

SJVIA PARTICIPATION AGREEMENT

THIS AGREEMENT ("Agreement") is made and entered into this 13th day of December 2021, by and between **COUNTY OF FRESNO**, a political subdivision of the State of California, hereinafter referred to as "**COUNTY OF FRESNO**," and the **SAN JOAQUIN VALLEY INSURANCE AUTHORITY**, a joint powers agency, hereinafter referred to as "**SJVIA**."

WITNESSETH:

WHEREAS, the purpose of the SJVIA is to develop and provide various health insurance programs for health, pharmacy, vision, dental, mental health and life insurance, including related administrative services for such programs to be provided by the insurance provider(s) and the SJVIA and its agents and consultants (collectively, "Various Benefits"), for the benefit of participating entities; and

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

WHEREAS, the COUNTY OF FRESNO elects to participate in the selected SJVIA health insurance programs as referenced in Exhibit "A" (collectively, "SELECTED PROGRAMS"); and

WHEREAS, a true and correct copy of a summary of applicable SJVIA health insurance programs is attached hereto and incorporated herein by reference as Exhibit "A"; and

WHEREAS, the SJVIA represents that it will contract with Insurance Providers which will provide its Various Benefits under the terms and conditions of a written contract between the SJVIA and the Insurance Provider (the "Insurance Contract") for each of the COUNTY OF FRESNO's participating employees; and

WHEREAS, the SJVIA represents that the rates for the Various Benefits under the SELECTED PROGRAMS to be provided under the Insurance Contract and by the SJVIA, including the costs of its agents and consultants, are set forth in Exhibit "B" which is attached hereto and incorporated herein by reference; and

WHEREAS, the COUNTY OF FRESNO and the SJVIA now desire to enter into this Agreement to secure the COUNTY OF FRESNO's commitment to remit premium payments to the SJVIA for the Various Benefits to be provided under the Insurance Contract, and the COUNTY OF FRESNO's portion of the costs of the SJVIA's agents and consultants, as provided herein.

NOW THEREFORE, in consideration of their mutual promises, covenants and conditions, the parties agree as follows:

1. COUNTY OF FRESNO's OBLIGATIONS: The COUNTY OF FRESNO acknowledges that this agreement requires a commitment to participate in SJVIA Various Benefits effective December 13, 2021 through December 11, 2022. Within ten business days of the date that SJVIA is required under the Insurance Contract to pay any insurance premium and/or similar charge to the Insurance Provider, the COUNTY OF FRESNO shall remit to SJVIA the amount necessary to pay the required premium payment based on the intervals of such payments under the Insurance Contract.

The COUNTY OF FRESNO may also participate in SELECTED PROGRAMS as referenced in Exhibit “A” and shall comply with all applicable terms and provisions of the Insurance Contract and this Agreement, effective December 13, 2021. The attached rates in Exhibit “B” reference only the SELECTED PROGRAMS the COUNTY OF FRESNO is electing. Exhibit “B” also references the effective term such rates apply to the COUNTY OF FRESNO which are effective December 13, 2021 through December 11, 2022. The COUNTY OF FRESNO agrees that it may only elect to participate in additional health insurance programs, or elect to make changes to the SELECTED PROGRAMS, through subsequent amendment to this agreement or separate agreement. Subsequent renewals are based on the SJVIA underwriting guidelines. The SJVIA uses actuarially based underwriting standards.

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

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

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

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

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

COUNTY OF FRESNO

Hollis Magill
Director of Human Resources
2220 Tulare St, 16th Floor
Fresno, CA 93721
hmagill@fresnocountyca.gov

SJVIA

Lupe Garza
SJVIA Assistant Manager
2500 West Burrel
Visalia, CA 93291
lugarza@co.tulare.ca.us

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

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

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

8. **TERM:** This Agreement shall become effective beginning at 12:01 a.m. on December 13, 2021 and shall terminate on December 11, 2022.

9. **TERMINATION:**

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

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

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

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

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

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(Go to next page for signatures)

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

**SAN JOAQUIN VALLEY INSURANCE
AUTHORITY:**

COUNTY OF FRESNO:

By: _____
Pete Vander Poel
SJVIA Board President

By: _____
Steve Brandau
Chairman of the Board of Supervisors of
the County of Fresno

Date: _____

Date: _____

**REVIEWED & RECOMMENDED
FOR APPROVAL**

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

By: _____
Lupe Garza
SJVIA Assistant Manager

By: _____



BOARD OF DIRECTORS

STEVE BRANDAU

NATHAN MAGSIG

BUDDY MENDES

LARRY MICARI

BRIAN PACHECO

AMY SHUKLIAN

PETE VANDER POEL

Exhibit A

County of Fresno

**Plan Year 2022
Benefit Summaries**

- Anthem Blue Cross EPO 0
- Anthem Blue Cross EPO 500
- Anthem Blue Cross EPO 100
- Anthem Blue Cross PPO 250
- Anthem Blue Cross HDHD PPO 1500 (Retirees only)
- Anthem Blue Cross HDHP PPO 3000
- EmpiRx Health Prescription Benefit
- Kaiser Permanente HMO
- 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 Fresno: Custom EPO 0

Your Network: EPO

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	\$0 person	Not covered
Out-of-Pocket Limit	\$1,000 person / \$2,000 family	Not covered
<p>The family deductible and out-of-pocket maximum are embedded, meaning the cost shares of one family member will be applied to both per person deductible and per person out-of-pocket maximum; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket maximum. No one member will pay more than the per person deductible or per person out-of-pocket maximum.</p> <p>Your copays, coinsurance and deductible count toward your out of pocket amount(s).</p>		
Preventive Care / Screening / Immunization	No charge	Not covered
Preventive Care for Chronic Conditions <i>per IRS guidelines</i>	No charge	Not covered
<p><u>Virtual Care (Telemedicine / Telehealth Visits)</u></p> <p>Virtual Visits - Online visits with Doctors who also provide services in person</p>		
Primary Care (PCP)	\$15 copay per visit	Not covered
Mental Health and Substance Use Disorder care	\$15 copay per visit	Not covered
Specialist	\$15 copay per visit	Not covered
<p>Virtual Visits from Online Provider LiveHealth Online <i>via www.livehealthonline.com; our mobile app, website or Anthem-enabled device</i></p>		
Primary Care (PCP) and Mental Health and Substance Use Disorder	\$15 copay per visit	Not covered
Specialist Care	\$15 copay per visit	Not covered
<p><u>Visits in an Office</u></p>		
Primary Care (PCP)	\$15 copay per visit	Not covered

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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 Fresno: Custom EPO/706G/01-01-2022

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Specialist Care	\$15 copay per visit	Not covered
<u>Other Practitioner Visits</u> Routine Maternity Care (Prenatal and Postnatal) Retail Health Clinic Manipulation Therapy <i>Coverage is limited to 40 visits per benefit period.</i> Acupuncture	No charge \$15 copay per visit \$10 copay per visit \$15 copay per visit	Not covered Not covered Not covered Not covered
<u>Other Services in an Office</u> Allergy Testing Chemo/Radiation Therapy Dialysis/Hemodialysis Prescription Drugs <i>Dispensed in the office</i> <i>Maximum of \$250 member cost share per drug.</i> Surgery	No charge No charge No charge No charge 0% coinsurance after deductible is met	Not covered Not covered Not covered Not covered Not covered
<u>Diagnostic Services</u> Lab Office Freestanding Lab Outpatient Hospital	No charge No charge No charge	Not covered Not covered Not covered
X-Ray Office Freestanding Radiology Center Outpatient Hospital	No charge No charge No charge	Not covered Not covered Not covered

