



BOARD OF DIRECTORS

STEVE BRANDAU

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Exhibit A

County of Tulare

**Plan Year 2024
Benefit Summaries**

- Anthem Blue Cross PPO 0
- Anthem Blue Cross PPO 500
- Anthem Blue Cross PPO 750
- Anthem Blue Cross HDHP 2500
- EmpiRx Health Prescription Benefit PPO
- EmpiRx Health Prescription Benefit HDHP
- Kaiser Permanente HMO
- Kaiser Permanente HDHP
- Delta Dental PPO
- Delta Dental DHMO
- VSP Vision Benefit

Your summary of benefits



Anthem® Blue Cross

Your Plan: San Joaquin Valley Insurance Authority (JPA) - County of Tulare: PPO 0

Your Network: Prudent Buyer PPO

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	\$0 person	\$500 person / \$1,000 family
Overall Out-of-Pocket Limit	\$2,000 person / \$4,000 family	\$5,000 person / \$10,000 family
<p>The family deductible and out-of-pocket limit are embedded, meaning the cost shares of one family member will be applied to the per person deductible and per person out-of-pocket limit; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket limit. No one member will pay more than the per person deductible or per person out-of-pocket limit.</p> <p>Your copays, coinsurance and deductible count toward your out of pocket limit(s).</p> <p>In-Network and Non-Network out-of-pocket limit amounts are separate and do not accumulate toward each other.</p>		
<p>Doctor Visits (virtual and office) <i>You are encouraged to select a Primary Care Physician (PCP).</i></p>		
<p>Virtual Visits from online provider LiveHealth Online <i>for urgent/acute medical and mental health and substance abuse disorder care via www.livehealthonline.com are covered at \$20 copay per visit.</i></p>		
<p>Primary Care (PCP) and Mental Health and Substance Abuse Disorder Care <i>virtual and office</i></p>	\$20 copay per visit	30% coinsurance after deductible is met
<p>Specialist Care <i>virtual and office</i></p>	\$20 copay per visit	30% coinsurance after deductible is met
<p>Other Practitioner Visits</p>		
<p>Routine Maternity Care (Prenatal and Postnatal)</p>	\$20 copay per visit	30% coinsurance after deductible is met
<p>Retail Health Clinic <i>for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.</i></p>	\$20 copay per visit	30% coinsurance after deductible is met
<p>Manipulation Therapy <i>Coverage is limited to 12 visits per benefit period.</i></p>	\$25 copay per visit	30% coinsurance after deductible is met

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

Questions: (855) 333-5730 or visit us at www.anthem.com/ca

CA/LG/San Joaquin Valley Insurance Authority (JPA) - County of Tulare: PPO 0/02P4/01-01-2023

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Acupuncture <i>Coverage is limited to 20 visits per benefit period.</i>	\$25 copay per visit	\$25 copay per visit after deductible is met
<u>Other Services in an Office</u> Allergy Testing Prescription Drugs <i>Dispensed in the office</i> <i>Maximum of \$250 member cost share per drug.</i> Surgery	10% coinsurance after deductible is met 10% coinsurance after deductible is met 10% coinsurance after deductible is met	30% coinsurance after deductible is met 30% coinsurance after deductible is met 30% coinsurance after deductible is met
Preventive care / screenings / immunizations	No charge	30% coinsurance after deductible is met
Preventive Care for Chronic Conditions <i>per IRS guidelines</i>	No charge	30% coinsurance after deductible is met
<u>Diagnostic Services</u> Lab Office Freestanding Lab Outpatient Hospital	No charge No charge No charge	30% coinsurance after deductible is met 30% coinsurance after deductible is met 30% coinsurance after deductible is met
X-Ray Office Freestanding Radiology Center Outpatient Hospital	No charge No charge No charge	30% coinsurance after deductible is met 30% coinsurance after deductible is met 30% coinsurance after deductible is met
Advanced Diagnostic Imaging <i>for example: MRI, PET and CAT scans</i> Office Freestanding Radiology Center Outpatient Hospital	10% coinsurance 10% coinsurance 10% coinsurance	30% coinsurance after deductible is met 30% coinsurance after deductible is met 30% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><u>Emergency and Urgent Care</u></p> <p>Urgent Care <i>includes doctor services. Additional charges may apply depending on the care provided.</i></p> <p>Emergency Room Facility Services <i>Copay waived if admitted.</i></p> <p>Emergency Room Doctor and Other Services</p> <p>Ambulance</p>	<p>\$20 copay per visit</p> <p>10% coinsurance after deductible is met</p> <p>10% coinsurance</p> <p>10% coinsurance</p>	<p>30% coinsurance after deductible is met</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p>
<p><u>Outpatient Mental Health and Substance Abuse Disorder Care at a Facility</u></p> <p>Facility Fees Doctor Services</p> <p>Doctor Office Visit</p>	<p>10% coinsurance</p> <p>\$20 copay per visit</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>
<p><u>Outpatient Surgery</u></p> <p>Facility Fees</p> <p>Hospital</p> <p>Ambulatory Surgical Center</p> <p>Doctor and Other Services</p> <p>Hospital</p>	<p>10% coinsurance</p> <p>10% coinsurance</p> <p>10% coinsurance</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>
<p><u>Hospital (Including Maternity, Mental Health and Substance Abuse Disorder)</u></p> <p><i>Anthem's maximum payment is up to \$600 per day for non-emergency Inpatient admissions to non-network providers.</i></p> <p>Facility Fees</p> <p>Physician and other services <i>including surgeon fees</i></p>	<p>10% coinsurance</p> <p>10% coinsurance</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>
<p>Home Health Care</p> <p><i>Coverage is limited to 100 visits per benefit period.</i></p>	<p>10% coinsurance</p>	<p>10% coinsurance after deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p>Rehabilitation and Habilitation services <i>including physical, occupational and speech therapies. Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 40 visits per benefit period. Coverage for rehabilitative and habilitative speech therapy is limited to 20 visits per benefit period.</i></p> <p>Office</p> <p>Outpatient Hospital</p>	<p>\$25 copay per visit</p> <p>10% coinsurance</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>
<p>Pulmonary rehabilitation</p> <p>Office</p> <p>Outpatient Hospital</p>	<p>\$25 copay per visit</p> <p>10% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>
<p>Cardiac rehabilitation <i>Coverage is limited to 36 visits per benefit period</i></p> <p>Office</p> <p>Outpatient Hospital</p>	<p>\$25 copay per visit</p> <p>10% coinsurance</p>	<p>30% coinsurance after deductible is met</p> <p>30% coinsurance after deductible is met</p>
<p>Dialysis/Hemodialysis <i>office and outpatient hospital</i></p>	<p>10% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p>
<p>Chemo/Radiation Therapy <i>office and outpatient hospital</i></p>	<p>10% coinsurance after deductible is met</p>	<p>30% coinsurance after deductible is met</p>
<p>Skilled Nursing Care (facility) <i>Coverage is limited to 100 days per benefit period.</i></p>	<p>10% coinsurance</p>	<p>10% coinsurance after deductible is met</p>
<p>Inpatient Hospice</p>	<p>No charge</p>	<p>0% coinsurance after deductible is met</p>
<p>Durable Medical Equipment</p>	<p>10% coinsurance</p>	<p>30% coinsurance after deductible is met</p>
<p>Prosthetic Devices</p>	<p>10% coinsurance</p>	<p>30% coinsurance after deductible is met</p>

Notes:

- If you have an office visit with your Primary Care Physician, Specialist or Urgent Care at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under “Outpatient Facility Services”.
- Costs may vary by the site of service. Other cost shares may apply depending on services provided. Check your Certificate of Coverage for details.
- Outpatient Facility tests and treatments are limited to \$350 per admission for Non-Network Providers. Includes: Diagnostic Services; X-ray; Surgery; Rehabilitation; Habilitation; Cardiac Therapy; Surgery at Ambulatory Surgical Centers.
- Coverage includes standard fertility preservation services as a basic healthcare service including but are not limited to, injections, cryopreservation and storage for both male and female members when a medically necessary treatment may cause iatrogenic infertility. Member cost share for fertility preservation services is based on provider type and service rendered.

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

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Get help in your language

Language Assistance Services



Curious to know what all this says? We would be too. Here's the English version:

IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call right away at 1-888-254-2721. (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

Spanish

IMPORTANTE: ¿Puede leer esta carta? De lo contrario, podemos hacer que alguien lo ayude a leerla. También puede recibir esta carta escrita en su idioma. Para obtener ayuda gratuita, llame de inmediato al 1-888-254-2721. (TTY/TDD: 711)

Arabic

مهم: هل يمكنك قراءة هذه الرسالة؟ إذا لم تستطع، فيمكننا الاستعانة بشخص ما ليساعدك على قراءتها. كما يمكنك أيضًا الحصول على هذا الخطاب مكتوبًا بلغتك. للحصول على المساعدة المجانية، يُرجى الاتصال فورًا بالرقم 1-888-254-2721 (TTY/TDD: 711).

Armenian

ՌԻՇԱԴՐՈՒԹՅՈՒՆ. Կարողանո՞ւմ եք ընթերցել այս նամակը: Եթե ոչ, մենք կարող ենք տրամադրել ինչ-որ մեկին, ով կօգնի Ձեզ՝ կարդալ այն: Կարող ենք նաև այս նամակը Ձեզ գրավոր տարբերակով տրամադրել: Անվճար օգնություն ստանալու համար կարող եք անհապաղ զանգահարել 1-888-254-2721 հեռախոսահամարով: (TTY/TDD: 711)

Chinese

重要事項: 您能看懂這封信函嗎? 如果您看不懂, 我們能夠找人協助您。您有可能可以獲得以您的語言而寫的本信函。如需免費協助, 請立即撥打1-888-254-2721。(TTY/TDD: 711)

Farsi

مهم: آیا می‌توانید این نامه را بخوانید؟ اگر نمی‌توانید، می‌توانیم شخصی را به شما معرفی کنیم تا در خواندن این نامه شما را کمک کند. همچنین می‌توانید این نامه را به صورت مکتوب به زبان خودتان دریافت کنید. برای دریافت کمک رایگان، همین حالا با شماره 1-888-254-2721 تماس بگیرید. (TTY/TDD: 711)

Hindi

महत्वपूर्ण: क्या आप यह पत्र पढ़ सकते हैं? अगर नहीं, तो हम आपको इसे पढ़ने में मदद करने के लिए किसी को उपलब्ध करा सकते हैं। आप यह पत्र अपनी भाषा में लिखवाने में भी सक्षम हो सकते हैं। निःशुल्क मदद के लिए, कृपया 1-888-254-2721 पर तुरंत कॉल करें। (TTY/TDD: 711)

Hmong

TSEEM CEEB: Koj puas muaj peev xwm nyeem tau daim ntawv no? Yog hais tias koj nyeem tsis tau, peb muaj peev xwm cia lwm tus pab nyeem rau koj mloog. Tsis tas li ntawd tej zaum koj kuj tseem yuav tau txais daim ntawv no sau ua koj hom lus thiab. Txog rau kev pab dawb, thov hu tam sim no rau tus xov tooj 1-888-254-2721. (TTY/TDD: 711)

Japanese

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重要：この書簡を読めますか？もし読めない場合には、内容を理解するための支援を受けることができます。また、この書簡を希望する言語で書いたものを入手することもできます。次の番号にいますぐ電話して、無料支援を受けてください。
1-888-254-2721 (TTY/TDD: 711)

Khmer
សំខាន់៖ តើអ្នកអាចអានលិខិតនេះទេ? បើមិនអាចទេ យើងអាចឱ្យនរណាម្នាក់អានជូនអ្នក។ អ្នកក៏អាចទទួលបានលិខិតនេះដោយសេរីដោយមិនមានការបង្ខំអ្នកផងដែរ។ ដើម្បីទទួលបានជំនួយភតគិតផ្លូវ សូមហៅទូរស័ព្ទភ្លាមៗទៅលេខ 1-888-254-2721។ (TTY/TDD: 711)

Korean
중요: 이 서신을 읽으실 수 있으십니까? 읽으실 수 없을 경우 도움을 드릴 사람이 있습니다. 귀하가 사용하는 언어로 쓰여진 서신을 받으실 수도 있습니다. 무료 도움을 받으시려면 즉시 1-888-254-2721로 전화하십시오. (TTY/TDD: 711)

Punjabi
ਮਹੱਤਵਪੂਰਨ: ਕੀ ਤੁਸੀਂ ਇਹ ਪੱਤਰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇ ਨਹੀਂ, ਤਾਂ ਅਸੀਂ ਇਸ ਨੂੰ ਪੜ੍ਹ ਕੇ ਿਵੱਚ ਤੁਹਾਡੀ ਮਦਦ ਲਈ ਿਕਸੇ ਨੂੰ ਬੁਲਾ ਸਕਦਾ ਹਾਂ ਤੁਸੀਂ ਸ਼ਾਇਦ ਪੱਤਰ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਿਵੱਚ ਿਲਿਖਿਆ ਹੋਇਆ ਵਜ਼ੀ ਪੜ੍ਹਾ ਾਪ ਕਰ ਸਕਦੇ ਹੋ। ਮੁਫਤ ਮਦਦ ਲਈ, ਿਕਰਪਾ ਕਰਕੇ ਫੋਨ 1-888-254-2721 ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD: 711)

Russian
ВАЖНО. Можете ли вы прочитать данное письмо? Если нет, наш специалист поможет вам в этом. Вы также можете получить данное письмо на вашем языке. Для получения бесплатной помощи звоните по номеру 1-888-254-2721. (TTY/TDD: 711)

Tagalog
MAHALAGA: Nababasa ba ninyo ang liham na ito? Kung hindi, may taong maaaring tumulong sa inyo sa pagbasa nito. Maaari ninyo ring makuha ang liham na ito nang nakasulat sa ginagamit ninyong wika. Para sa libreng tulong, mangyaring tumawag kaagad sa 1-888-254-2721. (TTY/TDD: 711)

Thai
หมายเหตุสำคัญ: ท่านสามารถอ่านจดหมายฉบับนี้หรือไม่ หากท่านไม่สามารถอ่านจดหมายฉบับนี้ เราสามารถจัดหาเจ้าหน้าที่มาอ่านให้ท่านฟังได้ ท่านยังอาจให้เจ้าหน้าที่ช่วยเขียนจดหมายในภาษาของท่านอีกด้วย หากต้องการความช่วยเหลือโดยไม่มีค่าใช้จ่าย โปรดโทรติดต่อที่หมายเลข 1-888-254-2721 (TTY/TDD: 711)

Vietnamese
QUAN TRỌNG: Quý vị có thể đọc thư này hay không? Nếu không, chúng tôi có thể bố trí người giúp quý vị đọc thư này. Quý vị cũng có thể nhận thư này bằng ngôn ngữ của quý vị. Để được giúp đỡ miễn phí, vui lòng gọi ngay số 1-888-254-2721. (TTY/TDD: 711)

It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association.

Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

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Your summary of benefits



Anthem® Blue Cross

Your Plan: San Joaquin Valley Insurance Authority (JPA) - County of Tulare: PPO 500

Your Network: Prudent Buyer PPO

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	\$500 person / \$1,000 family	\$500 person / \$1,000 family
Overall Out-of-Pocket Limit	\$3,000 person / \$10,000 family	\$6,000 person / \$20,000 family
<p>The family deductible and out-of-pocket limit are embedded, meaning the cost shares of one family member will be applied to the per person deductible and per person out-of-pocket limit; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket limit. No one member will pay more than the per person deductible or per person out-of-pocket limit.</p> <p>Your copays, coinsurance and deductible count toward your out of pocket limit(s).</p> <p>In-Network and Non-Network deductibles and out-of-pocket limit amounts are separate and do not accumulate toward each other.</p>		
<p>Doctor Visits (virtual and office) <i>You are encouraged to select a Primary Care Physician (PCP).</i></p>		
<p>Virtual Visits from online provider LiveHealth Online <i>for urgent/acute medical and mental health and substance use disorder care via www.livehealthonline.com are covered at \$25 copay per visit deductible does not apply.</i></p>		
<p>Primary Care (PCP) and Mental Health and Substance Use Disorder Care <i>virtual and office</i></p>	\$25 copay per visit deductible does not apply	\$25 copay per visit deductible does not apply
<p>Specialist Care <i>virtual and office</i></p>	\$25 copay per visit deductible does not apply	\$25 copay per visit deductible does not apply
<p><u>Other Practitioner Visits</u></p>		
<p>Routine Maternity Care (Prenatal and Postnatal)</p>	\$25 copay per pregnancy deductible does not apply	40% coinsurance after deductible is met

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CA/LG/San Joaquin Valley Insurance Authority (JPA) - County of Tulare: PPO 500/02P5/01-01-2023

