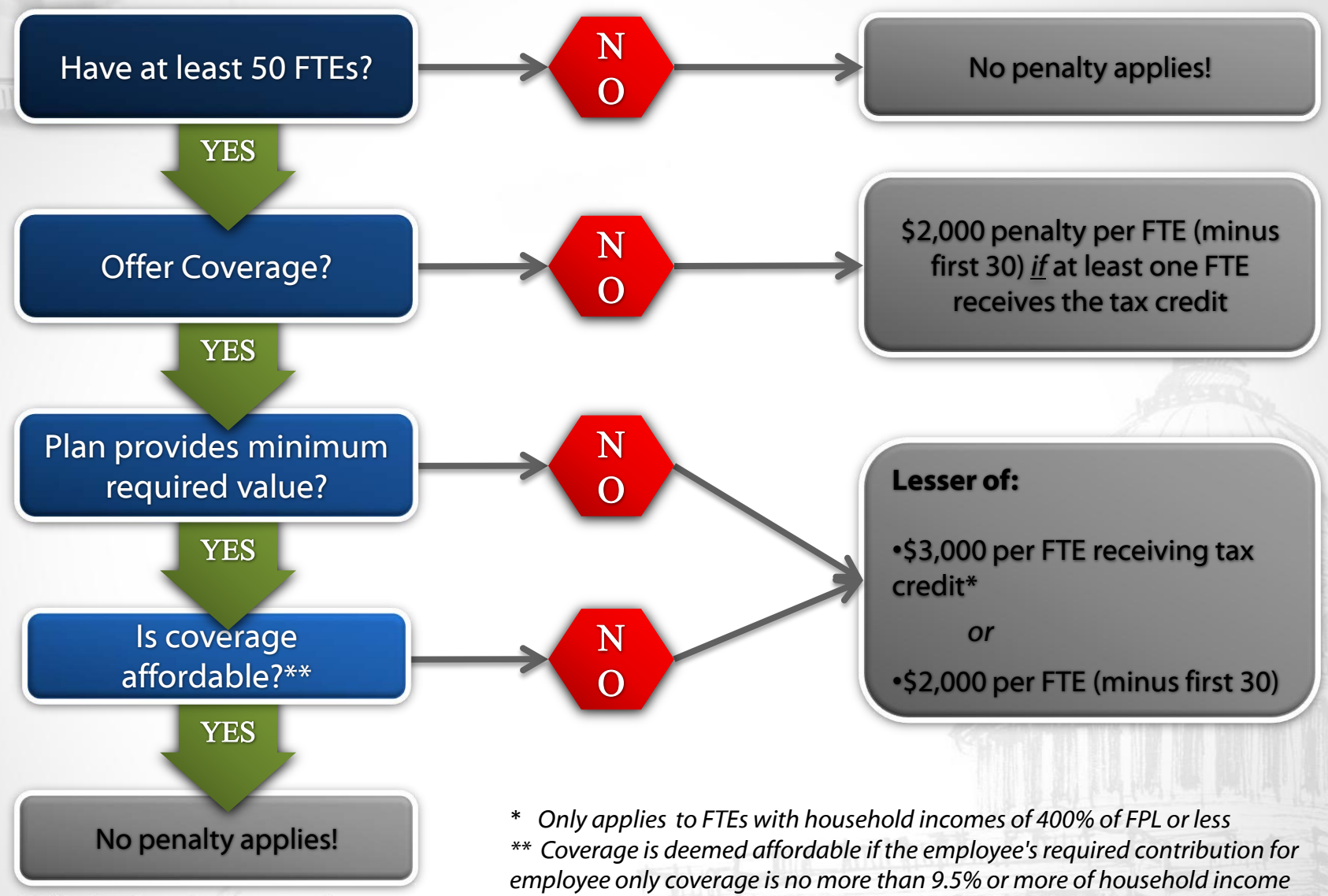
California's Health Benefit Exchange

- Independent public entity
- **2010:** $1 million planning grant
- **August 2011:** $39 million Level I federal grant for Exchange implementation
- **August 2011:** Five member board appointed by Governor and Legislature
- **June 2012:** $196.4 million additional Level 1 grant to fund implementation through June 2013
- **January 2013:** Certification by HHS
- **July 2013:** Enroll starting summer of 2013
- **January 2014:** 1st effective date for coverage
- **January 2015:** Exchange required to be financially self-supporting.