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>No charge</p> <p>No charge</p> <p>No charge</p>	<p>Not covered</p> <p>Not covered</p> <p>Not covered</p>
<p><u>Emergency and Urgent Care</u></p> <p>Urgent Care</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>\$15 copay per visit</p> <p>\$100 copay per visit</p> <p>No charge</p> <p>No charge</p>	<p>Not covered</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</u></p> <p>Doctor Office Visit</p> <p>Facility Visit</p> <p>Facility Fees</p> <p>Doctor Services</p>	<p>\$15 copay per visit</p> <p>No charge</p> <p>No charge</p>	<p>Not covered</p> <p>Not covered</p> <p>Not covered</p>
<p><u>Outpatient Surgery</u></p> <p>Facility Fees</p> <p>Hospital</p> <p>Freestanding Surgical Center</p> <p>Doctor and Other Services</p> <p>Hospital</p>	<p>No charge</p> <p>No charge</p> <p>No charge</p>	<p>Not covered</p> <p>Not covered</p> <p>Not covered</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<u>Hospital (Including Maternity, Mental Health and Substance Use Disorder)</u>		
Facility Fees	No charge	Not covered
Doctor and other services	No charge	Not covered
<u>Recovery & Rehabilitation</u>		
Home Health Care <i>Coverage is limited to 100 visits per benefit period.</i>	\$15 copay per visit	Not covered
Rehabilitation services <i>Coverage for physical therapy, occupational therapy and speech therapy is limited to 60 days combined per benefit period.</i>		
Office	\$15 copay per visit	Not covered
Outpatient Hospital	No charge	Not covered
Cardiac rehabilitation		
Office	\$15 copay per visit	Not covered
Outpatient Hospital	No charge	Not covered
Skilled Nursing Care (facility) <i>Coverage is limited to 100 days per benefit period.</i>	No charge	Not covered
Inpatient Hospice	No charge	Not covered
Durable Medical Equipment	No charge	Not covered
Prosthetic Devices	No charge	Not covered

Notes:

- If you have an office visit with your Primary Care Physician or Specialist 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.
- 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.

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

ՈՒՇԱԴՐՈՒԹՅՈՒՆ. 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។ អ្នកក៏អាចទទួលបានលិខិតនេះដោយសេរីដោយមិនមានការបង់ប្រាក់ផងដែរ។ 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 ਾ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)

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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, 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 Fresno: Custom EPO 500

Your Network: EPO

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	\$0 person	Not covered
Out-of-Pocket Limit	\$3,000 person / \$6,000 family	Not covered
<p>The family deductible and out-of-pocket maximum are embedded, meaning the cost shares of one family member will be applied to both per person deductible and per person out-of-pocket maximum; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket maximum. No one member will pay more than the per person deductible or per person out-of-pocket maximum.</p> <p>Your copays, coinsurance and deductible count toward your out of pocket amount(s).</p>		
Preventive Care / Screening / Immunization	No charge	Not covered
Preventive Care for Chronic Conditions <i>per IRS guidelines</i>	No charge	Not covered
<u>Virtual Care (Telemedicine / Telehealth Visits)</u>		
Virtual Visits - Online visits with Doctors who also provide services in person		
Primary Care (PCP)	\$35 copay per visit	Not covered
Mental Health and Substance Use Disorder care	\$35 copay per visit	Not covered
Specialist	\$35 copay per visit	Not covered
Virtual Visits from Online Provider LiveHealth Online <i>via www.livehealthonline.com; our mobile app, website or Anthem-enabled device</i>		
Primary Care (PCP) and Mental Health and Substance Use Disorder	\$35 copay per visit	Not covered
Specialist Care	\$35 copay per visit	Not covered
<u>Visits in an Office</u>		
Primary Care (PCP)	\$35 copay per visit	Not covered

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CA/LG/San Joaquin Valley Insurance Authority (JPA) - County of Fresno: Custom EPO//01-01-2022

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Specialist Care	\$35 copay per visit	Not covered
<u>Other Practitioner Visits</u> Routine Maternity Care (Prenatal and Postnatal) Retail Health Clinic Manipulation Therapy <i>Coverage is limited to 40 visits per benefit period.</i> Acupuncture	No Charge \$35 copay per visit \$35 copay per visit \$35 copay per visit	Not covered Not covered Not covered Not covered
<u>Other Services in an Office</u> Allergy Testing Chemo/Radiation Therapy Dialysis/Hemodialysis Prescription Drugs <i>Dispensed in the office</i> <i>Maximum of \$250 member cost share per drug.</i> Surgery	No charge No charge No charge No charge No charge	Not covered Not covered Not covered Not covered Not covered
<u>Diagnostic Services</u> Lab Office Freestanding Lab Outpatient Hospital	No charge No charge No charge	Not covered Not covered Not covered
X-Ray Office Freestanding Radiology Center Outpatient Hospital	No charge No charge No charge	Not covered Not covered Not covered

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>No charge</p> <p>No charge</p> <p>No charge</p>	<p>Not covered</p> <p>Not covered</p> <p>Not covered</p>
<p><u>Emergency and Urgent Care</u></p> <p>Urgent Care</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>\$35 copay per visit</p> <p>\$250 copay per visit</p> <p>No charge</p> <p>No charge</p>	<p>Not covered</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</u></p> <p>Doctor Office Visit</p> <p>Facility Visit</p> <p>Facility Fees</p> <p>Doctor Services</p>	<p>\$35 copay per visit</p> <p>No charge</p> <p>No charge</p>	<p>Not covered</p> <p>Not covered</p> <p>Not covered</p>
<p><u>Outpatient Surgery</u></p> <p>Facility Fees</p> <p>Hospital</p> <p>Freestanding Surgical Center</p> <p>Doctor and Other Services</p> <p>Hospital</p>	<p>No charge</p> <p>No charge</p> <p>No charge</p>	<p>Not covered</p> <p>Not covered</p> <p>Not covered</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<u>Hospital (Including Maternity, Mental Health and Substance Use Disorder)</u>		
Facility Fees	\$500 copay per admission	Not covered
Doctor and other services	No charge	Not covered
<u>Recovery & Rehabilitation</u>		
Home Health Care <i>Coverage is limited to 100 visits per benefit period.</i>	\$35 copay per visit	Not covered
Rehabilitation services <i>Coverage for physical therapy, occupational therapy and speech therapy is limited to 60 days combined per benefit period.</i>		
Office	\$35 copay per visit	Not covered
Outpatient Hospital	No charge	Not covered
Cardiac rehabilitation		
Office	\$35 copay per visit	Not covered
Outpatient Hospital	No charge	Not covered
Skilled Nursing Care (facility) <i>Coverage is limited to 100 days per benefit period.</i>	No charge	Not covered
Inpatient Hospice	No charge	Not covered
Durable Medical Equipment	No charge	Not covered
Prosthetic Devices	No charge	Not covered

Notes:

- If you have an office visit with your Primary Care Physician or Specialist 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.
- 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.

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

ՈՒՇԱԴՐՈՒԹՅՈՒՆ. 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 យើងអាចព្យាយាមបកប្រែអានជូនអ្នក។ អ្នកក៏អាចទទួលបានលិខិតនេះដោយសេរីដោយមិនមានការបង់ប្រាក់ផងដែរ។ 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 ਾ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 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)

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Your summary of benefits



Anthem® Blue Cross

Your Plan: San Joaquin Valley Insurance Authority (JPA) - County of Fresno: Custom EPO 1000

Your Network: EPO

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible	\$0 person	Not covered
Out-of-Pocket Limit	\$4,000 person / \$8,000 family	Not covered
<p>The family deductible and out-of-pocket maximum are embedded, meaning the cost shares of one family member will be applied to both per person deductible and per person out-of-pocket maximum; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket maximum. No one member will pay more than the per person deductible or per person out-of-pocket maximum.</p> <p>Your copays, coinsurance and deductible count toward your out of pocket amount(s).</p>		
Preventive Care / Screening / Immunization	No charge	Not covered
Preventive Care for Chronic Conditions <i>per IRS guidelines</i>	No charge	Not covered
<p><u>Virtual Care (Telemedicine / Telehealth Visits)</u></p> <p>Virtual Visits - Online visits with Doctors who also provide services in person</p>		
Primary Care (PCP)	\$35 copay per visit	Not covered
Mental Health and Substance Use Disorder care	\$35 copay per visit	Not covered
Specialist	\$35 copay per visit	Not covered
<p>Virtual Visits from Online Provider LiveHealth Online <i>via www.livehealthonline.com; our mobile app, website or Anthem-enabled device</i></p>		
Primary Care (PCP) and Mental Health and Substance Use Disorder	\$35 copay per visit	Not covered
Specialist Care	\$35 copay per visit	Not covered
<p><u>Visits in an Office</u></p>		
Primary Care (PCP)	\$35 copay per visit	Not covered