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Retail Health Clinic for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.	\$25 copay per visit deductible does not apply	40% coinsurance after deductible is met
Manipulation Therapy Coverage is limited to 12 visits per benefit period.	\$25 copay per visit deductible does not apply	40% coinsurance after deductible is met
Acupuncture Coverage is limited to 20 visits per benefit period.	20% coinsurance after deductible is met	40% coinsurance after deductible is met
<u>Other Services in an Office</u> Allergy Testing Prescription Drugs Dispensed in the office Maximum of \$250 member cost share per drug. Surgery	20% coinsurance after deductible is met 20% coinsurance after deductible is met 20% coinsurance after deductible is met	40% coinsurance after deductible is met 40% coinsurance after deductible is met 40% coinsurance after deductible is met
Preventive care / screenings / immunizations	No charge	40% coinsurance after deductible is met
Preventive Care for Chronic Conditions per IRS guidelines	No charge	40% coinsurance after deductible is met
<u>Diagnostic Services</u> Lab Office Freestanding Lab Outpatient Hospital	No Charge No Charge No Charge	40% coinsurance after deductible is met 40% coinsurance after deductible is met 40% coinsurance after deductible is met
X-Ray Office Freestanding Radiology Center Outpatient Hospital	No Charge No Charge No Charge	40% coinsurance after deductible is met 40% coinsurance after deductible is met 40% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p>Advanced Diagnostic Imaging <i>for example: MRI, PET and CAT scans</i></p> <p>Office</p> <p>Freestanding Radiology Center</p> <p>Outpatient Hospital</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>
<p><u>Emergency and Urgent Care</u></p> <p>Urgent Care <i>includes doctor services. Additional charges may apply depending on the care provided.</i></p> <p>Emergency Room Facility Services <i>\$100 deductible waived if admitted directly from ER.</i></p> <p>Emergency Room Doctor and Other Services</p> <p>Ambulance</p>	<p>\$25 copay per visit deductible does not apply</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p>
<p><u>Outpatient Mental Health and Substance Use Disorder Care at a Facility</u></p> <p>Facility Fees</p> <p>Doctor Services</p> <p>Doctor Office Visit</p>	<p>20% coinsurance after deductible is met</p> <p>\$25 copay per visit deductible does not apply</p>	<p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>
<p><u>Outpatient Surgery</u></p> <p>Facility Fees</p> <p>Hospital</p> <p>Ambulatory Surgical Center</p> <p>Doctor and Other Services</p> <p>Hospital</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><u>Hospital (Including Maternity, Mental Health and Substance Use Disorder)</u> <i>Anthem's maximum payment is up to \$600 per day for non-emergency Inpatient admissions to non-network providers.</i></p> <p>Facility Fees</p> <p>Physician and other services <i>including surgeon fees</i></p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>
<p>Home Health Care <i>Coverage is limited to 100 visits per benefit period.</i></p>	<p>20% coinsurance after deductible is met</p>	<p>20% coinsurance after deductible is met</p>
<p>Rehabilitation and Habilitation services <i>including physical, occupational and speech therapies. Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 40 visits per benefit period. Coverage for rehabilitative and habilitative speech therapy is limited to 20 visits per benefit period.</i></p> <p>Office</p> <p>Outpatient Hospital</p>	<p>\$25 copay per visit deductible does not apply</p> <p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p> <p>40% coinsurance after deductible is met</p>
<p>Pulmonary rehabilitation <i>office and outpatient hospital</i></p>	<p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p>
<p>Cardiac rehabilitation <i>office and outpatient hospital</i> <i>Coverage is limited to 36 visits per benefit period.</i></p>	<p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p>
<p>Dialysis/Hemodialysis <i>office and outpatient hospital</i></p>	<p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p>
<p>Chemo/Radiation Therapy <i>office and outpatient hospital</i></p>	<p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p>
<p>Skilled Nursing Care (facility) <i>Coverage is limited to 100 days per benefit period.</i></p>	<p>20% coinsurance after deductible is met</p>	<p>20% coinsurance after deductible is met</p>
<p>Inpatient Hospice</p>	<p>0% coinsurance after deductible is met</p>	<p>0% coinsurance after deductible is met</p>
<p>Durable Medical Equipment</p>	<p>20% coinsurance after deductible is met</p>	<p>20% coinsurance after deductible is met</p>
<p>Prosthetic Devices</p>	<p>20% coinsurance after deductible is met</p>	<p>40% coinsurance after deductible is met</p>

Notes:

- If you have an office visit with your Primary Care Physician, Specialist or Urgent Care at an Outpatient Facility (e.g., Hospital or Ambulatory Surgical Facility), benefits for Covered Services will be paid under "Outpatient Facility Services".
- Costs may vary by the site of service. Other cost shares may apply depending on services provided. Check your Certificate of Coverage for details.
- Outpatient Facility tests and treatments are limited to \$350 per admission for Non-Network Providers. Includes: Diagnostic Services; X-ray; Surgery; Rehabilitation; Habilitation; Cardiac Therapy; Surgery at Ambulatory Surgical Centers.
- Coverage includes standard fertility preservation services as a basic healthcare service including but are not limited to, injections, cryopreservation and storage for both male and female members when a medically necessary treatment may cause iatrogenic infertility. Member cost share for fertility preservation services is based on provider type and service rendered.

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

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Get help in your language

Language Assistance Services



Curious to know what all this says? We would be too. Here's the English version:

IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call right away at 1-888-254-2721. (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

Spanish

IMPORTANTE: ¿Puede leer esta carta? De lo contrario, podemos hacer que alguien lo ayude a leerla. También puede recibir esta carta escrita en su idioma. Para obtener ayuda gratuita, llame de inmediato al 1-888-254-2721. (TTY/TDD: 711)

Arabic

مهم: هل يمكنك قراءة هذه الرسالة؟ إذا لم تستطع، فيمكننا الاستعانة بشخص ما ليساعدك على قراءتها. كما يمكنك أيضًا الحصول على هذا الخطاب مكتوبًا بلغتك. للحصول على المساعدة المجانية، يُرجى الاتصال فورًا بالرقم 1-888-254-2721 (TTY/TDD: 711).

Armenian

ՌԻՇԱԴՐՈՒԹՅՈՒՆ. Կարողանո՞ւմ եք ընթերցել այս նամակը: Եթե ոչ, մենք կարող ենք տրամադրել ինչ-որ մեկին, ով կօգնի Ձեզ՝ կարդալ այն: Կարող ենք նաև այս նամակը Ձեզ գրավոր տարբերակով տրամադրել: Անվճար օգնություն ստանալու համար կարող եք անհապաղ զանգահարել 1-888-254-2721 հեռախոսահամարով: (TTY/TDD: 711)

Chinese

重要事項: 您能看懂這封信函嗎? 如果您看不懂, 我們能夠找人協助您。您有可能可以獲得以您的語言而寫的本信函。如需免費協助, 請立即撥打1-888-254-2721。(TTY/TDD: 711)

Farsi

مهم: آیا می‌توانید این نامه را بخوانید؟ اگر نمی‌توانید، می‌توانیم شخصی را به شما معرفی کنیم تا در خواندن این نامه شما را کمک کند. همچنین می‌توانید این نامه را به صورت مکتوب به زبان خودتان دریافت کنید. برای دریافت کمک رایگان، همین حالا با شماره 1-888-254-2721 تماس بگیرید. (TTY/TDD: 711)

Hindi

महत्वपूर्ण: क्या आप यह पत्र पढ़ सकते हैं? अगर नहीं, तो हम आपको इसे पढ़ने में मदद करने के लिए किसी को उपलब्ध करा सकते हैं। आप यह पत्र अपनी भाषा में लिखवाने में भी सक्षम हो सकते हैं। निःशुल्क मदद के लिए, कृपया 1-888-254-2721 पर तुरंत कॉल करें। (TTY/TDD: 711)

Hmong

TSEEM CEEB: Koj puas muaj peev xwm nyeem tau daim ntawv no? Yog hais tias koj nyeem tsis tau, peb muaj peev xwm cia lwm tus pab nyeem rau koj mloog. Tsis tas li ntawd tej zaum koj kuj tseem yuav tau txais daim ntawv no sau ua koj hom lus thiab. Txog rau kev pab dawb, thov hu tam sim no rau tus xov tooj 1-888-254-2721. (TTY/TDD: 711)

Japanese

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重要：この書簡を読めますか？もし読めない場合には、内容を理解するための支援を受けることができます。また、この書簡を希望する言語で書いたものを入手することもできます。次の番号にいますぐ電話して、無料支援を受けてください。
1-888-254-2721 (TTY/TDD: 711)

Khmer
សំខាន់៖ តើអ្នកអាចអានលិខិតនេះទេ? បើមិនអាចទេ យើងអាចឱ្យនរណាម្នាក់អានជូនអ្នក។ អ្នកក៏អាចទទួលបានលិខិតនេះដោយសរសេរជាភាសាបស្ចឹមផងដែរ។ ដើម្បីទទួលបានជំនួយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទតាមលេខ 1-888-254-2721។ (TTY/TDD: 711)

Korean
중요: 이 서신을 읽으실 수 있으십니까? 읽으실 수 없을 경우 도움을 드릴 사람이 있습니다. 귀하가 사용하는 언어로 쓰여진 서신을 받으실 수도 있습니다. 무료 도움을 받으시려면 즉시 1-888-254-2721로 전화하십시오. (TTY/TDD: 711)

Punjabi
ਮਹੱਤਵਪੂਰਨ: ਕੀ ਤੁਸੀਂ ਇਹ ਪੱਤਰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇ ਨਹੀਂ, ਤਾਂ ਅਸੀਂ ਇਸ ਨੂੰ ਪੜ੍ਹ ਕੇ ਿਵੱਚ ਤੁਹਾਡੀ ਮਦਦ ਲਈ ਿਕਸੇ ਨੂੰ ਬੁਲਾ ਸਕਦਾ ਹਾਂ ਤੁਸੀਂ ਸ਼ਾਇਦ ਪੱਤਰ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਿਵੱਚ ਿਲਿਖਿਆ ਹੋਇਆ ਵਜ਼ੀ ਪੜ੍ਹਾ ਕਰ ਸਕਦੇ ਹੋ। ਮੁਫਤ ਮਦਦ ਲਈ, ਿਕਰਪਾ ਕਰਕੇ ਫੋਨ 1-888-254-2721 ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD: 711)

Russian
ВАЖНО. Можете ли вы прочитать данное письмо? Если нет, наш специалист поможет вам в этом. Вы также можете получить данное письмо на вашем языке. Для получения бесплатной помощи звоните по номеру 1-888-254-2721. (TTY/TDD: 711)

Tagalog
MAHALAGA: Nababasa ba ninyo ang liham na ito? Kung hindi, may taong maaaring tumulong sa inyo sa pagbasa nito. Maaari ninyo ring makuha ang liham na ito nang nakasulat sa ginagamit ninyong wika. Para sa libreng tulong, mangyaring tumawag kaagad sa 1-888-254-2721. (TTY/TDD: 711)

Thai
หมายเหตุสำคัญ: ท่านสามารถอ่านจดหมายฉบับนี้หรือไม่ หากท่านไม่สามารถอ่านจดหมายฉบับนี้ เราสามารถจัดหาเจ้าหน้าที่มาอ่านให้ท่านฟังได้ ท่านยังอาจให้เจ้าหน้าที่ช่วยเขียนจดหมายในภาษาของท่านอีกด้วย หากต้องการความช่วยเหลือโดยไม่มีค่าใช้จ่าย โปรดโทรติดต่อที่หมายเลข 1-888-254-2721 (TTY/TDD: 711)

Vietnamese
QUAN TRỌNG: Quý vị có thể đọc thư này hay không? Nếu không, chúng tôi có thể bố trí người giúp quý vị đọc thư này. Quý vị cũng có thể nhận thư này bằng ngôn ngữ của quý vị. Để được giúp đỡ miễn phí, vui lòng gọi ngay số 1-888-254-2721. (TTY/TDD: 711)

It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association.

Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

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Your summary of benefits



Anthem® Blue Cross

Your Plan: San Joaquin Valley Insurance Authority (JPA) - County of Tulare: PPO 750

Your Network: Prudent Buyer PPO

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	\$750 person / \$1,500 family	\$750 person / \$1,500 family
Overall Out-of-Pocket Limit	\$3,500 person / \$7,000 family	\$10,000 person / \$20,000 family
<p>The family deductible and out-of-pocket limit are embedded, meaning the cost shares of one family member will be applied to the per person deductible and per person out-of-pocket limit; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket limit. No one member will pay more than the per person deductible or per person out-of-pocket limit.</p> <p>Your copays, coinsurance and deductible count toward your out of pocket limit(s).</p> <p>In-Network and Non-Network deductibles and out-of-pocket limit amounts are separate and do not accumulate toward each other.</p>		
<p>Doctor Visits (virtual and office) <i>You are encouraged to select a Primary Care Physician (PCP).</i></p>		
<p>Virtual Visits from online provider LiveHealth Online <i>for urgent/acute medical and mental health and substance abuse disorder care via www.livehealthonline.com are covered at \$25 copay per visit deductible does not apply.</i></p>		
<p>Primary Care (PCP) and Mental Health and Substance Abuse Disorder Care <i>virtual and office</i></p>	\$25 copay per visit deductible does not apply	50% coinsurance after deductible is met
<p>Specialist Care <i>virtual and office</i></p>	\$35 copay per visit deductible does not apply	50% coinsurance after deductible is met
<p><u>Other Practitioner Visits</u></p>		
<p>Routine Maternity Care (Prenatal and Postnatal)</p>	\$25 copay per visit deductible does not apply	50% coinsurance after deductible is met

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Questions: (855) 333-5730 or visit us at www.anthem.com/ca

CA/LG/San Joaquin Valley Insurance Authority (JPA) - County of Tulare: PPO 750/02P6/01-01-2023

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Retail Health Clinic for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.	\$25 copay per visit deductible does not apply	50% coinsurance after deductible is met
Manipulation Therapy Coverage is limited to 12 visits per benefit period.	\$25 copay per visit deductible does not apply	50% coinsurance after deductible is met
Acupuncture Coverage is limited to 20 visits per benefit period.	20% coinsurance after deductible is met	50% coinsurance after deductible is met
<u>Other Services in an Office</u> Allergy Testing Prescription Drugs Dispensed in the office Maximum of \$250 member cost share per drug. Surgery	20% coinsurance after deductible is met 20% coinsurance after deductible is met 20% coinsurance after deductible is met	50% coinsurance after deductible is met 50% coinsurance after deductible is met 50% coinsurance after deductible is met
Preventive care / screenings / immunizations	No charge	50% coinsurance after deductible is met
Preventive Care for Chronic Conditions per IRS guidelines	No charge	50% coinsurance after deductible is met
<u>Diagnostic Services</u> Lab Office Freestanding Lab Outpatient Hospital	No Charge No Charge No Charge	50% coinsurance after deductible is met 50% coinsurance after deductible is met 50% coinsurance after deductible is met
X-Ray Office Freestanding Radiology Center Outpatient Hospital	No Charge No Charge No Charge	50% coinsurance after deductible is met 50% coinsurance after deductible is met 50% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p>Advanced Diagnostic Imaging <i>for example: MRI, PET and CAT scans</i></p> <p>Office</p> <p>Freestanding Radiology Center</p> <p>Outpatient Hospital</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>
<p><u>Emergency and Urgent Care</u></p> <p>Urgent Care <i>includes doctor services. Additional charges may apply depending on the care provided.</i></p> <p>Emergency Room Facility Services <i>\$100 deductible waived if admitted directly from ER.</i></p> <p>Emergency Room Doctor and Other Services</p> <p>Ambulance</p>	<p>\$25 copay per visit deductible does not apply</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p>
<p><u>Outpatient Mental Health and Substance Abuse Disorder Care at a Facility</u></p> <p>Facility Fees</p> <p>Doctor Services</p> <p>Doctor Office Visit</p>	<p>20% coinsurance after deductible is met</p> <p>\$25 copay per visit deductible does not apply</p>	<p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>
<p><u>Outpatient Surgery</u></p> <p>Facility Fees</p> <p>Hospital</p> <p>Ambulatory Surgical Center</p> <p>Doctor and Other Services</p> <p>Hospital</p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p><u>Hospital (Including Maternity, Mental Health and Substance Abuse Disorder)</u> <i>Anthem's maximum payment is up to \$600 per day for non-emergency inpatient admissions to non-network providers.</i></p> <p>Facility Fees</p> <p>Physician and other services <i>including surgeon fees</i></p>	<p>20% coinsurance after deductible is met</p> <p>20% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>
<p>Home Health Care <i>Coverage is limited to 100 visits per benefit period.</i></p>	<p>20% coinsurance after deductible is met</p>	<p>20% coinsurance after deductible is met</p>
<p>Rehabilitation and Habilitation services <i>including physical, occupational and speech therapies. Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 40 visits per benefit period. Coverage for rehabilitative and habilitative speech therapy is limited to 20 visits per benefit period.</i></p> <p>Office</p> <p>Outpatient Hospital</p>	<p>\$25 copay per visit deductible does not apply</p> <p>20% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>
<p>Pulmonary rehabilitation</p> <p>Office</p> <p>Outpatient Hospital</p>	<p>\$25 copay per visit deductible does not apply</p> <p>20% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>
<p>Cardiac rehabilitation <i>Coverage is limited to 36 visits per benefit period</i></p> <p>Office</p> <p>Outpatient Hospital</p>	<p>\$25 copay per visit deductible does not apply</p> <p>20% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>
<p>Dialysis/Hemodialysis <i>office and outpatient hospital</i></p>	<p>20% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p>
<p>Chemo/Radiation Therapy <i>office and outpatient hospital</i></p>	<p>20% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Skilled Nursing Care (facility) <i>Coverage is limited to 100 days per benefit period.</i>	20% coinsurance after deductible is met	20% coinsurance after deductible is met
Inpatient Hospice	0% coinsurance after deductible is met	0% coinsurance after deductible is met
Durable Medical Equipment	50% coinsurance after deductible is met	50% coinsurance after deductible is met
Prosthetic Devices	50% coinsurance after deductible is met	50% coinsurance after deductible is met

Notes:

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Hmong

TSEEM CEEB: Koj puas muaj peev xwm nyeem tau daim ntawv no? Yog hais tias koj nyeem tsis tau, peb muaj peev xwm cia lwm tus pab nyeem rau koj mloog. Tsis tas li ntawd tej zaum koj kuj tseem yuav tau txais daim ntawv no sau ua koj hom lus thiab. Txog rau kev pab dawb, thov hu tam sim no rau tus xov tooj 1-888-254-2721. (TTY/TDD: 711)

Japanese

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重要：この書簡を読めますか？もし読めない場合には、内容を理解するための支援を受けることができます。また、この書簡を希望する言語で書いたものを入手することもできます。次の番号にいますぐ電話して、無料支援を受けてください。
1-888-254-2721 (TTY/TDD: 711)

Khmer
សំខាន់៖ តើអ្នកអាចអានលិខិតនេះទេ? បើមិនអាចទេ យើងអាចឱ្យនរណាម្នាក់អានជូនអ្នក។ អ្នកក៏អាចទទួលបានលិខិតនេះដោយសរសេរជាភាសាបស្ចឹមផងដែរ។ ដើម្បីទទួលបានជំនួយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទតាមលេខ 1-888-254-2721។ (TTY/TDD: 711)