CA.GOV CALIFORNIA HEALTH BENEFIT EXCHANGE

www.healthexchange.ca.gov

Employer Shared Responsibility



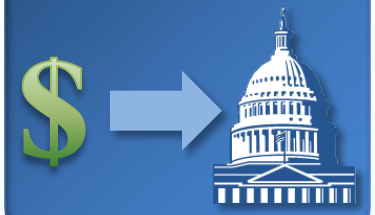
* *Only applies to FTEs with household incomes of 400% of FPL or less*

** *Coverage is deemed affordable if the employee's required contribution for employee only coverage is no more than 9.5% or more of household income regardless of the employee's required contribution to coverage eligible dependents.*

“Cadillac” Tax – 2018

COBRA Rate ≥ $10,200 for individual or $27,500 for family

Excise Tax



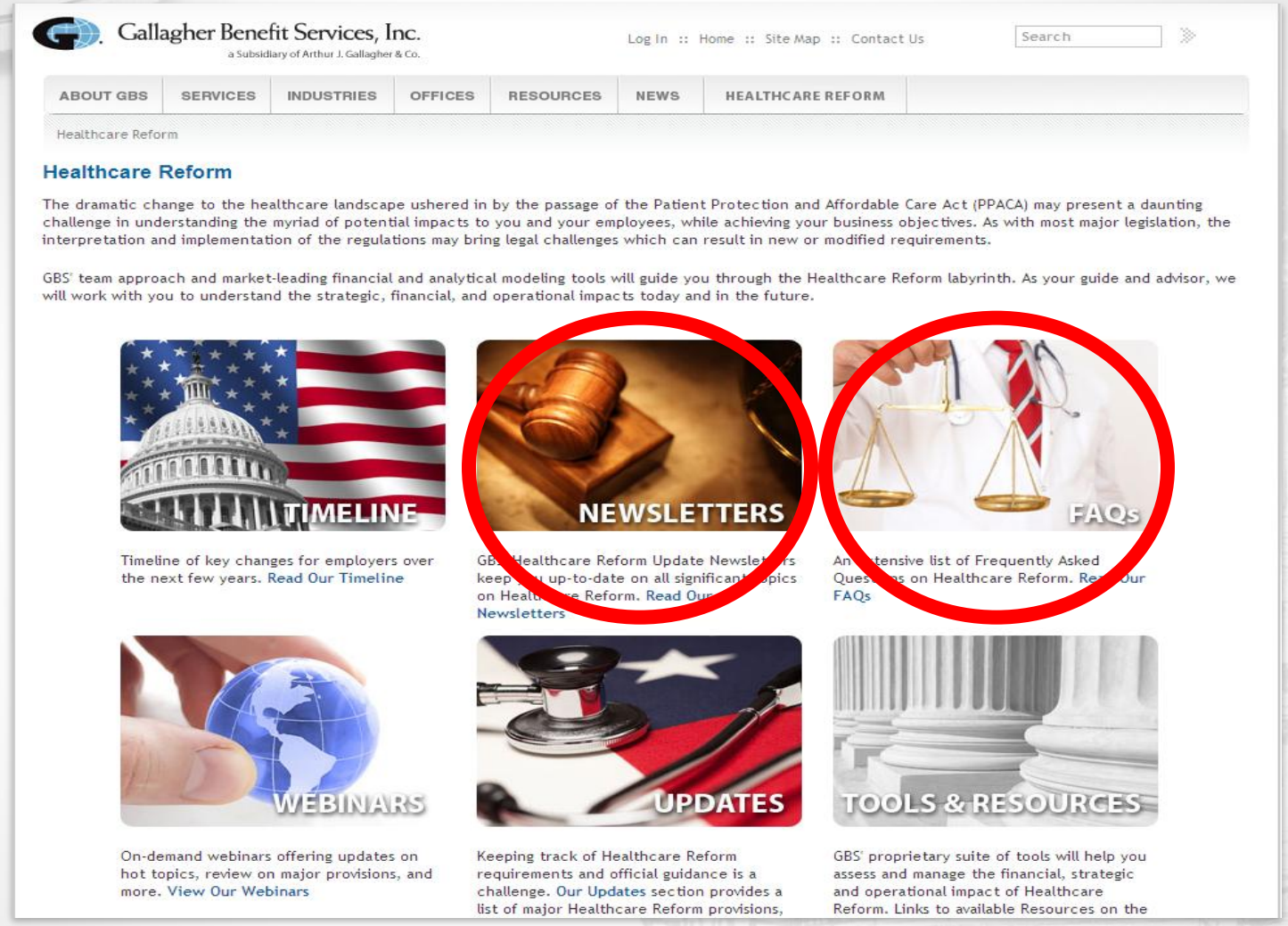
= 40% of plan value that exceeds threshold

Special Provisions

- High risk professions
- Early retirees
- Age & Gender

Online Healthcare Reform Resources

GBShealthcarereform.com



SJVIA
San Joaquin Valley Insurance Authority

Meeting Location:
Tulare County Employee Retirement Association Board Chambers
136 N. Akers Street
Visalia, CA 93291
November 9, 2012
9:00 AM

AGENDA DATE: November 9, 2012

ITEM NUMBER 12

SUBJECT SJVIA Growth and Savings Potential

REQUEST(S): That the Board receive and file information on SJVIA growth and savings potential.