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CA/LG/San Joaquin Valley Insurance Authority (JPA) - County of Fresno: Custom EPO//01-01-2022

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Specialist Care	\$35 copay per visit	Not covered
<u>Other Practitioner Visits</u> Routine Maternity Care (Prenatal and Postnatal) Retail Health Clinic Manipulation Therapy <i>Coverage is limited to 40 visits per benefit period.</i> Acupuncture	No Charge \$35 copay per visit \$35 copay per visit \$35 copay per visit	Not covered Not covered Not covered Not covered
<u>Other Services in an Office</u> Allergy Testing Chemo/Radiation Therapy Dialysis/Hemodialysis Prescription Drugs <i>Dispensed in the office</i> <i>Maximum of \$250 member cost share per drug.</i> Surgery	No charge No charge No charge No charge No charge	Not covered Not covered Not covered Not covered Not covered
<u>Diagnostic Services</u> Lab Office Freestanding Lab Outpatient Hospital	No charge No charge No charge	Not covered Not covered Not covered
X-Ray Office Freestanding Radiology Center Outpatient Hospital	No charge No charge No charge	Not covered Not covered Not covered

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>No charge</p> <p>No charge</p> <p>No charge</p>	<p>Not covered</p> <p>Not covered</p> <p>Not covered</p>
<p><u>Emergency and Urgent Care</u></p> <p>Urgent Care</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>\$35 copay per visit</p> <p>\$300 copay per visit</p> <p>No charge</p> <p>No charge</p>	<p>Not covered</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</u></p> <p>Doctor Office Visit</p> <p>Facility Visit</p> <p>Facility Fees</p> <p>Doctor Services</p>	<p>\$35 copay per visit</p> <p>No charge</p> <p>No charge</p>	<p>Not covered</p> <p>Not covered</p> <p>Not covered</p>
<p><u>Outpatient Surgery</u></p> <p>Facility Fees</p> <p>Hospital</p> <p>Freestanding Surgical Center</p> <p>Doctor and Other Services</p> <p>Hospital</p>	<p>No charge</p> <p>No charge</p> <p>No charge</p>	<p>Not covered</p> <p>Not covered</p> <p>Not covered</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></p> <p>Facility Fees</p> <p>Doctor and other services</p>	<p>\$1,000 copay per admission</p> <p>No charge</p>	<p>Not covered</p> <p>Not covered</p>
<p><u>Recovery & Rehabilitation</u></p> <p>Home Health Care <i>Coverage is limited to 100 visits per benefit period.</i></p>	<p>\$35 copay per visit</p>	<p>Not covered</p>
<p>Rehabilitation services <i>Coverage for physical therapy, occupational therapy and speech therapy is limited to 60 days combined per benefit period.</i></p> <p>Office</p> <p>Outpatient Hospital</p>	<p>\$35 copay per visit</p> <p>No charge</p>	<p>Not covered</p> <p>Not covered</p>
<p>Cardiac rehabilitation</p> <p>Office</p> <p>Outpatient Hospital</p>	<p>\$35 copay per visit</p> <p>No charge</p>	<p>Not covered</p> <p>Not covered</p>
<p>Skilled Nursing Care (facility) <i>Coverage is limited to 100 days per benefit period.</i></p>	<p>No charge</p>	<p>Not covered</p>
<p>Inpatient Hospice</p>	<p>No charge</p>	<p>Not covered</p>
<p>Durable Medical Equipment</p>	<p>No charge</p>	<p>Not covered</p>
<p>Prosthetic Devices</p>	<p>No charge</p>	<p>Not covered</p>

Notes:

- If you have an office visit with your Primary Care Physician or Specialist 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.
- 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.

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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។ អ្នកក៏អាចទទួលបានលិខិតនេះដោយសរសេរជាភាសាបស្ចុកផងដែរ។ 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 ਾ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)

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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, 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 Fresno: PPO 250

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	\$250 person / \$500 family	\$250 person / \$500 family
Out-of-Pocket Limit	\$3,000 person / \$5,000 family	\$10,000 person / \$15,000 family
<p>When more than a single person is enrolled, the per person deductible does not apply and the family deductible must be met by any one person or collection of persons, but each is capped at his or her per person out-of-pocket maximum for covered services applied to the family deductible.</p> <p>Your copays, coinsurance and deductible count toward your out of pocket amount(s).</p> <p>In-network and out-of-network deductibles are combined and accumulate toward each other; however, in-network and out-of-network out-of-pocket maximum amounts accumulate separately and do not accumulate toward each other.</p>		
Preventive Care / Screening / Immunization	No charge	50% coinsurance after medical deductible is met
Preventive Care for Chronic Conditions <i>per IRS guidelines</i>	No charge	50% coinsurance after medical deductible is met
<p><u>Virtual Care (Telemedicine / Telehealth Visits)</u></p> <p>Virtual Visits - Online visits with Doctors who also provide services in person</p> <p>Primary Care (PCP) including Mental Health and Substance Abuse care by a PCP</p> <p>Mental Health and Substance Abuse care by Providers other than a PCP</p>		
	\$20 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
	\$20 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Specialist	\$20 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met
Virtual Visits from Online Provider LiveHealth Online via www.livehealthonline.com ; our mobile app, website or Anthem-enabled device Primary Care (PCP) and Mental Health and Substance Use Disorder Specialist Care	\$20 copay per visit medical deductible does not apply	\$20 copay per visit medical deductible does not apply
<u>Visits in an Office</u> Primary Care (PCP) Specialist Care	\$20 copay per visit medical deductible does not apply \$20 copay per visit medical deductible does not apply	50% coinsurance after medical deductible is met 50% coinsurance after medical deductible is met
<u>Other Practitioner Visits</u> Routine Maternity Care (Prenatal and Postnatal) Retail Health Clinic Manipulation Therapy <i>Coverage is limited to 24 visits per benefit period.</i> Acupuncture <i>Coverage is limited to 12 visits per benefit period.</i>	0% coinsurance after medical deductible is met \$20 copay per visit medical deductible does not apply 0% coinsurance after medical deductible is met 0% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met 50% coinsurance after medical deductible is met 50% coinsurance after medical deductible is met 50% coinsurance after medical deductible is met
<u>Other Services in an Office</u> Allergy Testing	0% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
<p>Chemo/Radiation Therapy</p> <p>Dialysis/Hemodialysis</p> <p>Prescription Drugs <i>Dispensed in the office</i> <i>Maximum of \$250 member cost share per drug.</i></p> <p>Surgery</p>	<p>0% coinsurance after medical deductible is met</p> <p>0% coinsurance after medical deductible is met</p> <p>0% coinsurance after medical deductible is met</p> <p>0% coinsurance after medical deductible is met</p>	<p>50% coinsurance after medical deductible is met</p> <p>50% coinsurance after medical deductible is met</p> <p>50% coinsurance after medical deductible is met</p> <p>50% coinsurance after medical deductible is met</p>
<p><u>Diagnostic Services</u></p> <p>Lab</p> <p>Office</p> <p>Freestanding Lab</p> <p>Outpatient Hospital</p>	<p>0% coinsurance after medical deductible is met</p> <p>0% coinsurance after medical deductible is met</p> <p>0% coinsurance after medical deductible is met</p>	<p>50% coinsurance after medical deductible is met</p> <p>50% coinsurance after medical deductible is met</p> <p>50% coinsurance after medical deductible is met</p>
<p>X-Ray</p> <p>Office</p> <p>Freestanding Radiology Center</p> <p>Outpatient Hospital</p>	<p>0% coinsurance after medical deductible is met</p> <p>0% coinsurance after medical deductible is met</p> <p>0% coinsurance after medical deductible is met</p>	<p>50% coinsurance after medical deductible is met</p> <p>50% coinsurance after medical deductible is met</p> <p>50% coinsurance after medical deductible is met</p>

