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

Beth Bandy
Director of Personnel Services
2220 Tulare St, 16th Floor
Fresno, CA 93721
Bbandv@co.fresno.ca.us

SJVIA

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)*	20%	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	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.

Anthem Blue Cross

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 Deductibles waived for D & P?	$50 per person / $150 per family each calendar year 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		