Korean
중요: 이 서신을 읽으실 수 있으십니까? 읽으실 수 없을 경우 도움을 드릴 사람이 있습니다. 귀하가 사용하는 언어로 쓰여진 서신을 받으실 수도 있습니다. 무료 도움을 받으시려면 즉시 1-888-254-2721로 전화하십시오. (TTY/TDD: 711)

Punjabi
ਮਹੱਤਵਪੂਰਨ: ਕੀ ਤੁਸੀਂ ਇਹ ਪੱਤਰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇ ਨਹੀਂ, ਤਾਂ ਅਸੀਂ ਇਸ ਨੂੰ ਪੜ੍ਹ ਕੇ ਿਵੱਚ ਤੁਹਾਡੀ ਮਦਦ ਲਈ ਿਕਸੇ ਨੂੰ ਬੁਲਾ ਸਕਦਾ ਹਾਂ ਤੁਸੀਂ ਸ਼ਾਇਦ ਪੱਤਰ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਿਵੱਚ ਿਲਿਖਿਆ ਹੋਇਆ ਵਜ਼ੀ ਪੜ੍ਹਾ ਕਰ ਸਕਦੇ ਹੋ। ਮੁਫਤ ਮਦਦ ਲਈ, ਿਕਰਪਾ ਕਰਕੇ ਫੋਨ 1-888-254-2721 ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD: 711)

Russian
ВАЖНО. Можете ли вы прочитать данное письмо? Если нет, наш специалист поможет вам в этом. Вы также можете получить данное письмо на вашем языке. Для получения бесплатной помощи звоните по номеру 1-888-254-2721. (TTY/TDD: 711)

Tagalog
MAHALAGA: Nababasa ba ninyo ang liham na ito? Kung hindi, may taong maaaring tumulong sa inyo sa pagbasa nito. Maaari ninyo ring makuha ang liham na ito nang nakasulat sa ginagamit ninyong wika. Para sa lib्रेng tulong, mangyaring tumawag kaagad sa 1-888-254-2721. (TTY/TDD: 711)

Thai
หมายเหตุสำคัญ: ท่านสามารถอ่านจดหมายฉบับนี้หรือไม่ หากท่านไม่สามารถอ่านจดหมายฉบับนี้ เราสามารถจัดหาเจ้าหน้าที่มาอ่านให้ท่านฟังได้ ท่านยังอาจให้เจ้าหน้าที่ช่วยเขียนจดหมายในภาษาของท่านอีกด้วย หากต้องการความช่วยเหลือโดยไม่มีค่าใช้จ่าย โปรดโทรติดต่อที่หมายเลข 1-888-254-2721 (TTY/TDD: 711)

Vietnamese
QUAN TRỌNG: Quý vị có thể đọc thư này hay không? Nếu không, chúng tôi có thể bố trí người giúp quý vị đọc thư này. Quý vị cũng có thể nhận thư này bằng ngôn ngữ của quý vị. Để được giúp đỡ miễn phí, vui lòng gọi ngay số 1-888-254-2721. (TTY/TDD: 711)

It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, Washington, DC 20092. Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association.

Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

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Your summary of benefits



Anthem® Blue Cross

Your Plan: San Joaquin Valley Insurance Authority (JPA): Anthem PPO (HSA) 2500

Your Network: Prudent Buyer PPO

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	\$2,500 person / \$5,000 family	\$2,500 person / \$5,000 family
Overall Out-of-Pocket Limit	\$5,000 person / \$8,150 family	\$5,000 person / \$8,150 family
<p>The family deductible and out-of-pocket limit are non-embedded, meaning the cost shares of one family member will be applied to the per person deductible and per person out-of-pocket limit; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket limit. No one member will pay more than the per person deductible or per person out-of-pocket limit.</p> <p>Your copays, coinsurance and deductible count toward your out of pocket limit(s).</p> <p>In-network and out-of-network deductibles and out-of-pocket maximum amounts are combined and accumulate toward each other.</p>		
<p>Doctor Visits (virtual and office) <i>You are encouraged to select a Primary Care Physician (PCP).</i></p>		
<p>Virtual Visits from online provider LiveHealth Online for urgent/acute medical and mental health and substance abuse disorder care via www.livehealthonline.com are covered at \$59 per visit until the deductible is met.</p>		
<p>Primary Care (PCP) and Mental Health and Substance Abuse Disorder Care <i>virtual and office</i></p>	10% coinsurance after deductible is met	50% coinsurance after deductible is met
<p>Specialist Care <i>virtual and office</i></p>	10% coinsurance after deductible is met	50% coinsurance after deductible is met
<p><u>Other Practitioner Visits</u></p>		
<p>Routine Maternity Care (Prenatal and Postnatal)</p>	10% coinsurance after deductible is met	50% coinsurance after deductible is met
<p>Retail Health Clinic for routine care and treatment of common illnesses; usually found in major pharmacies or retail stores.</p>	10% coinsurance after deductible is met	50% coinsurance after deductible is met

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CA/LG/San Joaquin Valley Insurance Authority (JPA): Anthem PPO (HSA) 2500/48B4/01-01-2023

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Manipulation Therapy <i>Coverage is limited to 12 visits per benefit period.</i>	10% coinsurance after deductible is met	50% coinsurance after deductible is met
Acupuncture <i>Coverage is limited to 20 visits per benefit period.</i>	10% coinsurance after deductible is met	50% coinsurance after deductible is met
<u>Other Services in an Office</u> Allergy Testing Prescription Drugs <i>Dispensed in the office</i> <i>Maximum of \$250 member cost share per drug.</i> Surgery	10% coinsurance after deductible is met 10% coinsurance after deductible is met 10% coinsurance after deductible is met	50% coinsurance after deductible is met 50% coinsurance after deductible is met 50% coinsurance after deductible is met
Preventive care / screenings / immunizations	No charge	50% coinsurance after deductible is met
Preventive Care for Chronic Conditions <i>per IRS guidelines</i>	No charge	50% coinsurance after deductible is met
<u>Diagnostic Services</u> Lab Office Freestanding Lab Outpatient Hospital	10% coinsurance after deductible is met 10% coinsurance after deductible is met 10% coinsurance after deductible is met	50% coinsurance after deductible is met 50% coinsurance after deductible is met 50% coinsurance after deductible is met
X-Ray Office Freestanding Radiology Center Outpatient Hospital	10% coinsurance after deductible is met 10% coinsurance after deductible is met 10% coinsurance after deductible is met	50% coinsurance after deductible is met 50% coinsurance after deductible is met 50% coinsurance after deductible is met
Advanced Diagnostic Imaging <i>for example: MRI, PET and CAT scans</i> Office Freestanding Radiology Center	10% coinsurance after deductible is met 10% coinsurance after deductible is met	50% coinsurance after deductible is met 50% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Outpatient Hospital	10% coinsurance after deductible is met	50% coinsurance after deductible is met
<p><u>Emergency and Urgent Care</u></p> <p>Urgent Care <i>includes doctor services. Additional charges may apply depending on the care provided.</i></p> <p>Emergency Room Facility Services</p> <p>Emergency Room Doctor and Other Services</p> <p>Ambulance</p>	<p>10% coinsurance after deductible is met</p> <p>10% coinsurance after deductible is met</p> <p>10% coinsurance after deductible is met</p> <p>10% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p> <p>Covered as In-Network</p>
<p><u>Outpatient Mental Health and Substance Use Disorder Care at a Facility</u></p> <p>Facility Fees Doctor Services</p> <p>Doctor office Visit</p>	<p>10% coinsurance after deductible is met</p> <p>10% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>
<p><u>Outpatient Surgery</u></p> <p>Facility Fees</p> <p>Hospital</p> <p>Ambulatory Surgical Center</p> <p>Doctor and Other Services</p> <p>Hospital</p>	<p>10% coinsurance after deductible is met</p> <p>10% coinsurance after deductible is met</p> <p>10% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>
<p><u>Hospital (Including Maternity, Mental Health and Substance Use Disorder)</u></p> <p>Facility Fees</p> <p>Physician and other services <i>including surgeon fees</i></p>	<p>10% coinsurance after deductible is met</p> <p>10% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>
<p>Home Health Care</p> <p><i>Coverage is limited to 100 visits per benefit period.</i></p>	10% coinsurance after deductible is met	10% coinsurance after deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p>Rehabilitation and Habilitation services including physical, occupational and speech therapies. Coverage for physical therapy and occupational therapy is limited to 12 visits combined per benefit period. Chiropractic visits count towards your physical and occupational therapy limits.</p> <p>Office</p> <p>Outpatient Hospital</p>	<p>10% coinsurance after deductible is met</p> <p>10% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>
Pulmonary rehabilitation office and outpatient hospital	10% coinsurance after deductible is met	50% coinsurance after deductible is met
Cardiac rehabilitation office and outpatient hospital Coverage is limited to 36 visits per benefit period	10% coinsurance after deductible is met	50% coinsurance after deductible is met
Dialysis/Hemodialysis office and outpatient hospital	10% coinsurance after deductible is met	50% coinsurance after deductible is met
Chemo/Radiation Therapy office and outpatient hospital	10% coinsurance after deductible is met	50% coinsurance after deductible is met
Skilled Nursing Care (facility) Coverage is limited to 100 days per benefit period.	10% coinsurance after deductible is met	10% coinsurance after deductible is met
Inpatient Hospice Coverage is limited to \$10,000 maximum per lifetime.	10% coinsurance after deductible is met	10% coinsurance after deductible is met
Durable Medical Equipment	10% coinsurance after deductible is met	10% coinsurance after deductible is met
Prosthetic Devices	10% coinsurance after deductible is met	10% coinsurance after deductible is met

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महत्वपूर्ण: क्या आप यह पत्र पढ़ सकते हैं? अगर नहीं, तो हम आपको इसे पढ़ने में मदद करने के लिए किसी को उपलब्ध करा सकते हैं। आप यह पत्र अपनी भाषा में लिखवाने में भी सक्षम हो सकते हैं। निःशुल्क मदद के लिए, कृपया 1-888-254-2721 पर तुरंत कॉल करें। (TTY/TDD: 711)

Hmong

TSEEM CEEB: Koj puas muaj peev xwm nyeem tau daim ntawv no? Yog hais tias koj nyeem tsis tau, peb muaj peev xwm cia lwm tus pab nyeem rau koj mloog. Tsis tas li ntawd tej zaum koj kuj tseem yuav tau txais daim ntawv no sau ua koj hom lus thiab. Txog rau kev pab dawb, thov hu tam sim no rau tus xov tooj 1-888-254-2721. (TTY/TDD: 711)

Japanese

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

重要：この書簡を読めますか？もし読めない場合には、内容を理解するための支援を受けることができます。また、この書簡を希望する言語で書いたもの入手することもできます。次の番号にいますぐ電話して、無料支援を受けてください。
1-888-254-2721 (TTY/TDD: 711)

Khmer
សំខាន់៖ តើអ្នកអាចអានលិខិតនេះទេ? បើមិនអាចទេ យើងអាចជួយអ្នកក្នុងការអានលិខិតនេះដោយសេរីដោយមិនមានការបង្ខំអ្នកឡើយ។ ដើម្បីទទួលបានជំនួយភ្នាក់ងារស្តីពី តេឡេហ្វូនស៊ីនេម៉ាស៊ីន ឬសូមហៅទូរស័ព្ទភ្លាមៗទៅលេខ 1-888-254-2721។ (TTY/TDD: 711)

Korean
중요: 이 서신을 읽으실 수 있으십니까? 읽으실 수 없을 경우 도움을 드릴 사람이 있습니다. 귀하가 사용하는 언어로 쓰여진 서신을 받으실 수도 있습니다. 무료 도움을 받으시려면 즉시 1-888-254-2721로 전화하십시오. (TTY/TDD: 711)

Punjabi
ਮਹੱਤਵਪੂਰਨ: ਕੀ ਤੁਸੀਂ ਇਹ ਪੱਤਰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇ ਨਹੀਂ, ਤਾਂ ਅਸੀਂ ਇਸ ਨੂੰ ਪੜ੍ਹ ਕੇ ਿਵੱਚ ਤੁਹਾਡੀ ਮਦਦ ਲਈ ਿਕਸੇ ਨੂੰ ਬੁਲਾ ਸਕਦਾ ਹਾਂ ਤੁਸੀਂ ਸ਼ਾਇਦ ਪੱਤਰ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਿਵੱਚ ਿਲਿਖਿਆ ਹੋਇਆ ਵਜ਼ੀ ਪੜ੍ਹਾ ਕਰ ਸਕਦੇ ਹੋ। ਮੁਫਤ ਮਦਦ ਲਈ, ਿਕਰਪਾ ਕਰਕੇ ਫੋਨ 1-888-254-2721 ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD: 711)

Russian
ВАЖНО. Можете ли вы прочитать данное письмо? Если нет, наш специалист поможет вам в этом. Вы также можете получить данное письмо на вашем языке. Для получения бесплатной помощи звоните по номеру 1-888-254-2721. (TTY/TDD: 711)

Tagalog
MAHALAGA: Nababasa ba ninyo ang liham na ito? Kung hindi, may taong maaaring tumulong sa inyo sa pagbasa nito. Maaari ninyo ring makuha ang liham na ito nang nakasulat sa ginagamit ninyong wika. Para sa libreng tulong, mangyaring tumawag kaagad sa 1-888-254-2721. (TTY/TDD: 711)

Thai
หมายเหตุสำคัญ: ท่านสามารถอ่านจดหมายฉบับนี้หรือไม่ หากท่านไม่สามารถอ่านจดหมายฉบับนี้ เราสามารถจัดหาเจ้าหน้าที่มาอ่านให้ท่านฟังได้ ท่านยังอาจให้เจ้าหน้าที่ช่วยเขียนจดหมายในภาษาของท่านอีกด้วย หากต้องการความช่วยเหลือโดยไม่มีค่าใช้จ่าย โปรดโทรติดต่อที่หมายเลข 1-888-254-2721 (TTY/TDD: 711)

Vietnamese
QUAN TRỌNG: Quý vị có thể đọc thư này hay không? Nếu không, chúng tôi có thể bố trí người giúp quý vị đọc thư này. Quý vị cũng có thể nhận thư này bằng ngôn ngữ của quý vị. Để được giúp đỡ miễn phí, vui lòng gọi ngay số 1-888-254-2721. (TTY/TDD: 711)

It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association.

Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

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Standard Brochure 1.2022



SJVIA County of Tulare PPO Plans

**Prescription
Benefit Plan**



EmpiRx Health Member Services

1-877-262-7435

TDD: 1-888-907-0020

24 hours a day, 7 days a week, 365 days a year

Your Prescription Benefit Program

Annual Maximum Out of Pocket

There is a \$2,000 individual/ \$4,000 family maximum out of pocket.

Retail Pharmacy Copay

You are responsible for paying the retail pharmacist the copay per prescription that is listed below:

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

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

Retail quantities will be dispensed according to your physician's instructions, as written on the prescription, for up to a maximum of a 30-day supply or up to 100 units of a medication, whichever is greater.

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

Mail Service Pharmacy Copay

Prescriptions for maintenance medications (medications you take on an ongoing basis) can be submitted to Benecard Central Fill, the EmpiRx Health mail service pharmacy. Your plan allows for up to a 90-day supply with three (3) refills, according to your physician's instructions. Your copay amount will be:

30-Day Supply	90-Day Supply
\$10.00 for a Generic Medication	\$15.00 for a Generic Medication
\$20.00 for a Preferred Brand Medication	\$30.00 for a Preferred Brand Medication
\$35.00 for a Non-Preferred Brand Medication	\$50.00 for a Non-Preferred Brand Medication

Specialty Medication Copay

Specialty medications are high-cost biotechnology drugs that require special distribution, handling, and administration. These medications are typically designed to treat chronic diseases. Your copay amount will be:

30% (max of \$100) for a Generic Specialty Medication

30% (max of \$100) for a Preferred Brand Specialty Medication

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

Specialty medications can be filled one time at a retail pharmacy. After that, all prescriptions must be obtained through Benecard Central Fill specialty pharmacy. Please note that specialty medications are limited to a 30-day supply.

Frequently Asked Questions

How can I find a participating network pharmacy?

You can use your EmpiRx Health ID card at over 63,000 pharmacies nationwide, including all pharmacy chains. You can locate a nearby network pharmacy by logging on to myempirxhealth.com or calling 1-877-262-7435 toll-free.

What is a clinical review, and why is it necessary?

A clinical review of the request for medication is typically due to potential side effects, interactions, and FDA-guidelines. This is a safety measure to ensure you're getting the most appropriate treatment possible. EmpiRx Health will work directly with your physician to obtain the necessary information before your prescription is filled. Once the review is complete, you'll be notified by mail, or via the online member portal. You can also check your status on the member portal any time at myempirxhealth.com.

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

You can check coverage easily by calling 1-877-262-7435 or logging onto myempirxhealth.com for details.

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

Log onto the member portal myempirxhealth.com and select "Drug Pricing." Then search for your medication. If a generic is available, you'll see the cost for both the brand and generic. You can also call 1-877-262-7435 or consult with your physician or pharmacist.

Why does my copayment change from month to month?

We do not set the cost of medications. Pricing fluctuates based on market cost and may vary by pharmacy. If your copay is based on a percentage, rather than a fixed dollar amount, the cost can be different depending on which pharmacy you use and the pricing of the medication at the time.

Preferred Medication List

The preferred medication list serves as a guide to clinically and therapeutically-appropriate medications covered under your plan. This does not take the place of your physician or pharmacist's judgment regarding your individual needs. Refer to myempirxhealth.com to review the most recent preferred medication list.

Exclusions

Your prescription program covers most medically necessary, federal legend, state-restricted, and compounded medications, which by law may not be dispensed without a prescription.

Online Member Portal and Mobile App

Registration is easy. Along with your ID card, you will need basic member information, a phone number, and an email address. Log onto the member portal at myempirxhealth.com or download the app on Google Play or the App Store to access all your benefits information, including:

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

Retail Pharmacy Network

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

Mail Order Pharmacy

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

For your first order, have your physician submit your prescription electronically to Benecard Central Fill or fax it to 1-888-907-0040. Be sure that your physician includes the cardholder name, ID number, shipping address, and patient's date of birth. Only prescriptions sent directly from a doctor's office will be accepted via fax. To submit a prescription yourself, complete the enclosed mail service order form and mail it, along with the original prescription, to Benecard Central Fill in the preaddressed envelope provided. To request additional mail order forms with preaddressed envelopes, please call 1-877-262-7435.