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>0% coinsurance after medical deductible is met</p> <p>0% coinsurance after medical deductible is met</p> <p>0% coinsurance after medical deductible is met</p>	<p>50% coinsurance after medical deductible is met</p> <p>50% coinsurance after medical deductible is met</p> <p>50% coinsurance after medical deductible is met</p>
<p><u>Emergency and Urgent Care</u></p> <p>Urgent Care</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>\$20 copay per visit medical deductible does not apply</p> <p>0% coinsurance after medical deductible is met</p> <p>0% coinsurance after medical deductible is met</p> <p>0% coinsurance after medical deductible is met</p>	<p>50% coinsurance after medical 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</u></p> <p>Doctor Office Visit</p> <p>Facility Visit</p> <p>Facility Fees</p> <p>Doctor Services</p>	<p>\$20 copay per visit medical deductible does not apply</p> <p>0% coinsurance after medical deductible is met</p> <p>0% coinsurance after medical deductible is met</p>	<p>50% coinsurance after medical deductible is met</p> <p>50% coinsurance after medical deductible is met</p> <p>50% coinsurance after medical 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>Outpatient Surgery</u></p> <p>Facility Fees</p> <p>Hospital</p> <p>Freestanding Surgical Center</p> <p>Doctor and Other Services</p> <p>Hospital</p>	<p>0% coinsurance after medical deductible is met</p> <p>0% coinsurance after medical deductible is met</p> <p>0% coinsurance after medical deductible is met</p>	<p>50% coinsurance after medical deductible is met</p> <p>50% coinsurance after medical deductible is met</p> <p>50% coinsurance after medical deductible is met</p>
<p><u>Hospital (Including Maternity, Mental Health and Substance Use Disorder)</u></p> <p>Facility Fees</p> <p>Doctor and other services</p>	<p>0% coinsurance after medical deductible is met</p> <p>0% coinsurance after medical deductible is met</p>	<p>50% coinsurance after medical deductible is met</p> <p>50% coinsurance after medical deductible is met</p>
<p><u>Recovery & Rehabilitation</u></p> <p>Home Health Care</p> <p><i>Coverage is limited to 100 visits per benefit period.</i></p>	<p>0% coinsurance after medical deductible is met</p>	<p>50% coinsurance after medical deductible is met</p>
<p>Rehabilitation services</p> <p><i>Coverage for physical therapy and occupational therapy is limited to 24 visits combined per benefit period. Chiropractic visits count towards your physical and occupational therapy limits.</i></p> <p>Office</p> <p>Outpatient Hospital</p>	<p>0% coinsurance after medical deductible is met</p> <p>0% coinsurance after medical deductible is met</p>	<p>50% coinsurance after medical deductible is met</p> <p>50% coinsurance after medical deductible is met</p>

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Cardiac rehabilitation <i>Coverage is limited to 36 visits per benefit period.</i> Office Outpatient Hospital	0% coinsurance after medical deductible is met 0% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met 50% coinsurance after medical deductible is met
Skilled Nursing Care (facility) <i>Coverage is limited to 100 days per benefit period.</i>	0% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Inpatient Hospice	0% coinsurance after medical deductible is met	0% coinsurance after medical deductible is met
Durable Medical Equipment	0% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met
Prosthetic Devices	0% coinsurance after medical deductible is met	50% coinsurance after medical deductible is met

Notes:

- If you have an office visit with your Primary Care Physician or Specialist 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 service for Non-Network Providers. Includes Diagnostic Services, X-ray, Surgery, Rehabilitation, Habilitation, and Cardiac Therapy. This also includes Surgery at Freestanding Facilities. Inpatient Hospital/Residential Treatment Centers \$500 per service for Non-Network Providers (waived for Emergency Admissions).
- 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.

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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 យើងអាចព្យាយាមបកប្រែអានជូនអ្នក។ អ្នកក៏អាចទទួលបានលិខិតនេះដោយសេរីដោយមិនមានការបង់ប្រាក់ផងដែរ។ ដើម្បីទទួលបានជំនួយភតគិតផ្លូវ 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 ਾ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)

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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, 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 Fresno: Anthem PPO (HSA) 1500

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	\$1,500 person / \$2,800 member/ \$3,000 family	\$1,500 person / \$2,800 member/ \$3,000 family
Out-of-Pocket Limit	\$3,000 person / \$3,000 member/ \$5,000 family	\$10,000 person / \$10,000 member/ \$15,000 family
<p>The family deductible and out-of-pocket maximum are embedded, meaning the cost shares of one family member will be applied to both per person deductible and per person out-of-pocket maximum; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket maximum. No one member will pay more than the per person deductible or per person out-of-pocket maximum.</p> <p>Your copays, coinsurance and deductible count toward your out of pocket amount(s).</p> <p>In-network and out-of-network deductibles and out-of-pocket maximum amounts are separate and do not accumulate toward each other.</p>		
Preventive Care / Screening / Immunization	No charge	40% coinsurance after deductible is met
Preventive Care for Chronic Conditions <i>per IRS guidelines</i>	No charge	40% coinsurance after deductible is met
<u>Virtual Care (Telemedicine / Telehealth Visits)</u>		
Virtual Visits - Online visits with Doctors who also provide services in person		
Primary Care (PCP) including Mental Health and Substance Abuse care by a PCP	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Mental Health and Substance Abuse care by Providers other than a PCP	20% coinsurance after deductible is met	40% 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 Fresno: Modified Anthem PPO Health Savings Account (HSA-H)/48C5/01-01-2022

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Specialist	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Virtual Visits from Online Provider LiveHealth Online via www.livehealthonline.com ; our mobile app, website or Anthem-enabled device Primary Care (PCP) and Mental Health and Substance Use Disorder Specialist Care	20% coinsurance after deductible is met 20% coinsurance after deductible is met	
<u>Visits in an Office</u> Primary Care (PCP) Specialist Care	20% coinsurance after deductible is met 20% coinsurance after deductible is met	40% coinsurance after deductible is met 40% coinsurance after deductible is met
<u>Other Practitioner Visits</u> Routine Maternity Care (Prenatal and Postnatal) Retail Health Clinic Manipulation Therapy <i>Coverage is limited to 24 visits per benefit period.</i> Acupuncture <i>Coverage is limited to 12 visits per benefit period.</i>	20% coinsurance after deductible is met 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 40% coinsurance after deductible is met
<u>Other Services in an Office</u> Allergy Testing Chemo/Radiation Therapy Dialysis/Hemodialysis Prescription Drugs <i>Dispensed in the office</i> <i>Maximum of \$250 member cost share per drug.</i> Surgery	20% coinsurance after deductible is met 20% coinsurance after deductible is met 20% coinsurance after deductible is met 30% 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 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
<u>Diagnostic Services</u> Lab Office Freestanding Lab Outpatient Hospital	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
X-Ray Office Freestanding Radiology Center Outpatient Hospital	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
Advanced Diagnostic Imaging <i>for example: MRI, PET and CAT scans</i> Office Freestanding Radiology Center Outpatient Hospital	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
<u>Emergency and Urgent Care</u> Urgent Care Emergency Room Facility Services Emergency Room Doctor and Other Services Ambulance	20% coinsurance after deductible is met 20% coinsurance after deductible is met 20% coinsurance after deductible is met 20% coinsurance after deductible is met	40% coinsurance after deductible is met Covered as In-Network Covered as In-Network Covered as In-Network
<u>Outpatient Mental Health and Substance Use Disorder</u> Doctor Office Visit	20% 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
Facility Visit Facility Fees Doctor Services	20% coinsurance after deductible is met 20% coinsurance after deductible is met	40% coinsurance after deductible is met 40% coinsurance after deductible is met
<u>Outpatient Surgery</u> Facility Fees Hospital Freestanding Surgical Center Doctor and Other Services Hospital	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
<u>Hospital (Including Maternity, Mental Health and Substance Use Disorder)</u> Facility Fees Doctor and other services	20% coinsurance after deductible is met 20% coinsurance after deductible is met	40% coinsurance after deductible is met 40% coinsurance after deductible is met
<u>Recovery & Rehabilitation</u> Home Health Care <i>Coverage is limited to 100 visits per benefit period.</i>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Rehabilitation services <i>Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 24 visits per benefit period. Chiropractic visits count towards your physical and occupational therapy limits</i> Office Outpatient Hospital	20% coinsurance after deductible is met 20% coinsurance after deductible is met	40% coinsurance after deductible is met 40% coinsurance after deductible is met
Cardiac rehabilitation <i>Coverage is limited to 36 visits per benefit period.</i> Office	20% 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
Outpatient Hospital	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Skilled Nursing Care (facility) <i>Coverage is limited to 100 days per benefit period.</i>	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Inpatient Hospice	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Durable Medical Equipment	20% coinsurance after deductible is met	40% coinsurance after deductible is met
Prosthetic Devices	20% coinsurance after deductible is met	40% coinsurance after deductible is met