DESCRIPTION:

This report is based on questions from your Board as to potential savings through the growth of the SJVIA.

SJVIA – Advantages to Growth

The SJVIA realizes many benefits from membership growth which can come in two distinct forms:

- First, growth is realized when new agencies join the JPA for medical plan coverage, as with the recent additional of the City of Tulare;
- Second, the JPA can grow by offering additional benefit programs (dental, vision, life, disability) to current and future SJVIA members, some of these are options currently under review.

Below we address each of these types of growth separately, as they have different impact on the current and future SJVIA plan offerings.

AGENDA: San Joaquin Valley Insurance Authority

DATE: November 9, 2012

Medical Plan Membership Growth

Growth in the current medical plan offerings provides several specific advantages to the SJVIA member agencies. Some of these growth advantages have already been realized and others will be realized as the SJVIA continues to grow in the future. The key advantages to growth of the medical plan membership for the SJVIA are outlined below:

1. **Improved Underwriting Risk**

The goal when developing renewal rates for the current SJVIA members, or rates for future members as they consider joining the SJVIA, is to develop rates that accurately represent the cost of the benefits offered through the SJVIA. This is completed by applying the approved underwriting model, developed by actuaries, to develop the expected claim costs using all the demographic and claims information available to the SJVIA.

While the model has proven very accurate, there will always be some level of variance between the projected and actual results under any plan. To cover this variance the rate projections include "margin", a variable designed to cover any fluctuation in the actual versus expected claim costs. The larger and more diverse the group becomes, the more predictable the overall claims expense becomes, reducing the need to build "margin" into the rating calculations. For general rating purposes medical benefit pools generally need to have 20,000+ employees before all margin is removed from the rating calculation.

So membership growth provides a greater degree of predictability and stability in the rates from year to year; something that benefits all members in the SJVIA. The key to making this work long-term is remaining diligent in the application of the underwriting model to ensure that new members brought into the SJVIA are rated appropriately when they join. This allows the current and future SJVIA members to benefit from the overall growth, while also ensuring the current members are not hurt by the addition of new agencies.

One additional benefit of growth in managing the spread of risk, is that as the SJVIA grows, the overall program reserves also grow. With larger program reserves the Board is in a better position to manage cost increases from year to year, by using excess reserves to offset costs in years with higher increases. This is a practice used by CalPERS and many JPAs, but can only be done if the programs are growing and producing the required reserve amounts, something far more likely to happen with a larger risk pool.

2. Reductions in Vendor's Fixed Costs

One direct benefit from growth is reductions in the plan's fixed costs. This was part of the initial reason to form the SJVIA, both Fresno and Tulare Counties could benefit from reduced fixed cost factors under the contracted rates that were negotiated based on the size of the combined group. This has resulted in fixed costs under the SJVIA of less than 10% of total costs; something that would not be available to the participating agencies on a stand-alone basis. The fixed cost factors include the Anthem Blue Cross, HealthNow/Blue Shield, Chimenti, HighMark, US Script, Wellness, and Gallagher contracts.

As there is additional growth in the plans, the SJVIA is also in a better position to negotiate reductions, or the elimination of any fixed cost fee renewals. In some instances, as growth hits specific thresholds, there is even an opportunity to negotiate for additional fixed cost fee reductions.

3. Recover SJVIA Operating Expenses

The SJVIA has internal operating costs for services (finance, legal, administration, & management) that have been provided by Fresno and Tulare County staff. This time has been partially paid for through the collection of a per-head SJVIA fee administration that is built into the rates. However, this fee does not cover all of the time spent by staff members at Fresno and Tulare Counties for the SJVIA program administration or retroactive start-up costs.

As there is additional growth in the plans, the internal administration work will not grow as significantly, allowing the per-employee fee collected by the SJVIA to better cover the internal plan administration services currently being delivered through County personnel. In this way the growth helps ensure that Fresno and Tulare County will be fully compensated for the staff time spent managing the SJVIA.

Over the longer term, additional growth and the additional SJVIA administration fees collected as a result of this growth will also allow the SJVIA to hire a permanent Executive Director and staff to manage the JPA, apart from the current County staff. While it may take some time to reach this level of growth, it is something the SJVIA can aim for as your membership increases.