Refill orders can be submitted online, by phone, or by mail.

- Online: Visit myempirxhealth.com. If you have not yet registered, click on "Register." If you are a registered user, log in and select "Mail Order."
- By phone: Call Member Services toll-free at 1-877-262-7435, 24 hours-a-day, 7 days-a-week, 365 days-a-year. Have your ID number and credit card information ready.
- By mail: Send the refill request order form provided with your last shipment back to Benecard Central Fill in the preaddressed envelope.

Please note that EmpiRx Health does NOT automatically refill your prescriptions.

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

Specialty Pharmacy

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

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

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

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

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

Where Can I Ship My Medications?

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

- Your home
- Your work
- Your doctor's office
- A location of your choice

Specialty Medications and Manufacturer Programs

Members requiring specialty medications may be eligible to manufacture programs which financially assist members in the purchase of the medication.

Specialty drugs have the following key characteristics:

- Need frequent dosage adjustments.
- Cause more severe side effects than traditional drugs
- Need special storage, handling and/or administration.
- Have a narrow therapeutic range.
- Require periodic laboratory or diagnostic testing.

Members will never pay more than standard plan copay for specialty drugs. Not all specialty medications have an associated manufacturer programs.

Manufacturer programs have maximum dollar limits and can change program details at any time. The maximum copay support resets at specific manufacturer's program dates (generally Jan 1 each year, possible rolling 12 months from enrollment).

Unless stated otherwise, manufacturer's payments do not count toward the patient's deductible and or out-of-pocket maximum obligations.

Savings with Generic Medications

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

ID Cards

If your ID card is not handy and there is an emergency need for a prescription, call EmpiRx Health Member Services toll-free at 1-877-262-7435 (TDD: 1-888-907-0020), and we will provide your pharmacist with the information required to process your prescription.

Direct Member Reimbursement

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

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SJVIA County of Tulare HDHP 2500 Plan

**Prescription
Benefit Plan**



EmpiRx Health Member Services

1-877-262-7435

TDD: 1-888-907-0020

24 hours a day, 7 days a week, 365 days a year

Your Prescription Benefit Program

Upfront Deductible and Annual Maximum Out of Pocket

There is a \$2,500 individual/\$5,000 Family Deductible.

There is a \$5,000 individual/ \$8,150 family maximum out of pocket.

Retail Pharmacy Copay

You are responsible for paying the retail pharmacist the copay per prescription that is listed below:

30-Day Supply	90-Day Supply
\$7.00 for a Generic Medication	\$14.00 for a Generic Medication
\$25.00 for a Preferred Brand Medication	\$50.00 for a Preferred Brand Medication

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

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\$14.00 for a Generic Medication
\$50.00 for a Brand Medication

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Specialty medications are high-cost biotechnology drugs that require special distribution, handling, and administration. These medications are typically designed to treat chronic diseases. Your copay amount will be:

\$7.00 for a Generic Specialty Medication
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- Have a narrow therapeutic range.
- Require periodic laboratory or diagnostic testing.

Members will never pay more than standard plan copay for specialty drugs. Not all specialty medications have an associated manufacturer programs.

Manufacturer programs have maximum dollar limits and can change program details at any time.

The maximum copay support resets at specific manufacturer's program dates (generally Jan 1 each year, possible rolling 12 months from enrollment).

Unless stated otherwise, manufacturer's payments do not count toward the patient's deductible and or out-of-pocket maximum obligations.

Savings with Generic Medications

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

ID Cards

If your ID card is not handy and there is an emergency need for a prescription, call EmpiRx Health Member Services toll-free at 1-877-262-7435 (TDD: 1-888-907-0020), and we will provide your pharmacist with the information required to process your prescription.

Direct Member Reimbursement

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

Disclosure Form Part One

COUNTY OF TULARE
Group ID 39189 - HMO High Plan
Member Services 1-800-464-4000
Home Region: Northern California
1/1/24 through 12/31/24

Principal benefits for Kaiser Permanente Traditional HMO Plan

Health Plan believes this coverage is a “grandfathered health plan” under the Patient Protection and Affordable Care Act. If you have questions about grandfathered health plans, please call Member Services.

Accumulation Period

The Accumulation Period for this plan is January 1 through December 31.

Out-of-Pocket Maximums and Deductibles

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

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

Plan Provider Office Visits

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

Telehealth Visits

	You Pay
Primary Care Visits and Non-Physician Specialist Visits by interactive video	No charge
Physician Specialist Visits by interactive video	No charge
Primary Care Visits and Non-Physician Specialist Visits by telephone..	No charge
Physician Specialist Visits by telephone	No charge

Outpatient Services

	You Pay
Outpatient surgery and certain other outpatient procedures	\$25 per procedure
Most immunizations (including the vaccine).....	No charge
Most X-rays and laboratory tests.....	No charge

Hospital Inpatient Services

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

Emergency Services

	You Pay
Emergency department visits	\$100 per visit

Note: If you are admitted directly to the hospital as an inpatient for covered Services, you will pay the inpatient Cost Share instead of the emergency department Cost Share (see “Hospital Inpatient Services” for inpatient Cost Share)

Ambulance Services

	You Pay
Ambulance Services.....	\$50 per trip

Prescription Drug Coverage

	You Pay
Covered outpatient items in accord with our drug formulary guidelines:	
Most generic items (Tier 1) at a Plan Pharmacy or through our mail-order service.....	\$10 for up to a 100-day supply
Most brand-name items (Tier 2) at a Plan Pharmacy or through our mail-order service	\$20 for up to a 100-day supply
Most specialty items (Tier 4) at a Plan Pharmacy	\$20 for up to a 30-day supply

Durable Medical Equipment (DME)

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

(continues)

Mental Health Services	You Pay
Inpatient psychiatric hospitalization.....	\$250 per admission
Individual outpatient mental health evaluation and treatment	\$25 per visit
Group outpatient mental health treatment.....	\$12 per visit
Substance Use Disorder Treatment	You Pay
Inpatient detoxification.....	\$250 per admission
Individual outpatient substance use disorder evaluation and treatment	\$25 per visit
Group outpatient substance use disorder treatment	\$5 per visit
Home Health Services	You Pay
Home health care (up to 100 visits per Accumulation Period)	No charge
Other	You Pay
Eyeglasses or contact lenses every 24 months	Amount in excess of \$150 Allowance
Skilled nursing facility care (up to 100 days per benefit period).....	No charge
Prosthetic and orthotic devices as described in the <i>EOC</i>	No charge
Diagnosis and treatment of infertility and artificial insemination (such as outpatient procedures or laboratory tests) as described in the <i>EOC</i>	50% Coinsurance
Assisted reproductive technology (“ART”) Services.....	Not covered
Hospice care	No charge

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

Your Kaiser Permanente **CHIROPRACTIC** benefits

When you need chiropractic care, follow these simple steps:

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

(See the reverse for more details.)

YOUR KAISER PERMANENTE CHIROPRACTIC BENEFIT

Office Visits	Cost Sharing and Visit Limits
<p>Covered Services are limited to Medically Necessary Chiropractic Services authorized and provided by ASH Participating Providers except for the initial examination, Emergency Chiropractic Services, Urgent Chiropractic Services, and Services that are not available from ASH Participating Providers or other licensed providers with which ASH contracts to provide covered care. You can obtain an initial examination from any ASH Participating Provider without a referral from a Kaiser Permanente Plan Physician. Each office visit counts toward any visit limit, if applicable.</p>	<p>Office visit cost share: \$10 copayment per visit (if your <i>Amendment</i> is paired with an HDHP HMO evidence of coverage, this cost share is subject to the Plan Deductible described in your <i>EOC</i>)</p> <p>Office visit limit: 30 visits per year</p> <p>Chiropractic supports and appliances: If the amount of the appliance in the ASH Plans fee schedule exceeds \$50, you will pay the amount in excess of \$50. Covered chiropractic appliances are limited to: elbow supports, back supports, cervical collars, cervical pillows, heel lifts, hot or cold packs, lumbar braces and supports, lumbar cushions, orthotics, wrist supports, rib belts, home traction units, ankle braces, knee braces, rib supports, and wrist braces.</p>

X-rays and laboratory tests: Medically Necessary X-rays and laboratory tests are covered at no charge when prescribed as part of covered chiropractic care and an ASH Participating Provider provides the Services or refers you to another licensed provider with which ASH contracts for the Services. If your *Amendment* is paired with an HDHP HMO evidence of coverage, this cost share is subject to the Plan Deductible described in your *EOC*.

ASH Participating Providers

ASH Plans contracts with ASH Participating Providers and other licensed providers to provide covered Chiropractic Services. You must receive these services from an ASH Participating Provider or another licensed provider with which ASH contracts, except for Emergency Chiropractic Services, Urgent Chiropractic Services, and Services that are not available from contracted providers that are authorized in advance by ASH Plans. The list of ASH Participating Providers is available on the ASH Plans website at ashlink.com/ash/kaisercamedicare for Kaiser Permanente Senior Advantage members, or ashlink.com/ash/kp for all other members, or from the ASH Plans Customer Service Department toll free at 1-800-678-9133 (TTY 711). The list of ASH Participating Providers is subject to change at any time without notice.

How to obtain services

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

Second Opinions

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

Your costs

When you receive covered Chiropractic Services, you must pay the cost share described below. The cost share does not apply toward the Plan Deductible or Plan Out-of-Pocket Maximum described in your Health Plan *Evidence of Coverage* ("EOC"), unless your *Chiropractic Services Amendment* ("*Amendment*") is amending an HSA-Qualified High Deductible Health Plan (HDHP) HMO plan evidence of coverage. If your *Amendment* is paired with an HDHP HMO evidence of coverage, the cost share you pay for covered Services is subject to the Plan Deductible and Plan Out-of-Pocket Maximum described in your *EOC*.

Emergency and Urgent Chiropractic Services

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

Getting Assistance

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

Grievances

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

Exclusions

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

Definitions

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

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

Chiropractic Services: Chiropractic services include spinal and extremity manipulation and adjunctive therapies such as ultrasound, therapeutic exercise, or electrical muscle stimulation, when provided during the same course of treatment and in conjunction with chiropractic manipulative services, and other services provided or prescribed by a chiropractor (including laboratory tests, X-rays, and chiropractic supports and appliances) for the treatment of your Musculoskeletal and Related Disorder.

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

Medically Necessary: A Service is Medically Necessary if it is medically appropriate and required to prevent, diagnose, or treat your condition or clinical symptoms in accord with generally accepted professional standards of practice that are consistent with a standard of care in the medical community.

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

Non-Participating Provider: A provider other than an ASH Participating Provider.

Services: Health care services or items.

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

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

This is a summary and is intended to highlight only the most frequently asked questions about the chiropractic benefit, including cost share. Please refer to the *Amendment* for a detailed description of the chiropractic coverage.

Language Assistance Services

English: Language assistance is available at no cost to you, 24 hours a day, 7 days a week. You can request interpreter services, materials translated into your language, or in alternative formats. Just call us at **1-800-464-4000**, 24 hours a day, 7 days a week (closed holidays). TTY users call **711**.

Arabic: خدمات الترجمة الفورية متوفرة لك مجاناً على مدار الساعة كافة أيام الأسبوع. بإمكانك طلب خدمة الترجمة الفورية أو ترجمة وثائقك أو لصيغ أخرى. ما عليك سوى الاتصال بنا على الرقم **1-800-464-4000** على مدار الساعة كافة أيام الأسبوع (مغلق أيام العطلات). لاستخدمي خدمة الهاتف التلمي يرحي الاتصال على الرقم **(711)**.

Armenian: Ձեզ կարող է անվճար օգնություն արանադրվել լեզվի հարցում՝ օրը 24 ժամ, շաբաթը 7 օր: Դուք կարող եք պահանջել բանավոր թարգմանի ծառայություններ, Ձեր լեզվով թարգմանված կամ այլընտրանքային մեքսայինով պատրաստված նյութեր: Դարգասեւ զանգահարել՝ մեզ՝ **1-800-464-4000** հեռախոսահամարով՝ օրը 24 ժամ՝ շաբաթը 7 օր (տոն օրերին փակ է): TTY-ից օգնվողները պետք է զանգահարեն **711**:

Chinese: 您每週 7 天，每天 24 小時均可獲得免費語言協助。您可以申請口譯服務、要求將資料翻譯成您所用語言或轉換為其他格式。我們每週 7 天，每天 24 小時均歡迎您打電話 **1-800-757-7585** 前來聯絡（節假日休息）。聽障及語障專線 (TTY) 使用者請撥 **711**。

Farsi: خدمات زبانی در 24 ساعت شبانه روز و 7 روز هفته بدون اخذ هزینه در اختیار شما است. شما می توانید برای خدمات مترجم شفاهی، ترجمه جزوات به زبان شما و یا به صورت های دیگر درخواست کنید. کفایت در 24 ساعت شبانه روز و 7 روز هفته (به استثنای روز های تعطیل) با ما به شماره **1-800-464-4000** تماس بگیرید. کلردان TTY با شماره **711** تماس بگیرند.

Hindi: बिना किसी लागत के दुभाषिया सेवाएँ, दिन के 24 घंटे, सप्ताह के सातों दिन उपलब्ध हैं। आप एक दुभाषिये की सेवाओं के लिए, बिना किसी लागत के सामग्रियों को अपनी भाषा में अनुवाद करवाने के लिए, या वैकल्पिक प्रारूपों के लिए अनुरोध कर सकते हैं। बस केवल हमें **1-800-464-4000** पर, दिन के 24 घंटे, सप्ताह के सातों दिन (छुट्टियों वाले दिन बंद रहता है) कॉल करें। TTY उपयोगकर्ता **711** पर कॉल करें।

Hmong: Muajkwc pab txhais lus pub dawb rau koj, 24 teev ib hnub twg, 7 hnub ib lim tiam twg. Koj thov tau cov kev pab txhais lus, muab cov ntab ntab txhais ua koj hom lus, los yog ua lwm hom. Tsuas hu rau **1-800-464-4000**, 24 teev ib hnub twg, 7 hnub ib lim tiam twg (cov hnub caiv kaw). Cov neeg siv TTY hu **711**.

Japanese: 当院では、言語支援を無料で、年中無休、終日ご利用いただけます。通訳サービス、日本語に翻訳された資料、あるいは資料を別の書式でも依頼できます。お気軽に **1-800-464-4000** までお電話ください（祭日を除き年中無休）。TTY ユーザーは **711** までお電話ください。

Khmer: ជំនួយភាសា គឺមានឥតគិតថ្លៃជូនអ្នកឡើយ 24 ម៉ោងមួយថ្ងៃ 7 ថ្ងៃមួយអាទិត្យ។ អ្នកអាចស្នើសុំសេវាអ្នកបកប្រែសំភារៈដែលបានបកប្រែទៅជាភាសាខ្មែរ ឬជាទម្រង់ផ្សេងទៀត។ គ្រាន់តែទូរស័ព្ទមកយើង តាមលេខ **1-800-464-4000** បាន 24 ម៉ោងមួយថ្ងៃ 7 ថ្ងៃមួយអាទិត្យ (បិទថ្ងៃបុណ្យ)។ អ្នកប្រើ TTY ហៅលេខ **711**។

Korean: 요일 및 시간에 관계없이 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하는 통역 서비스, 귀하의 언어로 번역된 자료 또는 대체 형식의 자료를 요청할 수 있습니다. 요일 및 시간에 관계없이 **1-800-464-4000**번으로 전화하십시오 (공휴일 휴무). TTY 사용자 번호 **711**.

Laotian: ການຊ່ວຍເຫຼືອດ້ານພາສາມີໃຫ້ໂດຍບໍ່ເສັງຄ່າ ແກ່ທ່ານ, ຕະຫຼອດ 24 ຊົ່ວໂມງ, 7 ວັນຕໍ່ອາທິດ. ທ່ານສາມາດຮ້ອງຂໍຮັບບໍລິການນາຍພາສາ, ໃຫ້ແປເອກະສານເປັນພາສາຂອງທ່ານ, ຫຼື ໃນຮູບແບບອື່ນ. ພຽງແຕ່ໂທອາທາຍອກເຮົາທີ່ **1-800-464-4000**, ຕະຫຼອດ 24 ຊົ່ວໂມງ, 7 ວັນຕໍ່ອາທິດ (ປິດວັນພັກຕ່າງໆ). ຜູ້ໃຊ້ສາຍ TTY ໂທ **711**.

Navajo: Saad bee áká'a'ayeed náhóló t'ásá jiik'é, naadiin doo bibaa' diji' ahéé'íikeed tsosts'id yiskáajj damoo ná'ádleejjí. Atah halne'é áká'adoolwołígíí jókí, t'áadoo le'é t'ásá hóhazaadji hadilyaa'go, éí doodaii' náána lá al'aa'ádaat'ehígíí bee hádadilyaa'go. Kojj hodiilnih 1-800-464-4000, naadiin doo bibaa' diji' ahéé'íikeed tsosts'id yiskáajj damoo ná'ádleejjí (Dahodiyin biniiyé e'e'aahgo éí da'deelkaal). TTY chodeeyoolinígíí koj hodiilnih 711.