Covered Services	Traditional Health Coverage Insured Person Copay	
	In-Network	Out-of-Network (Insured is also responsible for charges in excess of the prescription drug maximum allowed amount)

Outpatient Prescription Drug Benefits

➤ Preventive immunizations administered by a retail pharmacy -	No copay (<i>deductible waived</i>)	
➤ Female oral contraceptives generic and single source brand,	No copay (<i>deductible waived</i>)	
➤ Flu, Zostavax & Pneumococcal vaccines	No copay	
➤ Retail pharmacy prescription drug maximum allowed amount	20%	40% ¹
➤ Home Delivery prescription drug maximum allowed amount	20%	Not applicable
➤ Specialty pharmacy drugs (<i>obtained through specialty pharmacy program</i>)	20%	Not applicable

Supply Limits²

➤ Retail Pharmacy (<i>participating and non-participating</i>)	30-day supply; 60-day supply for federally classified Schedule II attention deficit disorder drugs that require a triplicate prescription form, but require a double copay; 6 tablets or units/30-day period for impotence and/or sexual dysfunction drugs (available only at retail pharmacies)
➤ Home Delivery	90-day supply
➤ Specialty Pharmacy	30-day supply

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

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

The Outpatient Prescription Drug Benefit covers the following:

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

Notes:

- If you have an office visit with your Primary Care Physician or Specialist 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 service for Non-Network Providers. Includes Diagnostic Services, X-ray, Surgery, Rehabilitation, Habilitation, and Cardiac Therapy. This also includes Surgery at Freestanding Facilities.
- 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.

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

ՈՒՇԱԴՐՈՒԹՅՈՒՆ. 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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1-888-254-2721 (TTY/TDD: 711)

Khmer
សំខាន់៖ តើអ្នកអាចអានលិខិតនេះទេ? បើមិនអាចទេ យើងអាចព្យាយាមបកប្រែអានជូនអ្នក។ អ្នកក៏អាចទទួលបានលិខិតនេះដោយសេរីដោយសារសេវាសម្រាប់អ្នកផងដែរ។ 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 ਾ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)

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.

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, 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 Fresno: Anthem PPO (HSA) 3000

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	\$3,000 person / \$6,000 family	\$3,000 person / \$6,000 family
Out-of-Pocket Limit	\$3,000 person / \$6,000 family	\$5,000 person / \$10,000 family
<p>The family deductible and out-of-pocket maximum are embedded, meaning the cost shares of one family member will be applied to both per person deductible and per person out-of-pocket maximum; in addition, amounts for all covered family members apply to both the family deductible and family out-of-pocket maximum. No one member will pay more than the per person deductible or per person out-of-pocket maximum.</p> <p>Your copays, coinsurance and deductible count toward your out of pocket amount(s).</p> <p>In-network and out-of-network deductibles and out-of-pocket maximum amounts are separate and do not accumulate toward each other.</p>		
Preventive Care / Screening / Immunization	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
<p><u>Virtual Care (Telemedicine / Telehealth Visits)</u></p> <p>Virtual Visits - Online visits with Doctors who also provide services in person</p> <p>Primary Care (PCP) including Mental Health and Substance Abuse care by a PCP</p> <p>Mental Health and Substance Abuse care by Providers other than a PCP</p> <p>Specialist</p>		
	0% coinsurance after deductible is met	50% coinsurance after deductible is met
	0% coinsurance after deductible is met	50% coinsurance after deductible is met
	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Virtual Visits from Online Provider LiveHealth Online <i>via www.livehealthonline.com; our mobile app, website or Anthem-enabled device</i>		

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Primary Care (PCP) and Mental Health and Substance Use Disorder Specialist Care	0% coinsurance after deductible is met	0% coinsurance after deductible is met
<u>Visits in an Office</u> Primary Care (PCP) Specialist Care	0% coinsurance after deductible is met	50% coinsurance after deductible is met
<u>Other Practitioner Visits</u> Routine Maternity Care (Prenatal and Postnatal) Retail Health Clinic Manipulation Therapy <i>Coverage is limited to 24 visits per benefit period.</i> Acupuncture <i>Coverage is limited to 12 visits per benefit period.</i>	0% coinsurance after deductible is met	50% coinsurance after deductible is met
<u>Other Services in an Office</u> Allergy Testing Chemo/Radiation Therapy Dialysis/Hemodialysis Prescription Drugs <i>Dispensed in the office</i> <i>Maximum of \$250 member cost share per drug.</i> Surgery	0% coinsurance after deductible is met	50% coinsurance after deductible is met
<u>Diagnostic Services</u> Lab Office Freestanding Lab	0% 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	0% coinsurance after deductible is met	50% coinsurance after deductible is met
X-Ray Office Freestanding Radiology Center Outpatient Hospital	0% coinsurance after deductible is met 0% coinsurance after deductible is met 0% 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 Outpatient Hospital	0% coinsurance after deductible is met 0% coinsurance after deductible is met 0% coinsurance after deductible is met	50% coinsurance after deductible is met 50% coinsurance after deductible is met 50% coinsurance after deductible is met
<u>Emergency and Urgent Care</u> Urgent Care Emergency Room Facility Services Emergency Room Doctor and Other Services Ambulance	0% coinsurance after deductible is met 0% coinsurance after deductible is met 0% coinsurance after deductible is met 0% coinsurance after deductible is met	50% coinsurance after deductible is met Covered as In-Network Covered as In-Network Covered as In-Network
<u>Outpatient Mental Health and Substance Use Disorder</u> Doctor Office Visit Facility Visit Facility Fees Doctor Services	0% coinsurance after deductible is met 0% coinsurance after deductible is met 0% coinsurance after deductible is met 0% coinsurance after deductible is met	50% coinsurance after deductible is met 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><u>Outpatient Surgery</u></p> <p>Facility Fees</p> <p>Hospital</p> <p>Freestanding Surgical Center</p> <p>Doctor and Other Services</p> <p>Hospital</p>	<p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p> <p>0% 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>Doctor and other services</p>	<p>0% coinsurance after deductible is met</p> <p>0% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p> <p>50% coinsurance after deductible is met</p>
<p><u>Recovery & Rehabilitation</u></p> <p>Home Health Care</p> <p><i>Coverage is limited to 100 visits per benefit period.</i></p>	<p>0% coinsurance after deductible is met</p>	<p>50% coinsurance after deductible is met</p>
<p>Rehabilitation services</p> <p><i>Coverage for rehabilitative and habilitative physical therapy and occupational therapy combined is limited to 24 visits per benefit period. Chiropractic visits count towards your physical and occupational therapy limits</i></p> <p>Office</p> <p>Outpatient Hospital</p>	<p>0% coinsurance after deductible is met</p> <p>0% 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</p> <p><i>Coverage is limited to 36 visits per benefit period.</i></p> <p>Office</p> <p>Outpatient Hospital</p>	<p>0% coinsurance after deductible is met</p> <p>0% 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
Skilled Nursing Care (facility) <i>Coverage is limited to 100 days per benefit period.</i>	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Inpatient Hospice	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Durable Medical Equipment	0% coinsurance after deductible is met	50% coinsurance after deductible is met
Prosthetic Devices	0% coinsurance after deductible is met	50% coinsurance after deductible is met