4. Broader Plan Options / Flexibility

The initial SJVIA medical plans were all offered through contracts and provider networks with Anthem Blue Cross. With the addition of the City of Tulare, the SJVIA was able to activate a second medical contract with Blue Shield/HealthNow. The ability to offer multiple medical plan options is only available with additional growth, as it is important to maintain a level of critical mass with all of the vendors.

Having more than one medical plan vendor provides the SJVIA an option to leverage negotiations around contract renewals that you do not have with only one vendor in place. It also allows the SJVIA to have more flexibility as you look to pursue other agencies for future growth. This may become more critical in the future, ensuring the SJVIA does not have "all eggs in one basket" with regard to the key medical plan providers.

Offering Additional SJVIA Benefit Programs

Growth in the number of benefit plans offered through the JPA will provide many of the same advantages outlined for growth in the medical plans above. This would include the offering of dental, vision, life and disability programs. Below we outline like key advantages of offering each of these types of programs under the JPA umbrella.

1. Dental and Vision Coverage

Dental and Vision coverage is generally self-funded within a JPA and does not represent a significant underwriting risk to the JPA. Many JPAs see this as an advantage to offer these programs to round out their benefit options and stabilize the more volatile medical benefit plans.

- Allow agencies the ability to share risk under a larger, more statistically credible risk pool.
- Ability to develop overall reserves on programs with more predictable cash-flow, smoothing out fluctuations in overall SJVIA reserve requirements.
- Allow agencies to reduce plan administrative costs.
- Provide an option to collect additional SJVIA administrative fees to offset current staff costs.
- Ability of the SJVIA to provide a broader range of the benefit solutions to member agencies.

2. Life and Disability Coverage

Life and Disability coverage is generally fully insured even within the JPA setting, so the advantages are slightly different.

- Shared claims experience under the JPA can allow groups to benefit from the stability of the larger group pool at renewal.
- Generally allow agencies to reduce costs based on premium volume rating factors that are directly tied to overall group size.
- Provide an option to collect additional SJVIA administrative fees to offset current staff costs.
- Ability of the SJVIA to provide a broader range of the benefit solutions to member agencies.

These additional programs effectively allow the SJVIA to spread its operating costs over a greater number of plans and at the same time give members and opportunity to reduce the costs to their agency on a stand-alone basis. This provides a win-win for both current and future members.

Risk of Pursuing Growth

The downside risk to pursuing additional members in the SJVIA is really limited to a couple of manageable factors.

First, over time there may be a loss of control of the initial agencies. This would only happen if the Board was expanded or reconfigured to provide representation beyond the two founding agencies. Currently this is not an issue based on how the SJVIA agreements are structured to provide Board representation from only Fresno and Tulare Counties.

We only mention this point based on the fact that as other JPAs have grown they have also faced pressure to open up their Board to new member representatives as well.

Second, if the groups brought into the SJVIA are not properly screened and rated, they could hurt the overall integrity of the SJVIA pool. While this is a significant concern, we believe it is addressed in the development and application of a sound actuarial based underwriting model to ensure that new members are rated properly and "carry their weight" when joining the SJVIA.

Summary - SJVIA Growth

Based on the issues covered above, we believe it is in the best interest of all SJVIA members to continue to pursue additional growth in both the medical plans, as well as by introducing additional plan coverages as this becomes feasible.

We believe that properly managed growth will produce cost advantages to all SJVIA agencies, especially the founding JPA members, Fresno and Tulare Counties as they look to offset the cost of services provided to the JPA in these initial years of operation.

FISCAL IMPACT/FINANCING:

None

ADMINISTRATIVE SIGN-OFF:

Paul Nerland
SJVIA Manager

Jeffrey Cardell
Assistant SJVIA Manager

BEFORE THE BOARD OF DIRECTORS
SAN JOAQUIN VALLEY INSURANCE AUTHORITY

IN THE MATTER OF SJVIA Growth and Savings Potential

RESOLUTION NO. _____
AGREEMENT NO. _____

UPON MOTION OF DIRECTOR _____, SECONDED BY DIRECTOR _____, THE FOLLOWING WAS ADOPTED BY THE BOARD OF DIRECTORS, AT AN OFFICIAL MEETING HELD _____ _____, BY THE FOLLOWING VOTE:

AYES:
NOES:
ABSTAIN:
ABSENT:

ATTEST:

BY: _____

* * * * * * * * * * * * * * * * * * *

That the Board received and filed information on SJVIA growth and savings potential.