Punjabi: ਬਿਨਾਂ ਕਿਸੀ ਲਾਗਤ ਦੇ, ਦਿਨ ਦੇ 24 ਘੰਟੇ, ਹਫ਼ਤੇ ਦੇ 7 ਦਿਨ, ਦੁਬਾਰੀਆ ਸੇਵਾਵਾਂ ਤੁਹਾਡੇ ਲਈ ਉਪਲਬਧ ਹੈ। ਤੁਸੀਂ ਇੱਕ ਦੁਬਾਰੀਏ ਦੀ ਮਦਦ ਲਈ, ਸਮੱਗਰੀਆਂ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਅਨੁਵਾਦ ਕਰਵਾਉਣ ਲਈ, ਜਾਂ ਕਿਸੇ ਵੱਖ ਵਾਰਸੈਟ ਵਿੱਚ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ ਬੇਨਤੀ ਕਰ ਸਕਦੇ ਹੋ। ਬਸ ਸਿਰਫ਼ ਸਾਨੂੰ 1-800-464-4000 ਤੇ, ਦਿਨ ਦੇ 24 ਘੰਟੇ, ਹਫ਼ਤੇ ਦੇ 7 ਦਿਨ (ਛੁੱਟੀਆਂ ਵਾਲੇ ਦਿਨ ਬੰਦ ਰਹਿੰਦਾ ਹੈ) ਫ਼ੋਨ ਕਰੋ। TTY ਦਾ ਉਪਯੋਗ ਕਰਨ ਵਾਲੇ 711 'ਤੇ ਫ਼ੋਨ ਕਰਨ।

Russian: Мы бесплатно обеспечиваем Вас услугами перевода 24 часа в сутки, 7 дней в неделю. Вы можете воспользоваться помощью устного переводчика, запросить перевод материалов на свой язык или запросить их в одном из альтернативных форматов. Просто позвоните нам по телефону 1-800-464-4000, который доступен 24 часа в сутки, 7 дней в неделю (кроме праздничных дней). Пользователи линии TTY могут звонить по номеру 711.

Spanish: Contamos con asistencia de idiomas sin costo alguno para usted 24 horas al día, 7 días a la semana. Puede solicitar los servicios de un intérprete, que los materiales se traduzcan a su idioma o en formatos alternativos. Solo llame al 1-800-788-0616, 24 horas al día, 7 días a la semana (cerrado los días festivos). Los usuarios de TTY, deben llamar al 711.

Tagalog: May magagamit na tulong sa wika nang wala kang babayaran, 24 na oras bawat araw, 7 araw bawat linggo. Maaari kang humingi ng mga serbisyo ng tagasalin sa wika, mga babasahin na isinalin sa iyong wika o sa mga alternatibong format. Tawagan lamang kami sa 1-800-464-4000, 24 na oras bawat araw, 7 araw bawat linggo (sarado sa mga pista opisyal). Ang mga gumagamit ng TTY ay maaaring tumawag sa 711.

Thai: เรามีบริการสามฟรีสำหรับคุณตลอด 24 ชั่วโมง ทุกวันตลอดชั่วโมงทำการของเราคุณสามารถขอให้ล่าม ช่วยตอบคำถามของคุณที่เกี่ยวกับความคุ้มครองการดูแล สุขภาพของเราและคุณยังสามารถขอให้มีการแปลเอกสาร เป็นภาษาที่คุณเข้าใจได้โดยไม่มีค่าธรรมเนียมการเพียงโทรหาเราที่หมายเลข 1-800-464-4000 ตลอด 24 ชั่วโมงทุกวัน (ปิดให้บริการในวันหยุดราชการ) ผู้ใช้ TTY โปรดโทรไปที่ 711

Vietnamese: Dịch vụ thông dịch được cung cấp miễn phí cho quý vị 24 giờ mỗi ngày, 7 ngày trong tuần. Quý vị có thể yêu cầu dịch vụ thông dịch, tài liệu phiên dịch ra ngôn ngữ của quý vị hoặc tài liệu bằng nhiều hình thức khác. Quý vị chỉ cần gọi cho chúng tôi tại số 1-800-464-4000, 24 giờ mỗi ngày, 7 ngày trong tuần (trừ các ngày lễ). Người dùng TTY xin gọi 711.

Disclosure Form Part One

COUNTY OF TULARE
Group ID 39189 - DHMO Low Plan
Member Services 1-800-464-4000
Home Region: Northern California
1/1/24 through 12/31/24

Principal benefits for Kaiser Permanente Deductible HMO Plan

Accumulation Period

The Accumulation Period for this plan is January 1 through December 31.

Out-of-Pocket Maximums and Deductibles

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

For Services that are subject to the Plan Deductible or the Drug Deductible, you must pay Charges for covered Services you receive during the Accumulation Period until you reach the deductible amounts listed below. All payments you make toward your deductibles apply to the Plan Out-of-Pocket Maximum amounts listed below.

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

Plan Provider Office Visits

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

Telehealth Visits

	You Pay
Primary Care Visits and Non-Physician Specialist Visits by interactive video	No charge (Plan Deductible doesn't apply)
Physician Specialist Visits by interactive video	No charge (Plan Deductible doesn't apply)
Primary Care Visits and Non-Physician Specialist Visits by telephone ..	No charge (Plan Deductible doesn't apply)
Physician Specialist Visits by telephone	No charge (Plan Deductible doesn't apply)

Outpatient Services

	You Pay
Outpatient surgery and certain other outpatient procedures	20% Coinsurance after Plan Deductible
Most immunizations (including the vaccine)	No charge (Plan Deductible doesn't apply)
Most X-rays and laboratory tests	\$10 per encounter after Plan Deductible
Preventive X-rays, screenings, and laboratory tests as described in the EOC	No charge (Plan Deductible doesn't apply)
MRI, most CT, and PET scans	20% Coinsurance up to a maximum of \$50 per procedure after Plan Deductible

Hospital Inpatient Services

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

Emergency Services

	You Pay
Emergency department visits	20% Coinsurance after Plan Deductible

Note: If you are admitted directly to the hospital as an inpatient for covered Services, you will pay the inpatient Cost Share instead of the emergency department Cost Share (see "Hospital Inpatient Services" for inpatient Cost Share)

Ambulance Services

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

Prescription Drug Coverage

	You Pay
Covered outpatient items in accord with our drug formulary guidelines: Most generic items (Tier 1) at a Plan Pharmacy	\$10 for up to a 30-day supply (Plan Deductible doesn't apply)

(continues)

Disclosure Form Part One

(continued)

Prescription Drug Coverage**You Pay**

Most generic (Tier 1) refills through our mail-order service	\$20 for up to a 100-day supply (Plan Deductible doesn't apply)
Most brand-name items (Tier 2) at a Plan Pharmacy	\$30 for up to a 30-day supply (Plan Deductible doesn't apply)
Most brand-name (Tier 2) refills through our mail-order service	\$60 for up to a 100-day supply (Plan Deductible doesn't apply)
Most specialty items (Tier 4) at a Plan Pharmacy	\$30 for up to a 30-day supply (Plan Deductible doesn't apply)

Durable Medical Equipment (DME)**You Pay**

DME items as described in the <i>EOC</i>	20% Coinsurance (Plan Deductible doesn't apply)
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Mental Health Services**You Pay**

Inpatient psychiatric hospitalization	20% Coinsurance after Plan Deductible
Individual outpatient mental health evaluation and treatment	\$20 per visit (Plan Deductible doesn't apply)
Group outpatient mental health treatment	\$10 per visit (Plan Deductible doesn't apply)

Substance Use Disorder Treatment**You Pay**

Inpatient detoxification	20% Coinsurance after Plan Deductible
Individual outpatient substance use disorder evaluation and treatment	\$20 per visit (Plan Deductible doesn't apply)
Group outpatient substance use disorder treatment	\$5 per visit (Plan Deductible doesn't apply)

Home Health Services**You Pay**

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

Skilled nursing facility care (up to 100 days per benefit period)	20% Coinsurance after Plan Deductible
Prosthetic and orthotic devices as described in the <i>EOC</i>	No charge (Plan Deductible doesn't apply)
Diagnosis and treatment of infertility and artificial insemination (such as outpatient procedures or laboratory tests) as described in the <i>EOC</i>	50% Coinsurance (Plan Deductible doesn't apply)
Assisted reproductive technology ("ART") Services	Not covered
Hospice care	No charge (Plan Deductible doesn't apply)

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

Summary of Benefits Chart for Kaiser Permanente Senior Advantage (HMO) with Part D (1/1/24—12/31/24)

Plan Out-of-Pocket Maximum

For Services subject to the maximum, you will not pay any more Cost Share for the rest of the calendar year if the Copayments and Coinsurance you pay for those Services add up to the following amount:
For any one Member\$1,000 per calendar year

Plan Deductible None

Professional Services (Plan Provider office visits) You Pay

Most Primary Care Visits and most Non-Physician Specialist Visits	\$15 per visit
Most Physician Specialist Visits	\$15 per visit
Annual Wellness visit and the “Welcome to Medicare” preventive visit	No charge
Routine physical exams	No charge
Routine eye exams with a Plan Optometrist	\$15 per visit
Urgent care consultations, evaluations, and treatment	\$15 per visit
Physical, occupational, and speech therapy	\$15 per visit

Telehealth Visits You Pay

Primary Care Visits and Non-Physician Specialist Visits by interactive video	No charge
Physician Specialist Visits by interactive video	No charge
Primary Care Visits and Non-Physician Specialist Visits by telephone	No charge
Physician Specialist Visits by telephone	No charge

Outpatient Services You Pay

Outpatient surgery and certain other outpatient procedures.....	\$15 per procedure
Most immunizations (including the vaccine)	No charge
Most X-rays and laboratory tests	No charge
Manual manipulation of the spine	\$15 per visit

Hospital Inpatient Services You Pay

Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	\$200 per admission
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Emergency Services You Pay

Emergency department visits.....	\$50 per visit
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Note: If you are admitted directly to the hospital as an inpatient for covered Services, you will pay the inpatient Cost Share instead of the emergency department Cost Share (see “Hospital Inpatient Services” for inpatient Cost Share)

Ambulance and Transportation Services You Pay

Ambulance Services	\$50 per trip
Other transportation Services when provided by our designated transportation provider as described in this EOC	No charge for up to 24 one-way trips (50 miles per trip) per calendar year

Prescription Drug Coverage You Pay

Covered outpatient items in accord with our drug formulary guidelines:	
Most generic items	\$10 for up to a 100-day supply

continued

Prescription Drug Coverage	You Pay
Most brand-name items	\$25 for up to a 100-day supply
Durable Medical Equipment (DME)	You Pay
Covered durable medical equipment for home use	20 percent Coinsurance
Mental Health Services	You Pay
Inpatient psychiatric hospitalization	\$200 per admission
Individual outpatient mental health evaluation and treatment.....	\$15 per visit
Group outpatient mental health treatment	\$7 per visit
Substance Use Disorder Treatment	You Pay
Inpatient detoxification	\$200 per admission
Individual outpatient substance use disorder evaluation and treatment.....	\$15 per visit
Group outpatient substance use disorder treatment.....	\$5 per visit
Home Health Services	You Pay
Home health care (part-time, intermittent)	No charge
Other	You Pay
Eyeglasses or contact lenses every 24 months	Amount in excess of \$150 Allowance
Skilled nursing facility care (up to 100 days per benefit period).....	No charge
External prosthetic and orthotic devices	20 percent Coinsurance
Meals delivered to your home immediately following discharge from a network hospital or Skilled Nursing Facility	No charge up to three meals per day in a consecutive four-week period, once per calendar year
Over-the-Counter (OTC) Health and Wellness products obtained through our OTC catalog	No charge for a quarterly benefit limit of \$70

This chart does not explain benefits, Cost Share, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Share amounts. For additional information, please refer to the *Summary of Benefits* booklet enclosed; for a complete explanation, refer to the *EOC*.

Your Kaiser Permanente **CHIROPRACTIC** benefits

When you need chiropractic care, follow these simple steps:

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

(See the reverse for more details.)

YOUR KAISER PERMANENTE CHIROPRACTIC BENEFIT

Office Visits	Cost Sharing and Visit Limits
<p>Covered Services are limited to Medically Necessary Chiropractic Services authorized and provided by ASH Participating Providers except for the initial examination, Emergency Chiropractic Services, Urgent Chiropractic Services, and Services that are not available from ASH Participating Providers or other licensed providers with which ASH contracts to provide covered care. You can obtain an initial examination from any ASH Participating Provider without a referral from a Kaiser Permanente Plan Physician. Each office visit counts toward any visit limit, if applicable.</p>	<p>Office visit cost share: \$15 copayment per visit (if your <i>Amendment</i> is paired with an HDHP HMO evidence of coverage, this cost share is subject to the Plan Deductible described in your <i>EOC</i>)</p> <p>Office visit limit: 30 visits per year</p> <p>Chiropractic supports and appliances: If the amount of the appliance in the ASH Plans fee schedule exceeds \$50, you will pay the amount in excess of \$50. Covered chiropractic appliances are limited to: elbow supports, back supports, cervical collars, cervical pillows, heel lifts, hot or cold packs, lumbar braces and supports, lumbar cushions, orthotics, wrist supports, rib belts, home traction units, ankle braces, knee braces, rib supports, and wrist braces.</p>
<p>X-rays and laboratory tests: Medically Necessary X-rays and laboratory tests are covered at no charge when prescribed as part of covered chiropractic care and an ASH Participating Provider provides the Services or refers you to another licensed provider with which ASH contracts for the Services. If your <i>Amendment</i> is paired with an HDHP HMO evidence of coverage, this cost share is subject to the Plan Deductible described in your <i>EOC</i>.</p>	
ASH Participating Providers	
<p>ASH Plans contracts with ASH Participating Providers and other licensed providers to provide covered Chiropractic Services. You must receive these services from an ASH Participating Provider or another licensed provider with which ASH contracts, except for Emergency Chiropractic Services, Urgent Chiropractic Services, and Services that are not available from contracted providers that are authorized in advance by ASH Plans. The list of ASH Participating Providers is available on the ASH Plans website at ashlink.com/ash/kaisercaremedicare for Kaiser Permanente Senior Advantage members, or ashlink.com/ash/kp for all other members, or from the ASH Plans Customer Service Department toll free at 1-800-678-9133 (TTY 711). The list of ASH Participating Providers is subject to change at any time without notice.</p>	
How to obtain services	
<p>To obtain covered Services, call an ASH Participating Provider to schedule an initial examination. If additional Services are required, verification that the Services are Medically Necessary may be required. Your ASH Participating Provider will request any medical necessity determinations. An ASH Plans clinician in the same or similar specialty as the provider of Services under review will decide whether the Services are or were Medically Necessary. ASH Plans will disclose to you, upon request, the written criteria it uses to make the decision to authorize, modify, delay, or deny a request for authorization. If you have questions or concerns, please contact the ASH Plans Customer Service Department.</p>	

Second Opinions

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

Your costs

When you receive covered Chiropractic Services, you must pay the cost share described below. The cost share does not apply toward the Plan Deductible or Plan Out-of-Pocket Maximum described in your Health Plan *Evidence of Coverage* (“*EOC*”), unless your *Chiropractic Services Amendment* (“*Amendment*”) is amending an HSA-Qualified High Deductible Health Plan (HDHP) HMO plan evidence of coverage. If your *Amendment* is paired with an HDHP HMO evidence of coverage, the cost share you pay for covered Services is subject to the Plan Deductible and Plan Out-of-Pocket Maximum described in your *EOC*.

Emergency and Urgent Chiropractic Services

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

Getting Assistance

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

Grievances

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

Exclusions

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

Definitions

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

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

Chiropractic Services: Chiropractic services include spinal and extremity manipulation and adjunctive therapies such as ultrasound, therapeutic exercise, or electrical muscle stimulation, when provided during the same course of treatment and in conjunction with chiropractic manipulative services, and other services provided or prescribed by a chiropractor (including laboratory tests, X-rays, and chiropractic supports and appliances) for the treatment of your Musculoskeletal and Related Disorder.

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

Medically Necessary: A Service is Medically Necessary if it is medically appropriate and required to prevent, diagnose, or treat your condition or clinical symptoms in accord with generally accepted professional standards of practice that are consistent with a standard of care in the medical community.

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

Non-Participating Provider: A provider other than an ASH Participating Provider.

Services: Health care services or items.

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

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

This is a summary and is intended to highlight only the most frequently asked questions about the chiropractic benefit, including cost share. Please refer to the *Amendment* for a detailed description of the chiropractic coverage.

Language Assistance Services

English: Language assistance is available at no cost to you, 24 hours a day, 7 days a week. You can request interpreter services, materials translated into your language, or in alternative formats. Just call us at **1-800-464-4000**, 24 hours a day, 7 days a week (closed holidays). TTY users call **711**.

Arabic: خدمات الترجمة الفورية متوفرة لك مجاناً على مدار الساعة كافة أيام الأسبوع. بإمكانك طلب خدمة الترجمة الفورية أو ترجمة وثائق للعتك أو لصيغ أخرى. ما عليك سوى الاتصال بنا على الرقم **1-800-464-4000** على مدار الساعة كافة أيام الأسبوع (مغلق أيام العطلات). لاستخدمى خدمة الهاتف النصي يرجى الاتصال على الرقم (711).

Armenian: Ձեզ կարող է անվճար օգնություն արանադրվել լեզվի հարցում՝ օրը 24 ժամ, շաբաթը 7 օր: Դուք կարող եք պահանջել բանավոր թարգմանի ծառայություններ, Ձեր լեզվով թարգմանված կամ այլընտրանքային ձևաչափով պատրաստված նյութեր: Մարզայես զանգահարեք մեզ՝ **1-800-464-4000** հեռախոսահամարով՝ օրը 24 ժամ՝ շաբաթը 7 օր (տոն օրերին վսակ է): TTY-ից օգտվողները պետք է զանգահարեն **711**:

Chinese: 您每週 7 天，每天 24 小時均可獲得免費語言協助。您可以申請口譯服務、要求將資料翻譯成您所用語言或轉換為其他格式。我們每週 7 天，每天 24 小時均歡迎您打電話 **1-800-757-7585** 前來聯絡（節假日休息）。聽障及語障專線 (TTY) 使用者請撥 **711**。

Farsi: خدمات زبانی در 24 ساعت شبانه روز و 7 روز هفته بدون احتلا هزینه در اختیار شما است. شما می توانید برای خدمات مترجم شفاهی، ترجمه جزوات به زبان شما و یا به صورتهای دیگر درخواست کنید. کیفیت در 24 ساعت شبانه روز و 7 روز هفته (به استثنای روزهای تعطیل) با ما به شماره **1-800-464-4000** تماس بگیرید. کاربران TTY با شماره **711** تماس بگیرند.