Covered Services	Traditional Health Coverage Insured Person Copay	
	In-Network	Out-of-Network (Insured is also responsible for charges in excess of the prescription drug maximum allowed amount)

Outpatient Prescription Drug Benefits

➤ Preventive immunizations administered by a retail pharmacy	No copay (<i>deductible waived</i>)	
➤ Female oral contraceptives generic and single source	No copay (<i>deductible waived</i>)	
➤ brand, Flu, Zostavax & Pneumococcal vaccines	No copay	
➤ Retail pharmacy prescription drug maximum allowed amount	No copay	50% ¹
➤ Home Delivery prescription drug maximum allowed amount	No copay	Not applicable
➤ Specialty pharmacy drugs (<i>obtained through specialty pharmacy program</i>)	No copay	Not applicable

Supply Limits²

➤ Retail Pharmacy (<i>participating and non-participating</i>)	30-day supply; 60-day supply for federally classified Schedule II attention deficit disorder drugs that require a triplicate prescription form, but require a double copay; 6 tablets or units/30-day period for impotence and/or sexual dysfunction drugs (available only at retail pharmacies)
➤ Home Delivery	90-day supply

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

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

The Outpatient Prescription Drug Benefit covers the following:

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

Notes:

- If you have an office visit with your Primary Care Physician or Specialist 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 service for Non-Network Providers. Includes Diagnostic Services, X-ray, Surgery, Rehabilitation, Habilitation, and Cardiac Therapy. This also includes Surgery at Freestanding Facilities.
- 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.

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

ՈՒՇԱԴՐՈՒԹՅՈՒՆ. 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។ អ្នកក៏អាចទទួលបានលិខិតនេះដោយសេរីដោយមិនមានការបង់ប្រាក់ផងដែរ។ 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 ਾ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)

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.

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, 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>.

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.

Frequently Asked Questions

How do I find a participating network pharmacy?

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

What is a prior authorization and why is it necessary?

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

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

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

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

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

Why does my copay change from month to month?

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

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

*Logos are service marks of EmpiRx Health.
Standard Brochure 1.2017*

CDPK.90.1800.000



SJVIA County of Fresno Prescription Benefit Plan



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

Your Prescription Benefit Program

Annual Maximum Out of Pocket Amount

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

Retail Pharmacy Copayment

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

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

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

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

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

Mail Order Pharmacy Copayment

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

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

Specialty Medication Copayment

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

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

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

Online Member Tools

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

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

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



Preferred Medication List

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

Exclusions

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

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

Retail Pharmacy Network

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

Mail Order Pharmacy

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

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

To order refills you have three options:

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

EmpiRx Health does NOT automatically refill your prescriptions.

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

Specialty Pharmacy

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

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

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

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

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

Where Can I Ship My Medications?

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

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

Save with Generic Medications

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

ID Cards

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

Direct Member Reimbursement

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

Benefit Summary

580 SJVIA - CO OF FRESNO (SAN JOAQUIN VALLEY INSURANCE AUTHORITY)

**Principal Benefits for
Kaiser Permanente Traditional HMO Plan (1/1/22—12/31/22)****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	\$1,000	\$1,000	\$2,000
Plan Deductible	None	None	None
Drug Deductible	None	None	None

Professional Services (Plan Provider office visits)

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

Outpatient Services

	You Pay
Outpatient surgery and certain other outpatient procedures.....	\$15 per procedure
Allergy antigens (including administration).....	\$3 per visit
Most immunizations (including the vaccine).....	No charge
Most X-rays and laboratory tests.....	No charge

Hospitalization Services

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

Emergency Health Coverage

	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 "Hospitalization Services" for inpatient Cost Share)

Ambulance Services

	You Pay
Ambulance Services.....	No charge

Prescription Drug Coverage

	You Pay
Covered outpatient items in accord with our drug formulary guidelines:	
Most generic items (Tier 1) at a Plan Pharmacy.....	\$10 for up to a 30-day supply
Most generic (Tier 1) refills through our mail-order service.....	\$20 for up to a 100-day supply
Most brand-name items (Tier 2) at a Plan Pharmacy.....	\$20 for up to a 30-day supply
Most brand-name (Tier 2) refills through our mail-order service.....	\$40 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.....	No charge

Mental Health Services

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

Substance Use Disorder Treatment

	You Pay
Inpatient detoxification.....	No charge
Individual outpatient substance use disorder evaluation and treatment.....	\$15 per visit
Group outpatient substance use disorder treatment.....	\$5 per visit

Home Health Services

	You Pay
Home health care (up to 100 visits per Accumulation Period).....	No charge

Benefit Summary*(continued)*

Other	You Pay
Eyeglasses or contact lenses every 24 months.....	Amount in excess of \$175 Allowance
Hearing aids every 36 months.....	Amount in excess of \$1,000 Allowance per aid
Skilled nursing facility care (up to 100 days per benefit period).....	No charge
Prosthetic and orthotic devices as described in the <i>EOC</i>	No charge
Services to diagnose or treat infertility and artificial insemination (such as outpatient procedures or laboratory tests) as described in the <i>EOC</i>	the Cost Share you would pay if the Services were to treat any other condition
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).

Choose Your Plan

Love your smile



Delta Dental PPO™ & DeltaCare® USA* County of Fresno, PPO #05879, DeltaCare #76744

Your company lets you choose between two dental plans from Delta Dental. Either way, you'll get reliable dentist networks, affordable preventive care and a healthy smile that you'll love to show. Your options are:

Delta Dental PPO¹

This preferred provider plan offers the convenience and flexibility of visiting any licensed dentist, anywhere. Covered services are paid based on a percentage — if, for example, fillings are covered at 80%, you pay the remaining 20%. Get the most plan value by choosing a Delta Dental PPO dentist.

DeltaCare USA

Under this HMO-type plan, you'll have your choice of skilled primary care dentists from the DeltaCare USA network. Select a primary care dentist, who will then coordinate any needed referrals to a specialist.² Covered services provided by your DeltaCare USA dentist have preset copayments (dollar amounts), which are listed in your plan booklet. There are no maximums or deductibles for covered services.³

*See the inside back page of this brochure for the underwriters and administrators of these plans in your state.

Newly covered?
Visit deltadentalins.com/welcome.

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

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

² In WY, you do not need to select a primary care dentist, but you must visit a network dentist to receive benefits. In the following states, you can maximize your savings when you visit a network dentist, although you may visit any licensed dentist and receive out-of-network coverage: AK, CT, LA, ME, MS, MT, NC, ND, NH, OK, SD, VT. Refer to your plan booklet for details about your out-of-network benefits.

³ Refer to your plan booklet for more information about covered services, deductibles and maximums.



We keep you smiling®

deltadentalins.com/enrollees

Delta Dental PPO™

Maximize your savings

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

Set up an online account

Get information about your plan anytime, anywhere by signing up for an online account at deltadentalins.com. This free service, available once your coverage kicks in, lets you check benefits and eligibility information, find a PPO dentist and more.

Check in without an ID card

You don't need a Delta Dental ID card when you visit the dentist. Just provide your name, birth date and enrollee ID or social security number. If your family members are covered under your plan, they will need your information. Prefer to take a paper or electronic ID card with you?

Simply log in to your account, where you can view or print your card with the click of a button.

Coordinate dual coverage

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

Understand transition of care

Did you start on a dental treatment plan before your PPO coverage kicked in? Generally, multi-stage procedures are only covered under your current plan if treatment began after your plan's effective date of coverage.⁴ You can find this date by logging in to your online account.

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 plan maximums and charges for non-covered services.

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 of Group Dental Service Contract for specific details about your plan.

Plan Benefit Highlights for: County of Fresno
 Group No: 05879

DELTA DENTAL PPO™
 BENEFIT HIGHLIGHTS

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

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

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

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

Delta Dental of California 560 Mission St., Suite 1300 San Francisco, CA 94105	Customer Service 800-765-8003	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.

DeltaCare[®] USA

Dental benefits made easy

When you enroll in a DeltaCare USA 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.

Convenient services

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

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

A partner in oral health

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

- Low or no copayments for services like cleanings and exams

Budget-friendly costs

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

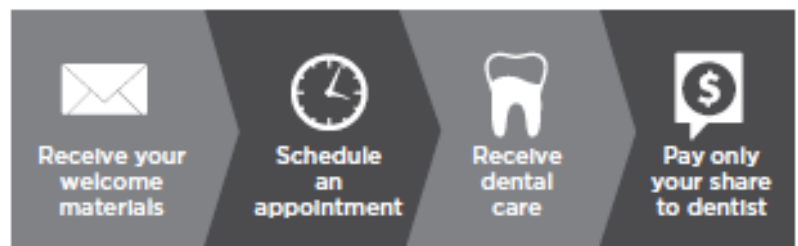
- No deductibles or maximums¹ for covered services
- Pay only your copayment (if any) at the time of treatment

Set up an online account

Sign up for an online account at deltadentalins.com. Available once your coverage kicks in, this free service lets you:

- Access plan information online
- Change your primary care dentist online — and more

Simple steps to get started



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

SCHEDULE A

Description of Benefits and Copayments

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

Text that appears in italics below is specifically intended to clarify the delivery of Benefits under the DeltaCare USA Program and is not to be interpreted as Current Dental Terminology ("CDT"), CDT-2019 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.

<u>CODE</u>	<u>DESCRIPTION</u>	<u>ENROLLEE PAYS</u>
D0100-D0999	I. DIAGNOSTIC	
D0120	Periodic oral evaluation - established patient	No Cost
D0140	Limited oral evaluation - problem focused	No Cost
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No Cost
D0150	Comprehensive oral evaluation - new or established patient	No Cost
D0160	Detailed and extensive oral evaluation - problem focused, by report	No Cost
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	No Cost
D0171	Re-evaluation - post-operative office visit	No Cost
D0180	Comprehensive periodontal evaluation - new or established patient	No Cost
D0190	Screening of a patient	No Cost
D0191	Assessment of a patient	No Cost
D0210	Intraoral - complete series of radiographic images - <i>limited to 1 series every 24 months</i>	No Cost
D0220	Intraoral - periapical first radiographic image	No Cost
D0230	Intraoral - periapical each additional radiographic image	No Cost
D0240	Intraoral - occlusal radiographic image	No Cost
D0250	Extraoral - 2D projection radiographic image created using a stationary radiation source, and detector	No Cost
D0251	Extraoral posterior dental radiographic image	No Cost
D0270	Bitewing - single radiographic image	No Cost
D0272	Bitewings - two radiographic images	No Cost
D0273	Bitewings three radiographic images	No Cost
D0274	Bitewings - four radiographic images - <i>limited to 1 series every 6 months</i>	No Cost
D0277	Vertical bitewings - 7 to 8 radiographic images	No Cost
D0330	Panoramic radiographic image	No Cost
D0415	Collection of microorganisms for culture and sensitivity	No Cost
D0425	Caries susceptibility tests	No Cost
D0460	Pulp vitality tests	No Cost
D0470	Diagnostic casts	No Cost
D0472	Accession of tissue, gross examination, preparation and transmission of written report - <i>available only when performed in conjunction with a covered biopsy</i>	No Cost
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report - <i>available only when performed in conjunction with a covered biopsy</i>	No Cost
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report - <i>available only when performed in conjunction with a covered biopsy</i>	No Cost
D0601	Caries risk assessment and documentation, with a finding of low risk - <i>1 every 3 years</i>	No Cost
D0602	Caries risk assessment and documentation, with a finding of moderate risk - <i>1 every 3 years</i>	No Cost
D0603	Caries risk assessment and documentation, with a finding of high risk - <i>1 every 3 years</i>	No Cost
D0999	Unspecified diagnostic procedure, by report - <i>includes office visit, per visit (in addition to other services)</i>	No Cost

D1000-D1999

II. PREVENTIVE

D1110	Prophylaxis cleaning - adult - 1 D1110, D1120 or D4346 per 6 month period	No Cost
D1110	Additional prophylaxis cleaning - adult (within the 6 month period)	\$45.00
D1120	Prophylaxis cleaning - child - 1 D1110, D1120 or D4346 per 6 month period	No Cost
D1120	Additional prophylaxis cleaning - child (within the 6 month period)	\$35.00
D1206	Topical application of fluoride varnish - 1 D1206 or D1208 per 6 month period	No Cost
D1208	Topical application of fluoride - excluding varnish - 1 D1206 or D1208 per 6 month period	No Cost
D1310	Nutritional counseling for control of dental disease	No Cost
D1320	Tobacco counseling for the control and prevention of oral disease	No Cost
D1330	Oral hygiene instructions	No Cost
D1351	Sealant - per tooth - limited to permanent molars through age 15	No Cost
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth - limited to permanent molars through age 15	No Cost
D1353	Sealant repair - per tooth - limited to permanent molars through age 15	No Cost
D1354	Interim caries arresting medicament application - per tooth - 1 per 6 month period	No Cost
D1510	Space maintainer - fixed - unilateral	No Cost
D1516	Space maintainer - fixed - bilateral, maxillary	No Cost
D1517	Space maintainer - fixed - bilateral, mandibular	No Cost
D1520	Space maintainer - removable - unilateral	No Cost
D1526	Space maintainer - removable - bilateral, maxillary	No Cost
D1527	Space maintainer - removable - bilateral, mandibular	No Cost
D1550	Re-cement or re-bond space maintainer	No Cost
D1555	Removal of fixed space maintainer	No Cost
D1575	Distal shoe space maintainer - fixed - unilateral - child to age 9	No Cost

D2000-D2999

III. RESTORATIVE

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

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

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

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

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

D2644	Onlay - porcelain/ceramic - four or more surfaces*	\$70.00
D2650	Inlay - resin-based composite - one surface	\$15.00
D2651	Inlay - resin-based composite - two surfaces	\$20.00
D2652	Inlay - resin-based composite - three or more surfaces	\$30.00
D2662	Onlay - resin-based composite - two surfaces	\$25.00
D2663	Onlay - resin-based composite - three surfaces	\$35.00
D2664	Onlay - resin-based composite - four or more surfaces	\$50.00
D2710	Crown - resin-based composite (indirect)	No Cost
D2712	Crown - 3/4 resin-based composite (indirect)	No Cost
D2720	Crown - resin with high noble metal	\$30.00
D2721	Crown - resin with predominantly base metal	\$15.00
D2722	Crown - resin with noble metal	\$20.00
D2740	Crown - porcelain/ceramic*	\$85.00
D2750	Crown - porcelain fused to high noble metal*	\$70.00
D2751	Crown - porcelain fused to predominantly base metal	\$55.00
D2752	Crown - porcelain fused to noble metal	\$60.00
D2780	Crown - 3/4 cast high noble metal	\$70.00
D2781	Crown - 3/4 cast predominantly base metal	\$55.00
D2782	Crown - 3/4 cast noble metal	\$60.00
D2783	Crown - 3/4 porcelain/ceramic*	\$70.00
D2790	Crown - full cast high noble metal	\$70.00
D2791	Crown - full cast predominantly base metal	\$55.00
D2792	Crown - full cast noble metal	\$60.00
D2794	Crown - titanium	\$70.00
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	No Cost
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	No Cost
D2920	Re-cement or re-bond crown	No Cost
D2921	Reattachment of tooth fragment, incisal edge or cusp (<i>anterior</i>)	No Cost
D2929	Prefabricated porcelain/ceramic crown - primary tooth - <i>anterior</i>	No Cost
D2930	Prefabricated stainless steel crown - primary tooth	No Cost
D2931	Prefabricated stainless steel crown - permanent tooth	No Cost
D2932	Prefabricated resin crown - <i>anterior primary tooth</i>	No Cost
D2933	Prefabricated stainless steel crown with resin window - <i>anterior primary tooth</i>	No Cost
D2940	Protective restoration	No Cost
D2941	Interim therapeutic restoration - primary dentition	No Cost
D2949	Restorative foundation for an indirect restoration	No Cost
D2950	Core buildup, including any pins when required	No Cost
D2951	Pin retention - per tooth, in addition to restoration	No Cost
D2952	Post and core in addition to crown, indirectly fabricated - <i>includes canal preparation</i>	No Cost
D2953	Each additional indirectly fabricated post - same tooth - <i>includes canal preparation</i>	No Cost
D2954	Prefabricated post and core in addition to crown - <i>base metal post; includes canal preparation</i>	No Cost
D2955	Post removal	No Cost
D2957	Each additional prefabricated post - same tooth - <i>base metal post; includes canal preparation</i>	No Cost
D2960	Labial veneer (resin laminate) - chairside - <i>limited to replacement of significant tooth structure loss due to caries or fracture</i>	\$245.00
D2961	Labial veneer (resin laminate) - laboratory - <i>limited to replacement of significant tooth structure loss due to caries or fracture</i>	\$295.00
D2962	Labial veneer (porcelain laminate) - laboratory - <i>limited to replacement of significant tooth structure loss due to caries or fracture</i>	\$345.00
D2971	Additional procedures to construct new crown under existing partial denture framework	\$14.00
D2980	Crown repair necessitated by restorative material failure	No Cost
D2981	Inlay repair necessitated by restorative material failure	No Cost
D2982	Onlay repair necessitated by restorative material failure	No Cost
D2983	Veneer repair necessitated by restorative material failure	No Cost
D2990	Resin infiltration of incipient smooth surface lesions - <i>limited to permanent molars through age 15</i>	No Cost