Hindi: बिना किसी लागत के दुभाषिया सेवाएँ, दिन के 24 घंटे, सप्ताह के सातों दिन उपलब्ध हैं। आप एक दुभाषिये की सेवाओं के लिए, बिना किसी लागत के सामग्रियों को अपनी भाषा में अनुवाद करवाने के लिए, या वैकल्पिक प्रारूपों के लिए अनुरोध कर सकते हैं। बस केवल हमें **1-800-464-4000** पर, दिन के 24 घंटे, सप्ताह के सातों दिन (छुट्टियों वाले दिन बंद रहता है) कॉल करें। TTY उपयोगकर्ता **711** पर कॉल करें।

Hmong: Muajkwe pab txhais lus pub dawb rau koj, 24 teev ib hnub twg, 7 hnub ib lim tiam twg. Koj thov tau cov kev pab txhais lus, muab cov ntaub ntawv txhais ua koj hom lus, los yog ua lwm hom. Tsuas hu rau **1-800-464-4000**, 24 teev ib hnub twg, 7 hnub ib lim tiam twg (cov hnub caiv kaw). Cov neeg siv TTY hu **711**.

Japanese: 当院では、言語支援を無料で、年中無休、終日ご利用いただけます。通訳サービス、日本語に翻訳された資料、あるいは資料を別の書式でも依頼できます。お気軽に **1-800-464-4000** までお電話ください（祭日を除き年中無休）。TTY ユーザーは **711** にお電話ください。

Khmer: ជំនួយភាសា គឺមានឥតអស់ថ្លៃដល់អ្នកឡើយ 24 ម៉ោងមួយថ្ងៃ 7 ថ្ងៃមួយអាទិត្យ។ អ្នកអាចស្នើសុំសេវាអ្នកបកប្រែ សំភារៈដែលបានបកប្រែទៅជាភាសាខ្មែរ ឬជាទម្រង់ផ្សេងទៀត។ គ្រាន់តែទូរស័ព្ទមកយើង តាមលេខ **1-800-464-4000** បាន 24 ម៉ោងមួយថ្ងៃ 7 ថ្ងៃមួយអាទិត្យ (បិទថ្ងៃបុណ្យ)។ អ្នកប្រើ TTY ហៅលេខ **711**។

Korean: 요일 및 시간에 관계없이 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하는 통역 서비스, 귀하의 언어로 번역된 자료 또는 대체 형식의 자료를 요청할 수 있습니다. 요일 및 시간에 관계없이 **1-800-464-4000**번으로 전화하십시오 (공휴일 휴무). TTY 사용자 번호 **711**.

Laotian: ການຊ່ວຍເຫຼືອດ້ານພາສາມີໃຫ້ໂດຍບໍ່ເສັງຄ່າ ແກ່ທ່ານ, ຕະຫຼອດ 24 ຊົ່ວໂມງ, 7 ວັນຕໍ່ອາທິດ. ທ່ານ ສາມາດຮ້ອງຂໍຮັບບໍລິການນາຍພາສາ, ໃຫ້ແປເອກະ ສານເປັນພາສາຂອງທ່ານ, ຫຼື ໃນຮູບແບບອື່ນ. ພຽງ ແຕ່ໂທຫາພວກເຮົາທີ່ **1-800-464-4000**, ຕະຫຼອດ 24 ຊົ່ວໂມງ, 7 ວັນຕໍ່ອາທິດ (ປິດວັນພັກຕ່າງໆ). ຜູ້ໃຊ້ສາຍ TTY ໂທ **711**.

Navajo: Saad bee áká'a' ayeed náhóló t'áá' jüik'é, naadiin doo bibaa' dji' ahéé' iikeed tsosts'id yiskáajj damoo ná'ádleejj. Atah halne'é áká' adoolwoligii jóki, t'áadoo le'é t'áá' hóhazaadji hadilyaa' go, éi doodaai' náaná lá al'aa' ádaat'ehigii bee hádadilyaa' go. Kojj hodiilnih 1-800-464-4000, naadiin doo bibaa' dji' ahéé' iikeed tsosts'id yiskáajj damoo ná'ádleejj (Dahodiyin biniiyé e'e' aahgo éi da' deelkaal).

TTY chodeeyoolinigii koj hodiilnih 711.

Punjabi: ਬਿਨਾਂ ਕਿਸੀ ਲਾਗਤ ਦੇ, ਦਿਨ ਦੇ 24 ਘੰਟੇ, ਹਫ਼ਤੇ ਦੇ 7 ਦਿਨ, ਦੁਬਾਰੀਆ ਸੇਵਾਵਾਂ ਤੁਹਾਡੇ ਲਈ ਉਪਲਬਧ ਹੈ। ਤੁਸੀਂ ਇੱਕ ਦੁਬਾਰੀਏ ਦੀ ਮਦਦ ਲਈ, ਸਮਗਰੀਆਂ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਅਨੁਵਾਦ ਕਰਵਾਉਣ ਲਈ, ਜਾਂ ਕਿਸੇ ਵੱਖ ਫਾਰਮੈਟ ਵਿੱਚ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ ਬੈਨਤੀ ਕਰ ਸਕਦੇ ਹੋ। ਬਸ ਸਿਰਫ ਸਾਨੂੰ 1-800-464-4000 ਤੇ, ਦਿਨ ਦੇ 24 ਘੰਟੇ, ਹਫ਼ਤੇ ਦੇ 7 ਦਿਨ (ਛੁੱਟੀਆਂ ਵਾਲੇ ਦਿਨ ਬੰਦ ਰਹਿੰਦਾ ਹੈ) ਫ਼ੋਨ ਕਰੋ। TTY ਦਾ ਉਪਯੋਗ ਕਰਨ ਵਾਲੇ 711 'ਤੇ ਫ਼ੋਨ ਕਰਨ।

Russian: Мы бесплатно обеспечиваем Вас услугами перевода 24 часа в сутки, 7 дней в неделю. Вы можете воспользоваться помощью устного переводчика, запросить перевод материалов на свой язык или запросить их в одном из альтернативных форматов. Просто позвоните нам по телефону 1-800-464-4000, который доступен 24 часа в сутки, 7 дней в неделю (кроме праздничных дней). Пользователи линии TTY могут звонить по номеру 711.

Spanish: Contamos con asistencia de idiomas sin costo alguno para usted 24 horas al día, 7 días a la semana. Puede solicitar los servicios de un intérprete, que los materiales se traduzcan a su idioma o en formatos alternativos. Solo llame al 1-800-788-0616, 24 horas al día, 7 días a la semana (cerrado los días festivos). Los usuarios de TTY, deben llamar al 711.

Tagalog: May magagamit na tulong sa wika nang wala kang babayaran, 24 na oras bawat araw, 7 araw bawat linggo. Maaari kang humingi ng mga serbisyo ng tagasalin sa wika, mga babasahin na isinalin sa iyong wika o sa mga alternatibong format. Tawagan lamang kami sa 1-800-464-4000, 24 na oras bawat araw, 7 araw bawat linggo (sarado sa mga pista opisyal). Ang mga gumagamit ng TTY ay maaaring tumawag sa 711.

Thai: เรามีบริการล่ามฟรีสำหรับคุณตลอด 24 ชั่วโมงทุกวันตลอดชั่วโมงทำการของเราคุณสามารถขอให้ล่ามช่วยตอบคำถามของคุณที่เกี่ยวกับความคุ้มครองการดูแลสุขภาพของเราและคุณยังสามารถขอให้มีการแปลเอกสารเป็นภาษาที่คุณเข้าใจได้โดยไม่มีค่าธรรมเนียมการเพียงโทรหาเราที่หมายเลข 1-800-464-4000 ตลอด 24 ชั่วโมงทุกวัน (ปิดให้บริการในวันหยุดราชการ) ผู้ใช้ TTY โปรดโทรไปที่ 711

Vietnamese: Dịch vụ thông dịch được cung cấp miễn phí cho quý vị 24 giờ mỗi ngày, 7 ngày trong tuần. Quý vị có thể yêu cầu dịch vụ thông dịch, tài liệu phiên dịch ra ngôn ngữ của quý vị hoặc tài liệu bằng nhiều hình thức khác. Quý vị chỉ cần gọi cho chúng tôi tại số 1-800-464-4000, 24 giờ mỗi ngày, 7 ngày trong tuần (trừ các ngày lễ). Người dùng TTY xin gọi 711.

Keep smiling

Delta Dental PPO™



Save with PPO

Visit a dentist in the PPO¹ network to maximize your savings.² These dentists have agreed to reduced fees, and you won't get charged more than your expected share of the bill.³ Find a PPO dentist at deltadentalins.com.

Set up an online account

Get information about your plan, check benefits and eligibility information, find a network dentist and more. Sign up for an online account at deltadentalins.com.

Check in without an ID card

You don't need a Delta Dental ID card when you visit the dentist. Just provide your name, birth date and enrollee ID or Social Security number. If your family members are covered under your plan, they'll need your information. Prefer to have an ID card? Simply log in to your account to view or print your card.

Coordinate dual coverage

If you're covered under two plans, ask your dental office to include information about both plans with your claim — we'll handle the rest.

Understand transition of care

Generally, multi-stage procedures are covered under your current plan only if treatment began after your plan's effective date of coverage.⁴ Log in to your online account to find this date.

Get LASIK and hearing aid discounts

With access to QualSight and Amplifon Hearing Health Care⁵, you can receive significant savings on LASIK procedures and hearing aids. To take advantage of these discounts, call QualSight at **855-248-2020** and Amplifon at **888-779-1429**.

Save with a PPO dentist



PPO



NON-PPO

¹ In Texas, Delta Dental Insurance Company provides a dental provider organization (DPO) plan.

² You can still visit any licensed dentist, but your out-of-pocket costs may be higher if you choose a non-PPO dentist. Network dentists are paid contracted fees.

³ You are responsible for any applicable deductibles, coinsurance, amounts over annual or lifetime maximums and charges for non-covered services. Out-of-network dentists may bill the difference between their usual fee and Delta Dental's maximum contract allowance.

⁴ Applies only to procedures covered under your plan. If you began treatment prior to your effective date of coverage, you or your prior carrier is responsible for any costs. Group- and state-specific exceptions may apply. If you are currently undergoing active orthodontic treatment, you may be eligible to continue treatment under Delta Dental PPO. Review your Evidence of Coverage, Summary Plan Description or Group Dental Service Contract for specific details about your plan.

⁵ Vision corrective services and Amplifon's hearing health care services are not insured benefits. Delta Dental makes the vision corrective services program and hearing health care services program available to you to provide access to the preferred pricing for LASIK surgery and for hearing aids and other hearing health services.

Benefit Highlights: Delta Dental PPO TM

Plan Benefit Highlights for: County of Tulare

Group No: 16128

Effective Date: 1/1/2024

Eligibility	For eligibility details, refer to the plan's Evidence/Certificate of Coverage (on file with your benefits administrator, plan sponsor or employer).			
Deductibles Deductibles waived for Diagnostic & Preventive (D & P)?	Delta Dental PPO dentists: None			
	Non-Delta Dental PPO dentists: \$25 per person / \$75 per family each calendar year			
Maximums D & P counts toward maximum?	Delta Dental PPO dentists: N/A			
	Non-Delta Dental PPO dentists: Yes			
Waiting Period(s)	\$2,000 per person each calendar year			
	D & P counts toward maximum?	Yes		
Waiting Period(s)	Basic Services	Major Services	Prosthodontics	Orthodontics
	None	None	None	None

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

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

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

Delta Dental of California 560 Mission St., Suite 1300 San Francisco, CA 94105	Customer Service 888-335-8227	Claims Address P.O. Box 997330 Sacramento, CA 95899-7330
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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.

Keep smiling

DeltaCare® USA



Dental benefits made easy!

When you enroll in a DeltaCare USA¹ plan, you'll choose a primary care dentist from our network of carefully screened, private-practice dentists. You must visit your primary care dentist to receive benefits.²

- No restrictions on pre-existing conditions (except work in progress)
- Access to specialty care and out-of-area emergency care

A partner in oral health

Your DeltaCare USA plan encourages regular dental care with an extensive list of covered services to help you stay healthy.

- Low or no copayments for services like cleanings and exams

Budget-friendly costs

With your DeltaCare USA plan, there are no surprises. You'll know your copayments, and your out-of-pocket costs are clearly defined before treatment begins.

- No deductibles or maximums³ for covered services
- Pay only your copayment (if any) at the time of treatment

Convenient services

We make it easy for you — there are no claim forms to complete, and no plan ID card is required to receive treatment.

- Access plan information online
- Change your primary care dentist by phone or online

LEGAL NOTICES: Access federal and state legal notices related to your plan: deltadentalins.com/about/legal/index-enrollee.html

¹ DeltaCare USA is underwritten in these states by these entities: AL — Alpha Dental of Alabama, Inc.; AZ — Alpha Dental of Arizona, Inc.; CA — Delta Dental of California; AR, CO, IA, MA, ME, MI, MN, NC, ND, NE, NH, OK, OR, RI, SC, SD, VA, VT, WA, WI, WY — Dentegra Insurance Company; AK, CT, DC, DE, FL, GA, KS, LA, MS, MT, TN, WV — Delta Dental Insurance Company; HI, ID, IL, IN, KY, MD, MO, NJ, OH, TX — Alpha Dental Programs, Inc.; NV — Alpha Dental of Nevada, Inc.; UT — Alpha Dental of Utah, Inc.; NM — Alpha Dental of New Mexico, Inc.; NY — Delta Dental of New York, Inc.; PA — Delta Dental of Pennsylvania. Delta Dental Insurance Company acts as the DeltaCare USA administrator in all these states. These companies are financially responsible for their own products. Delta Dental is a registered trademark of Delta Dental Plans Association.

² Verify your selected DeltaCare USA primary care dentist before each appointment.

³ Plans with an Accidental Injury Rider have a \$1,600 annual maximum for accidental injury. Consult your Evidence/Certificate of Coverage.



deltadentalins.com/enrollees

Frequently asked questions

What you need to know about your DeltaCare[®] USA plan

Getting started

1. How do I enroll in a DeltaCare USA plan?

Simply complete the enrollment process as directed by your benefits administrator. Be sure to select a primary care network dentist for yourself or your dependents, and indicate this dentist and the name of your group when you enroll.

2. How do I get started using my DeltaCare USA plan?

Once we process your enrollment, we'll mail you welcome materials that will include:

- **The name, address and phone number of your selected primary care dentist.** Simply call the dental facility to make an appointment. **Important note:** In order to receive benefits under your plan, you must visit your primary care network dentist for all services. If you require treatment from a specialist, your primary care dentist will coordinate a referral for you. You can change your primary care dentist by contacting us.
- **Your Evidence/Certificate of Coverage (plan booklet).** This useful document provides a thorough description of how to use your benefits, including covered services, copayments and any limitations and exclusions of your plan.
- **An ID card.** This card is for your records only — you do not need to present it in order to receive treatment.

3. How long will it take to get an appointment with my primary care dentist?

Two to four weeks¹ is a reasonable amount of time to wait for a routine, non-urgent appointment. If you require a specific time slot, you may need to wait longer. Most DeltaCare USA dentists are in private group practices, which generally offer greater appointment availability and extended office hours.

4. How much will my dental treatments cost? How do I pay?

With your DeltaCare USA plan, some services are covered at no cost, while others have a copayment (amount you pay) for certain services. To find out how much a treatment will cost, refer to the "Description of Benefits and Copayments" in this brochure for a list of covered services and copayments. It's a good idea to bring your Evidence/Certificate of Coverage to your appointment in case you need to discuss your copayment for a service with your dentist. If you have any questions about the charges for a service, please contact Customer Service. If you receive treatment that requires a copayment, simply pay the dental facility at the time of service.

Choosing a dentist

5. How do I select my primary care dentist?

When you enroll, you must select a primary care dentist from the DeltaCare USA network². To search for a dentist, use the **Find a dentist** tool at deltadentalins.com and select the DeltaCare USA network. You must visit your selected primary care dentist to use plan benefits. Important: Dental services provided by a dentist other than your selected primary care dentist will be denied. Your primary care dentist will refer you to a specialist if any specialty care is required.

6. Does everyone in my family have to choose the same primary care dentist?

No. Each family member can select his or her own primary care network dentist.³

7. Can I change my primary care dentist?

Yes. You can request to change your primary care dentist at any time. Simply visit our website and log on to your online account or contact Customer Service. Selections made by the 15th of the month are effective immediately. Selections made on or after the 16th of the month will be effective on the first day of the following month.

¹ In TX, three weeks is a reasonable amount of time to wait for a routine, non-urgent appointment. In TX, there is no limit on the number of miles or on the dollar amount per emergency.

² In AZ, MD, and TX, if you do not select a dentist when you enroll, we will choose one for you.

³ In MA, you cannot select more than three primary care dentist facilities per family.

- 8. My dentist says she is a Delta Dental dentist, but she isn't listed in the DeltaCare USA directory. Can I still visit her for services?**
No. Delta Dental has many networks, and participation may vary — not all Delta Dental dentists are DeltaCare USA dentists. You must visit your selected primary care network dentist to receive benefits under this plan.
- 9. What should I do if I need to see a specialist?**
If you require specialty dental care — such as oral surgery, endodontics, periodontics or pediatric dentistry — contact your primary care dentist to request a referral. Specialty dental services not performed by your selected primary care dentist must be authorized by us. You are responsible for any applicable copayments.

General plan information

- 10. If I'm traveling, is emergency treatment covered under my plan?**
You and your eligible dependents have out-of-area coverage for dental emergencies.³ Your out-of-area emergency benefit (typically limited to \$100 per person) is for services to relieve pain until you can return to your primary care network dentist.⁴ Standard plan limitations, exclusions and copayments may apply.
- 11. Can I access my plan online?**
Yes. Visit deltadentalins.com to create a free, secure online account. You can access your plan benefits and ID card, select (or change) your primary care dentist and more.

³ State-specific minimum distance requirements may apply.

⁴ In TX, there is no limit on the number of miles or on the dollar amount per emergency.

⁵ In TX, there is no exception for work in progress for covered DeltaCare USA benefits.

- 12. Does my plan cover pre-existing conditions? What about treatments that are in progress?**
Treatment for pre-existing conditions (except work in progress⁵), including missing or extracted teeth, is covered under your plan. Treatment in progress includes services such as preparations for crowns or root canals, or impressions for dentures. If you started treatment before your plan's effective date, you and your prior dental carrier are responsible for any costs. Some DeltaCare USA plans may cover in-progress orthodontic treatment.
- 13. Does my plan cover teeth whitening?**
Yes. External bleaching is a benefit under your DeltaCare USA plan. Review your plan booklet for more information and talk to your dentist about your options.
- 14. Does my plan cover tooth-colored fillings and crowns?**
Yes. Porcelain and other tooth-colored materials are included in this plan.
- 15. What if I have additional questions about my plan?**
Please contact us for additional support. Our Customer Service representatives can answer benefits questions as well as help you change your primary care dentist or arrange for urgent care referrals. See the back page of this brochure for our contact information.

We make it easy for you!



Select a
DeltaCare USA
dentist



Receive your
welcome materials



Schedule an
appointment



Receive
dental care



Pay only your
share to dentist

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. You should discuss all treatment options with Your Contract Dentist prior to services being rendered.

Text that appears in italics below is specifically intended to clarify the delivery of Benefits under the DeltaCare USA Program and is not to be interpreted as Current Dental Terminology ("CDT"), CDT-2023 procedure codes, descriptors or nomenclature that are under copyright by the American Dental Association ("ADA"). The ADA may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.

CODE	DESCRIPTION	ENROLLEE PAYS
D0100-D0999	I. DIAGNOSTIC	
D0120	Periodic oral evaluation - established patient	No Cost
D0140	Limited oral evaluation - problem focused	No Cost
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No Cost
D0150	Comprehensive oral evaluation - new or established patient	No Cost
D0160	Detailed and extensive oral evaluation - problem focused, by report	No Cost
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	No Cost
D0171	Re-evaluation - post-operative office visit	No Cost
D0180	Comprehensive periodontal evaluation - new or established patient	No Cost
D0190	Screening of a patient	No Cost
D0191	Assessment of a patient	No Cost
D0210	Intraoral - comprehensive series of radiographic images - <i>limited to 1 series every 24 months</i>	No Cost
D0220	Intraoral - periapical first radiographic image	No Cost
D0230	Intraoral - periapical each additional radiographic image	No Cost
D0240	Intraoral - occlusal radiographic image	No Cost
D0250	Extraoral - 2D projection radiographic image created using a stationary radiation source, and detector	No Cost
D0251	Extraoral posterior dental radiographic image	No Cost
D0270	Bitewing - single radiographic image	No Cost
D0272	Bitewings - two radiographic images	No Cost
D0273	Bitewings three radiographic images	No Cost
D0274	Bitewings - four radiographic images - <i>limited to 1 series every 6 months</i>	No Cost
D0277	Vertical bitewings - 7 to 8 radiographic images	No Cost
D0330	Panoramic radiographic image	No Cost
D0415	Collection of microorganisms for culture and sensitivity	No Cost
D0419	Assessment of salivary flow by measurement - <i>1 every 12 months</i>	No Cost
D0425	Caries susceptibility tests	No Cost
D0460	Pulp vitality tests	No Cost
D0470	Diagnostic casts	No Cost
D0472	Accession of tissue, gross examination, preparation and transmission of written report - <i>available only when performed in conjunction with a covered biopsy</i>	No Cost
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report - <i>available only when performed in conjunction with a covered biopsy</i>	No Cost
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report - <i>available only when performed in conjunction with a covered biopsy</i>	No Cost
D0601	Caries risk assessment and documentation, with a finding of low risk - <i>1 every 12 months</i>	No Cost
D0602	Caries risk assessment and documentation, with a finding of moderate risk - <i>1 every 12 months</i>	No Cost
D0603	Caries risk assessment and documentation, with a finding of high risk - <i>1 every 12 months</i>	No Cost
D0701	Panoramic radiographic image - image capture only	No Cost
D0702	2-D cephalometric radiographic image - image capture only	No Cost
D0703	2-D oral/facial photographic image obtained intra-orally or extra-orally - image capture only	No Cost
D0705	Extra-oral posterior dental radiographic image - image capture only	No Cost

D0706	Intraoral - occlusal radiographic image - image capture only	No Cost
D0707	Intraoral - periapical radiographic image - image capture only	No Cost
D0708	Intraoral - bitewing radiographic image - image capture only	No Cost
D0709	Intraoral - comprehensive series of radiographic images - image capture only	No Cost
D0999	Unspecified diagnostic procedure, by report - <i>includes office visit, per visit (in addition to other services)</i>	No Cost

D1000-D1999 II. PREVENTIVE

D1110	Prophylaxis cleaning - adult - 1 D1110, D1120 or D4346 per 6 month period	No Cost
D1110	<i>Additional prophylaxis cleaning - adult (within the 6 month period)</i>	\$45.00
D1120	Prophylaxis cleaning - child - 1 D1110, D1120 or D4346 per 6 month period	No Cost
D1120	<i>Additional prophylaxis cleaning - child (within the 6 month period)</i>	\$35.00
D1206	Topical application of fluoride varnish - 1 D1206 or D1208 per 6 month period	No Cost
D1208	Topical application of fluoride - excluding varnish - 1 D1206 or D1208 per 6 month period	No Cost
D1310	Nutritional counseling for control of dental disease	No Cost
D1320	Tobacco counseling for the control and prevention of oral disease	No Cost
D1330	Oral hygiene instructions	No Cost
D1351	Sealant - per tooth - <i>limited to permanent molars through age 15</i>	No Cost
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth - <i>limited to permanent molars through age 15</i>	No Cost
D1353	Sealant repair - per tooth - <i>limited to permanent molars through age 15</i>	No Cost
D1354	Application of caries arresting medicament - per tooth - 1 per 6 month period	No Cost
D1510	Space maintainer - fixed - unilateral - per quadrant	No Cost
D1516	Space maintainer - fixed - bilateral, maxillary	No Cost
D1517	Space maintainer - fixed - bilateral, mandibular	No Cost
D1520	Space maintainer - removable - unilateral - per quadrant	No Cost
D1526	Space maintainer - removable - bilateral, maxillary	No Cost
D1527	Space maintainer - removable - bilateral, mandibular	No Cost
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	No Cost
D1552	Re-cement or re-bond bilateral space maintainer - mandibular	No Cost
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant	No Cost
D1556	Removal of fixed unilateral space maintainer - per quadrant	No Cost
D1557	Removal of fixed bilateral space maintainer - maxillary	No Cost
D1558	Removal of fixed bilateral space maintainer - mandibular	No Cost
D1575	Distal shoe space maintainer - fixed, unilateral - per quadrant - <i>child to age 9</i>	No Cost

D2000-D2999 III. RESTORATIVE

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

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

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

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

D2140	Amalgam - one surface, primary or permanent	No Cost
D2150	Amalgam - two surfaces, primary or permanent	No Cost
D2160	Amalgam - three surfaces, primary or permanent	No Cost
D2161	Amalgam - four or more surfaces, primary or permanent	No Cost
D2330	Resin-based composite - one surface, anterior	No Cost
D2331	Resin-based composite - two surfaces, anterior	No Cost
D2332	Resin-based composite - three surfaces, anterior	No Cost
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	No Cost
D2390	Resin-based composite crown, anterior	No Cost
D2391	Resin-based composite - one surface, posterior	\$25.00
D2392	Resin-based composite - two surfaces, posterior	\$30.00
D2393	Resin-based composite - three surfaces, posterior	\$35.00
D2394	Resin-based composite - four or more surfaces, posterior	\$40.00
D2510	Inlay - metallic - one surface	No Cost

D2520	Inlay - metallic - two surfaces	No Cost
D2530	Inlay - metallic - three or more surfaces	No Cost
D2542	Onlay - metallic - two surfaces	No Cost
D2543	Onlay - metallic - three surfaces	No Cost
D2544	Onlay - metallic - four or more surfaces	No Cost
D2610	Inlay - porcelain/ceramic - one surface*	\$50.00
D2620	Inlay - porcelain/ceramic - two surfaces*	\$60.00
D2630	Inlay - porcelain/ceramic - three or more surfaces*	\$65.00
D2642	Onlay - porcelain/ceramic - two surfaces*	\$55.00
D2643	Onlay - porcelain/ceramic - three surfaces*	\$65.00
D2644	Onlay - porcelain/ceramic - four or more surfaces*	\$70.00
D2650	Inlay - resin-based composite - one surface	\$15.00
D2651	Inlay - resin-based composite - two surfaces	\$20.00
D2652	Inlay - resin-based composite - three or more surfaces	\$30.00
D2662	Onlay - resin-based composite - two surfaces	\$25.00
D2663	Onlay - resin-based composite - three surfaces	\$35.00
D2664	Onlay - resin-based composite - four or more surfaces	\$50.00
D2710	Crown - resin-based composite (indirect)	No Cost
D2712	Crown - 3/4 resin-based composite (indirect)	No Cost
D2720	Crown - resin with high noble metal	\$30.00
D2721	Crown - resin with predominantly base metal	\$15.00
D2722	Crown - resin with noble metal	\$20.00
D2740	Crown - porcelain/ceramic*	\$85.00
D2750	Crown - porcelain fused to high noble metal*	\$70.00
D2751	Crown - porcelain fused to predominantly base metal	\$55.00
D2752	Crown - porcelain fused to noble metal	\$60.00
D2753	Crown - porcelain fused to titanium and titanium alloys*	\$70.00
D2780	Crown - 3/4 cast high noble metal	\$70.00
D2781	Crown - 3/4 cast predominantly base metal	\$55.00
D2782	Crown - 3/4 cast noble metal	\$60.00
D2783	Crown - 3/4 porcelain/ceramic*	\$70.00
D2790	Crown - full cast high noble metal	\$70.00
D2791	Crown - full cast predominantly base metal	\$55.00
D2792	Crown - full cast noble metal	\$60.00
D2794	Crown - titanium and titanium alloys	\$70.00
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	No Cost
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	No Cost
D2920	Re-cement or re-bond crown	No Cost
D2921	Reattachment of tooth fragment, incisal edge or cusp (<i>anterior</i>)	No Cost
D2928	Prefabricated porcelain/ceramic crown - permanent tooth	No Cost
D2929	Prefabricated porcelain/ceramic crown - primary tooth - <i>anterior</i>	No Cost
D2930	Prefabricated stainless steel crown - primary tooth	No Cost
D2931	Prefabricated stainless steel crown - permanent tooth	No Cost
D2932	Prefabricated resin crown - <i>anterior primary tooth</i>	No Cost
D2933	Prefabricated stainless steel crown with resin window - <i>anterior primary tooth</i>	No Cost
D2940	Protective restoration	No Cost
D2941	Interim therapeutic restoration - primary dentition	No Cost
D2949	Restorative foundation for an indirect restoration	No Cost
D2950	Core buildup, including any pins when required	No Cost
D2951	Pin retention - per tooth, in addition to restoration	No Cost
D2952	Post and core in addition to crown, indirectly fabricated - <i>includes canal preparation</i>	No Cost
D2953	Each additional indirectly fabricated post - same tooth - <i>includes canal preparation</i>	No Cost
D2954	Prefabricated post and core in addition to crown - <i>base metal post; includes canal preparation</i>	No Cost
D2955	Post removal	No Cost
D2957	Each additional prefabricated post - same tooth - <i>base metal post; includes canal preparation</i>	No Cost

D2960	Labial veneer (resin laminate) - direct - <i>limited to replacement of significant tooth structure loss due to caries or fracture</i>	\$245.00
D2961	Labial veneer (resin laminate) - indirect - <i>limited to replacement of significant tooth structure loss due to caries or fracture</i>	\$295.00
D2962	Labial veneer (porcelain laminate) - indirect - <i>limited to replacement of significant tooth structure loss due to caries or fracture</i>	\$345.00
D2971	Additional procedures to customize a crown to fit under an existing partial denture framework.	\$14.00
D2980	Crown repair necessitated by restorative material failure	No Cost
D2981	Inlay repair necessitated by restorative material failure	No Cost
D2982	Onlay repair necessitated by restorative material failure	No Cost
D2983	Veneer repair necessitated by restorative material failure	No Cost
D2990	Resin infiltration of incipient smooth surface lesions - <i>limited to permanent molars through age 15</i> .	No Cost

D3000-D3999 IV. ENDODONTICS

D3110	Pulp cap - direct (excluding final restoration)	No Cost
D3120	Pulp cap - indirect (excluding final restoration)	No Cost
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medication	No Cost
D3221	Pulpal debridement, primary and permanent teeth	No Cost
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	No Cost
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	No Cost
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	No Cost
D3310	Root canal - endodontic therapy, anterior tooth (excluding final restoration)	\$20.00
D3320	Root canal - endodontic therapy, premolar tooth (excluding final restoration)	\$40.00
D3330	Root canal - endodontic therapy, molar tooth (excluding final restoration)	\$60.00
D3331	Treatment of root canal obstruction; non-surgical access	\$40.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	\$40.00
D3333	Internal root repair of perforation defects	\$40.00
D3346	Retreatment of previous root canal therapy - anterior	\$35.00
D3347	Retreatment of previous root canal therapy - premolar	\$50.00
D3348	Retreatment of previous root canal therapy - molar	\$95.00
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	\$55.00
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)	\$45.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/ calcific repair of perforations, root resorption, etc.)	\$45.00
D3410	Apicoectomy - anterior	No Cost
D3421	Apicoectomy - premolar (first root)	No Cost
D3425	Apicoectomy - molar (first root)	No Cost
D3426	Apicoectomy (each additional root)	No Cost
D3430	Retrograde filling - per root	No Cost
D3450	Root amputation - per root	No Cost
D3471	Surgical repair of root resorption - anterior	No Cost
D3472	Surgical repair of root resorption - premolar	No Cost
D3473	Surgical repair of root resorption - molar	No Cost
D3501	Surgical exposure of root surface without apicoectomy or repair of root resorption - anterior	No Cost
D3502	Surgical exposure of root surface without apicoectomy or repair of root resorption - premolar	No Cost
D3503	Surgical exposure of root surface without apicoectomy or repair of root resorption - molar	No Cost
D3920	Hemisection (including any root removal), not including root canal therapy	No Cost
D3921	Decoronation or submergence of an erupted tooth	No Cost

D4000-D4999 V. PERIODONTICS

- Includes pre-operative and post-operative evaluations and treatment under a local anesthetic.

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	No Cost
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	No Cost

Plan CA42N	DeltaCare USA	Description of Benefits and Copayments
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D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	No Cost
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	No Cost
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	No Cost
D4245	Apically positioned flap	\$45.00
D4249	Clinical crown lengthening - hard tissue	\$45.00
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	\$75.00
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	\$60.00
D4263	Bone replacement graft - retained natural tooth - first site in quadrant	\$125.00
D4264	Bone replacement graft - retained natural tooth - each additional site in quadrant	\$45.00
D4266	Guided tissue regeneration, natural teeth - resorbable barrier, per site	\$100.00
D4267	Guided tissue regeneration, natural teeth - non-resorbable barrier, per site	\$140.00
D4270	Pedicle soft tissue graft procedure	\$125.00
D4273	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft	\$75.00
D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	No Cost
D4275	Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft	\$115.00
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft	\$125.00
D4278	Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant, or edentulous tooth position in same graft site	\$125.00
D4283	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) - each additional contiguous tooth, implant or edentulous tooth position in same graft site	\$45.00
D4285	Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) - each additional contiguous tooth, implant or edentulous tooth position in same graft site	\$69.00
D4286	Removal of non-resorbable barrier	\$0.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant - <i>limited to 4 quadrants during any 12 consecutive months</i>	No Cost
D4342	Periodontal scaling and root planing - one to three teeth per quadrant - <i>limited to 4 quadrants during any 12 consecutive months</i>	No Cost
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation - <i>1 D1110, D1120 or D4346 per 6 month period</i>	No Cost
D4355	Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit - <i>limited to 1 treatment in any 12 consecutive months</i>	No Cost
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth - <i>for each of the first two teeth treated within a quadrant following root planing or periodontal maintenance</i>	\$60.00
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth - <i>for an additional tooth treated in the same quadrant following root planing or periodontal maintenance</i>	No Cost
D4910	Periodontal maintenance - <i>limited to 1 treatment each 6 month period</i>	No Cost
D4910	Additional periodontal maintenance (within the 6 month period)	\$55.00
D4921	Gingival irrigation with a medicinal agent - per quadrant	No Cost

D5000-D5899 VI. PROSTHODONTICS (removable)

- For all listed dentures and partial dentures, Copayment includes after delivery adjustments and tissue conditioning, if needed, for the first six months after placement. For all listed immediate dentures and immediate removable partial dentures, Copayment includes other delivery adjustments and tissue conditioning, if needed, for the first three months

after placement. You 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 retentive/clasping materials, rests, and teeth)	\$80.00
D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)	\$80.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/ clasping materials, rests and teeth)	\$95.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/ clasping materials, rests and teeth)	\$95.00
D5221	Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)	\$80.00
D5222	Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)	\$80.00
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	\$95.00
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	\$95.00
D5225	Maxillary partial denture - flexible base (including retentive/clasping materials, rests, and teeth) - prosthetic appliances will be replaced only after five years have elapsed from the time of delivery .	\$195.00
D5226	Mandibular partial denture - flexible base (including retentive/clasping materials, rests, and teeth) .	\$195.00
D5227	Immediate maxillary partial denture - flexible base (including any clasps, rests and teeth)	\$80.00
D5228	Immediate mandibular partial denture - flexible base (including any clasps, rests and teeth)	\$80.00
D5282	Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), maxillary	\$80.00
D5283	Removable unilateral partial denture - one piece cast metal (including retentive/clasping materias, rests, and teeth), mandibular	\$80.00
D5284	Removable unilateral partial denture - one piece flexible base (including retentive/clasping materials, rests, and teeth) - per quadrant	\$80.00
D5286	Removable unilateral partial denture - one piece resin (including retentive/clasping materials, rests, and teeth) - per quadrant	\$80.00
D5410	Adjust complete denture - maxillary	No Cost
D5411	Adjust complete denture - mandibular	No Cost
D5421	Adjust partial denture - maxillary	No Cost
D5422	Adjust partial denture - mandibular	No Cost
D5511	Repair broken complete denture base, mandibular	No Cost
D5512	Repair broken complete denture base, maxillary	No Cost
D5520	Replace missing or broken teeth - complete denture (each tooth)	No Cost
D5611	Repair resin partial denture base, mandibular	No Cost
D5612	Repair resin partial denture base, maxillary	No Cost
D5621	Repair cast partial framework, mandibular	No Cost
D5622	Repair cast partial framework, maxillary	No Cost
D5630	Repair or replace broken retentive/clasping materials - per tooth	No Cost
D5640	Replace broken teeth - per tooth	No Cost
D5650	Add tooth to existing partial denture	No Cost
D5660	Add clasp to existing partial denture - per tooth	No Cost
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	\$65.00
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	\$65.00
D5710	Rebase complete maxillary denture	\$30.00
D5711	Rebase complete mandibular denture	\$30.00
D5720	Rebase maxillary partial denture	\$30.00
D5721	Rebase mandibular partial denture	\$30.00
D5725	Rebase hybrid prosthesis	\$30.00
D5730	Reline complete maxillary denture (chairside)	No Cost

Plan CA42N	DeltaCare USA	Description of Benefits and Copayments
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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
D5765	Soft liner for complete or partial removable denture - indirect	\$25.00
D5820	Interim partial denture (including retentive/clasping materials, rests, and teeth), maxillary - <i>limited to 1 in any 12 consecutive months</i>	No Cost
D5821	Interim partial denture (including retentive/clasping materials, rests, and teeth), mandibular - <i>limited to 1 in any 12 consecutive months</i>	No Cost
D5850	Tissue conditioning, maxillary	No Cost
D5851	Tissue conditioning, mandibular	No Cost

D5900-D5999 VII. MAXILLOFACIAL PROSTHETICS - Not Covered

D6000-D6199 VIII. IMPLANT SERVICES - Not Covered

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

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

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

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

D6205	Pontic - indirect resin based composite	\$30.00
D6210	Pontic - cast high noble metal	\$70.00
D6211	Pontic - cast predominantly base metal	\$55.00
D6212	Pontic - cast noble metal	\$60.00
D6214	Pontic - titanium and titanium alloys	\$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
D6243	Pontic - porcelain fused to titanium and titanium alloys	\$60.00
D6245	Pontic - porcelain/ceramic*	\$70.00
D6250	Pontic - resin with high noble metal	\$30.00
D6251	Pontic - resin with predominantly base metal	\$15.00
D6252	Pontic - resin with noble metal	\$20.00
D6600	Retainer inlay - porcelain/ceramic, two surfaces	\$60.00
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces	\$65.00
D6602	Retainer inlay - cast high noble metal, two surfaces	\$70.00
D6603	Retainer inlay - cast high noble metal, three or more surfaces	\$70.00
D6604	Retainer inlay - cast predominantly base metal, two surfaces	No Cost
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces	No Cost
D6606	Retainer inlay - cast noble metal, two surfaces	\$60.00
D6607	Retainer inlay - cast noble metal, three or more surfaces	\$60.00
D6608	Retainer onlay - porcelain/ceramic, two surfaces	\$55.00
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces	\$65.00
D6610	Retainer onlay - cast high noble metal, two surfaces	\$70.00
D6611	Retainer onlay - cast high noble metal, three or more surfaces	\$70.00
D6612	Retainer onlay - cast predominantly base metal, two surfaces	No Cost
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	No Cost
D6614	Retainer onlay - cast noble metal, two surfaces	\$60.00
D6615	Retainer onlay - cast noble metal, three or more surfaces	\$60.00
D6710	Retainer crown - indirect resin based composite	\$30.00
D6720	Retainer crown - resin with high noble metal	\$30.00

Plan CA42N	DeltaCare USA	Description of Benefits and Copayments
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D6721	Retainer crown - resin with predominantly base metal	\$15.00
D6722	Retainer crown - resin with noble metal	\$20.00
D6740	Retainer crown - porcelain/ceramic*	\$70.00
D6750	Retainer crown - porcelain fused to high noble metal*	\$70.00
D6751	Retainer crown - porcelain fused to predominantly base metal	\$55.00
D6752	Retainer crown - porcelain fused to noble metal	\$60.00
D6753	Retainer crown - porcelain fused to titanium and titanium alloys*	\$70.00
D6780	Retainer crown - 3/4 cast high noble metal	\$70.00
D6781	Retainer crown - 3/4 cast predominantly base metal	\$55.00
D6782	Retainer crown - 3/4 cast noble metal	\$60.00
D6783	Retainer crown - 3/4 porcelain/ceramic*	\$70.00
D6784	Retainer crown - titanium and titanium alloys	\$70.00
D6790	Retainer crown - full cast high noble metal	\$70.00
D6791	Retainer crown - full cast predominantly base metal	\$50.00
D6792	Retainer crown - full cast noble metal	\$60.00
D6794	Retainer crown - titanium and titanium alloys	\$70.00
D6930	Re-cement or re-bond fixed partial denture	No Cost
D6940	Stress breaker	No Cost
D6980	Fixed partial denture repair necessitated by restorative material failure	No Cost

D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY

- Includes pre-operative and post-operative evaluations and treatment under a local anesthetic.

D7111	Extraction, coronal remnants - primary tooth	No Cost
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	No Cost
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	\$10.00
D7220	Removal of impacted tooth - soft tissue	\$15.00
D7230	Removal of impacted tooth - partially bony	\$25.00
D7240	Removal of impacted tooth - completely bony	\$35.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	\$50.00
D7250	Removal of residual tooth roots (cutting procedure)	No Cost
D7251	Coronectomy - intentional partial tooth removal, impacted teeth only	\$50.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	\$35.00
D7280	Exposure of an unerupted tooth	\$25.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	\$25.00
D7283	Placement of device to facilitate eruption of impacted tooth	No Cost
D7286	Incisional biopsy of oral tissue - soft - <i>does not include pathology laboratory procedures</i>	No Cost
D7310	Alveoplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	No Cost
D7311	Alveoplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	No Cost
D7320	Alveoplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	No Cost
D7321	Alveoplasty 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
D7509	Marsupialization of odontogenic cyst	No Cost
D7510	Incision and drainage of abscess - intraoral soft tissue	No Cost
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	No Cost
D7961	Buccal/labial frenectomy (frenulectomy)	No Cost
D7962	Lingual frenectomy (frenulectomy)	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 - comprehensive series of radiographic images	
D0322	Tomographic survey	
D0330	Panoramic radiographic image	
D0340	2D cephalometric radiographic image - acquisition, measurement and analysis	
D0350	2D oral/facial photographic images obtained intraorally or extraorally	
D0470	Diagnostic casts	
D0801	3D dental surface scan - direct	
D0802	3D dental surface scan - indirect	
D0803	3D facial surface scan - direct	
D0804	3D facial surface scan - indirect	
	The benefit for post-treatment records includes:	\$70.00
D0210	Intraoral - comprehensive series of radiographic images	
D0470	Diagnostic casts	
D8010	Limited orthodontic treatment of the primary dentition	\$725.00
D8020	Limited orthodontic treatment of the transitional dentition - <i>child or adolescent to age 19</i>	\$725.00
D8030	Limited orthodontic treatment of the adolescent dentition - <i>adolescent to age 19</i>	\$725.00
D8040	Limited orthodontic treatment of the adult dentition - <i>adults, including covered dependent adult children</i>	\$925.00
D8070	Comprehensive orthodontic treatment of the transitional dentition - <i>child or adolescent to age 19</i> .	\$1,700.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition - <i>adolescent to age 19</i>	\$1,700.00
D8090	Comprehensive orthodontic treatment of the adult dentition - <i>adults, including covered dependent adult children</i>	\$1,900.00
D8660	Pre-orthodontic treatment examination to monitor growth and development	\$25.00
D8670	Periodic orthodontic treatment visit - <i>included in comprehensive case fee</i>	No Cost
D8680	Orthodontic retention (removal of appliances, construction and placement of <i>removable</i> retainers)	\$275.00
D8681	Removable orthodontic retainer adjustment	No Cost
D8698	Re-cement or re-bond fixed retainer - maxillary - <i>limited to 2 per 6 month period</i>	No Cost
D8699	Re-cement or re-bond fixed retainer - mandibular - <i>limited to 2 per 6 month period</i>	No Cost
D8701	Repair of fixed retainer, includes reattachment - maxillary - <i>limited to 2 per 6 month period</i>	No Cost
D8702	Repair of fixed retainer, includes reattachment - mandibular - <i>limited to 2 per 6 month period</i>	No Cost
D8999	Unspecified orthodontic procedure, by report - <i>includes treatment planning session</i>	\$100.00

D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES

D9110	Palliative treatment of dental pain - per visit	No Cost
D9211	Regional block anesthesia	No Cost
D9212	Trigeminal division block anesthesia	No Cost
D9215	Local anesthesia in conjunction with operative or surgical procedures	No Cost
D9219	Evaluation for moderate sedation, deep sedation or general anesthesia	No Cost
D9222	Deep sedation/general anesthesia - first 15 minutes	\$80.00
D9223	Deep sedation/general anesthesia - each subsequent 15 minute increment	\$80.00
D9239	Intravenous moderate (conscious) sedation/analgesia - first 15 minutes	\$80.00
D9243	Intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment	\$80.00
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	No Cost
D9311	Consultation with a medical health care professional	No Cost
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	No Cost
D9440	Office visit - after regularly scheduled hours	\$20.00
D9450	Case presentation, subsequent to detailed and extensive treatment planning	No Cost
D9912	Pre-visit patient screening	\$0.00

D9932	Cleaning and inspection of removable complete denture, maxillary	No Cost
D9933	Cleaning and inspection of removable complete denture, mandibular	No Cost
D9934	Cleaning and inspection of removable partial denture, maxillary	No Cost
D9935	Cleaning and inspection of removable partial denture, mandibular	No Cost
D9943	Occlusal guard adjustment	\$10.00
D9944	Occlusal guard - hard appliance, full arch - <i>limited to 1 D9944, D9945 or D9946 in 3 years</i>	\$75.00
D9945	Occlusal guard - soft appliance, full arch - <i>limited to 1 D9944, D9945 or D9946 in 3 years</i>	\$75.00
D9946	Occlusal guard - hard appliance, partial arch - <i>limited to 1 D9944, D9945 or D9946 in 3 years</i>	\$75.00
D9951	Occlusal adjustment, limited	No Cost
D9952	Occlusal adjustment, complete	No Cost
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays - <i>limited to one bleaching tray and gel for two weeks of self-treatment</i>	\$125.00
D9986	Missed appointment - <i>without 24 hour notice - per 15 minutes of appointment time - up to an overall maximum of \$40.00</i>	\$10.00
D9987	Canceled appointment - <i>without 24 hour notice - per 15 minutes of appointment time - up to an overall maximum of \$40.00</i>	\$10.00
D9990	Certified translation or sign-language services - per visit	No Cost
D9991	Dental case management - addressing appointment compliance barriers	No Cost
D9992	Dental case management - care coordination	No Cost
D9995	Teledentistry - synchronous; real-time encounter	No Cost
D9996	Teledentistry - asynchronous; information stored and forwarded to Dentist for subsequent review ..	No Cost
D9997	Dental case management - Patients with special Health Care Needs	No Cost

Procedures with age restrictions will be subject to exceptions based on medical necessity.

If services for a listed procedure are performed by the Contract Dentist, You pay the specified Copayment. Listed procedures which require a Dentist to provide Specialized Services, and are referred by the Contract Dentist, must be authorized by Us. You pay the Copayment specified for such services.

SCHEDULE B

Limitations of Benefits

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

Exclusions of Benefits

1. Any procedure that is not specifically listed under *Schedule A, Description of Benefits and Copayments*.
2. Any procedure that in the professional opinion of the Contract Dentist:
 - a. has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, or
 - b. is inconsistent with generally accepted standards for dentistry.
3. Services solely for cosmetic purposes, with the exception of procedure D9975 (External bleaching for home application, per arch), or for conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel, except for the treatment of newborn children with congenital defects or birth abnormalities.
4. Porcelain crowns, porcelain fused to metal, cast metal or resin with metal type crowns and fixed partial dentures (bridges) for children under 16 years of age.
5. The replacement of lost or stolen appliances including, but not limited to, full or partial dentures, space maintainers, and crowns and fixed partial dentures (bridges).
6. Procedures, appliances or restoration if the purpose is to change vertical dimension, or to diagnose or treat abnormal conditions of the temporomandibular joint (TMJ).
7. Procedures that may include:
 - a. precious metal for removable appliances;
 - b. metallic or permanent soft bases for complete dentures;
 - c. porcelain denture teeth;

Limitations and Exclusions of Benefits

- d. precision abutments for removable partials or fixed partial dentures including but not limited to overlays and related specialized appliances; and/or
 - e. personalization and characterization of complete and partial dentures.
8. Precious metal for removable appliances, metallic or permanent soft bases for complete dentures, porcelain denture teeth, precision abutments for removable partials or fixed partial dentures (overlays, implants, and appliances associated therewith) and personalization and characterization of complete and partial dentures.
 9. Consultations for non-covered Benefits.
 10. Dental services received from any Dentist other than the assigned Contract Dentist, a preauthorized dental specialist, or a Contract Orthodontist except for *Emergency Services* as described in the Contract and/or Evidence of Coverage.
 11. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.
 12. Prescription drugs.
 13. Dental expenses incurred in connection with any dental or orthodontic procedure started before Your eligibility with the DeltaCare USA Plan. Examples include: teeth prepared for crowns, root canals in progress, full or partial dentures for which an impression has been taken and orthodontics unless qualified for the orthodontic treatment in progress provision.
 14. Lost, stolen or broken orthodontic appliances.
 15. Changes in orthodontic treatment necessitated by accident of any kind.
 16. Myofunctional and parafunctional appliances and/or therapies with the exception of procedures D9944 (Occlusal guard, hard appliance, full arch), D9945 (Occlusal guard - soft appliance, full arch), and D9946 (Occlusal guard-hard appliance, partial arch).
 17. Composite or ceramic brackets, lingual adaption of orthodontic bands.
 18. Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services.
 19. Orthodontic treatment must be provided by a licensed Dentist. Self-administered orthodontics are not covered.

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Find oral health resources, including articles, quizzes, videos and a subscription to *Grin!*, our free dental wellness e-magazine at deltadentalins.com/wellness.

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- Review your plan benefits
- Access your ID card

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Need help? Let us know.

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Write to:

Delta Dental Insurance Company
1130 Sanctuary Parkway
Alpharetta, GA 30009

Call toll-free: 800-422-4234

Customer Service agents are available Monday through Friday, 8 am to 9 pm, Eastern time. Or, use our automated phone system, available 24/7.

Underwritten by:

Delta Dental of California
18000 Studebaker Road, Suite 530
Cerritos, CA 90703

Administered by:

Delta Dental Insurance Company
1130 Sanctuary Parkway
Alpharetta, GA 30009

NOTE: This is only a brief summary of your plan.

This brochure is not intended to replace your legally required plan booklet. The Group Dental Service Contract determines the exact terms and conditions of your coverage. Please refer to the "Description of Benefits and Copayments" and "Limitations and Exclusions of Benefits" in this brochure for a complete list of covered procedures, copayments, plan limitations and exclusions. You may also consult your Evidence/Certificate of Coverage, which will be mailed to you upon enrollment. If you wish to review an Evidence/Certificate of Coverage prior to enrollment, you may request a copy by calling Customer Service at 800-422-4234.

A Look at your VSP Vision Coverage



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As a member, you'll get access to savings and personalized vision care from a VSP® network doctor for you and your family.

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+Coverage with a retail chain may be different or not apply.

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Classification: Restricted

BENEFIT	DESCRIPTION	COPAY
YOUR COVERAGE WITH A VSP PROVIDER		
WELLVISION EXAM	<ul style="list-style-type: none"> Focuses on your eyes and overall wellness Every 12 months 	\$10
ESSENTIAL MEDICAL EYE CARE	<ul style="list-style-type: none"> Retinal screening for members with diabetes Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more. Coordination with your medical coverage may apply. Ask your VSP doctor for details. Available as needed 	\$0 per screening \$20 per exam
PRESCRIPTION GLASSES \$25		
FRAME*	<ul style="list-style-type: none"> \$150 featured frame brands allowance \$130 frame allowance 20% savings on the amount over your allowance \$70 Costco® frame allowance Every 24 months 	Included in Prescription Glasses
LENSES	<ul style="list-style-type: none"> Single vision, lined bifocal, and lined trifocal lenses Impact-resistant lenses for dependent children Every 12 months 	Included in Prescription Glasses
LENS ENHANCEMENTS	<ul style="list-style-type: none"> Standard progressive lenses Premium progressive lenses Custom progressive lenses Average savings of 30% on other lens enhancements Every 12 months 	\$0 \$95 - \$105 \$150 - \$175
CONTACTS (INSTEAD OF GLASSES)	<ul style="list-style-type: none"> \$120 allowance for contacts and contact lens exam (fitting and evaluation) 15% savings on a contact lens exam (fitting and evaluation) Every 12 months 	\$0
EXTRA SAVINGS	<p>Glasses and Sunglasses</p> <ul style="list-style-type: none"> Extra \$20 to spend on featured frame brands. Go to vsp.com/offers for details. 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam. <p>Routine Retinal Screening</p> <ul style="list-style-type: none"> No more than a \$39 copay on routine retinal screening as an enhancement to a WellVision Exam <p>Laser Vision Correction</p> <ul style="list-style-type: none"> Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities 	
YOUR COVERAGE GOES FURTHER IN-NETWORK		

With so many in-network choices, VSP makes it easy to get the most out of your benefits. You'll have access to preferred private practice, retail, and online in-network choices. Log in to vsp.com to find an in-network provider.