D3000-D3999		IV. ENDODONTICS <i>When referable services are provided by a Participating Specialty Care Dentist, the Enrollee pays 75 percent of that Dentist's usual fee.*</i>
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 dentinoceamental junction and application of medicament	No Cost
D3221	Pulpal debridement, primary and permanent teeth	No Cost
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	No Cost
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	No Cost
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	No Cost
D3310	Root canal - endodontic therapy, anterior tooth (excluding final restoration)	\$20.00
D3320	Root canal - endodontic therapy, premolar tooth (excluding final restoration)	\$40.00
D3330	Root canal - endodontic therapy, molar tooth (excluding final restoration)	\$60.00
D3331	Treatment of root canal obstruction; non-surgical access	\$40.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	\$40.00
D3333	Internal root repair of perforation defects	\$40.00
D3346	Retreatment of previous root canal therapy - anterior	\$35.00
D3347	Retreatment of previous root canal therapy - premolar	\$50.00
D3348	Retreatment of previous root canal therapy - molar	\$95.00
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	\$55.00
D3352	Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)	\$45.00
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	\$45.00
D3410	Apicoectomy - anterior	No Cost
D3421	Apicoectomy - premolar (first root)	No Cost
D3425	Apicoectomy - molar (first root)	No Cost
D3426	Apicoectomy (each additional root)	No Cost
D3427	Periradicular surgery without apicoectomy	No Cost
D3430	Retrograde filling - per root	No Cost
D3450	Root amputation - per root	No Cost
D3920	Hemisection (including any root removal), not including root canal therapy	No Cost
D4000-D4999		V. PERIODONTICS
<i>- Includes preoperative and postoperative evaluations and treatment under a local anesthetic.</i>		
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	No Cost
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	No Cost
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	No Cost
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	No Cost
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	No Cost
D4245	Apically positioned flap	\$45.00
D4249	Clinical crown lengthening - hard tissue	\$45.00
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	\$75.00
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	\$60.00
D4263	Bone replacement graft - retained natural tooth - first site in quadrant	\$125.00
D4264	Bone replacement graft - retained natural tooth - each additional site in quadrant	\$45.00
D4266	Guided tissue regeneration - resorbable barrier, per site	\$100.00
D4267	Guided tissue regeneration - nonresorbable barrier, per site (includes membrane removal)	\$140.00
D4270	Pedicle soft tissue graft procedure	\$125.00
D4273	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft	\$75.00

D4274	Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	No Cost
D4275	Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft	\$115.00
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft	\$125.00
D4278	Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant, or edentulous tooth position in same graft site	\$125.00
D4283	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) - each additional contiguous tooth, implant or edentulous tooth position in same graft site	\$45.00
D4285	Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) - each additional contiguous tooth, implant or edentulous tooth position in same graft site	\$69.00
D4341	Periodontal scaling and root planing - four or more teeth per quadrant - <i>limited to 4 quadrants during any 12 consecutive months</i>	No Cost
D4342	Periodontal scaling and root planing - one to three teeth per quadrant - <i>limited to 4 quadrants during any 12 consecutive months</i>	No Cost
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation - <i>1 D1110, D1120 or D4346 per 6 month period</i>	No Cost
D4355	Full mouth debridement to enable a comprehensive oral 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 (<i>within the 6 month period</i>)	\$55.00
D4921	Gingival irrigation - per quadrant	No Cost

D5000-D5899 VI. PROSTHODONTICS (removable)

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

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

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

D5110	Complete denture - maxillary	\$75.00
D5120	Complete denture - mandibular	\$75.00
D5130	Immediate denture - maxillary	\$85.00
D5140	Immediate denture - mandibular	\$85.00
D5211	Maxillary partial denture - resin base (including 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 any conventional clasps, rests and teeth)	\$95.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	\$95.00
D5221	Immediate maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	\$80.00
D5222	Immediate mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	\$80.00
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	\$95.00
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	\$95.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	\$195.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	\$195.00
D5282	Removable unilateral partial denture - one piece cast metal (including clasps and teeth), maxillary	\$80.00
D5283	Removable unilateral partial denture - one piece cast metal (including clasps and teeth), mandibular	\$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
D5730	Reline complete maxillary denture (chairside)	No Cost
D5731	Reline complete mandibular denture (chairside)	No Cost
D5740	Reline maxillary partial denture (chairside)	No Cost
D5741	Reline mandibular partial denture (chairside)	No Cost
D5750	Reline complete maxillary denture (laboratory)	\$25.00
D5751	Reline complete mandibular denture (laboratory)	\$25.00
D5760	Reline maxillary partial denture (laboratory)	\$25.00
D5761	Reline mandibular partial denture (laboratory)	\$25.00
D5820	Interim partial denture (maxillary) - <i>limited to 1 in any 12 consecutive months</i>	No Cost
D5821	Interim partial denture (mandibular) - <i>limited to 1 in any 12 consecutive months</i>	No Cost
D5850	Tissue conditioning, maxillary	No Cost
D5851	Tissue conditioning, mandibular	No Cost

D5900-D5999 VII. MAXILLOFACIAL PROSTHETICS - Not Covered**D6000-D6199 VIII. IMPLANT SERVICES - Not Covered****D6200-D6999 IX. PROSTHODONTICS, fixed (each retainer and each pontic constitutes a unit in a fixed partial denture [bridge])**

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

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

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

D6205	Pontic - indirect resin based composite	\$30.00
D6210	Pontic - cast high noble metal	\$70.00
D6211	Pontic - cast predominantly base metal	\$55.00
D6212	Pontic - cast noble metal	\$60.00
D6214	Pontic - titanium	\$70.00
D6240	Pontic - porcelain fused to high noble metal*	\$70.00
D6241	Pontic - porcelain fused to predominantly base metal	\$55.00
D6242	Pontic - porcelain fused to noble metal	\$60.00
D6245	Pontic - porcelain/ceramic*	\$70.00
D6250	Pontic - resin with high noble metal	\$30.00
D6251	Pontic - resin with predominantly base metal	\$15.00
D6252	Pontic - resin with noble metal	\$20.00

D6600	Retainer inlay - porcelain/ceramic, two surfaces	\$60.00
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces	\$65.00
D6602	Retainer inlay - cast high noble metal, two surfaces	\$70.00
D6603	Retainer inlay - cast high noble metal, three or more surfaces	\$70.00
D6604	Retainer inlay - cast predominantly base metal, two surfaces	No Cost
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces	No Cost
D6606	Retainer inlay - cast noble metal, two surfaces	\$60.00
D6607	Retainer inlay - cast noble metal, three or more surfaces	\$60.00
D6608	Retainer onlay - porcelain/ceramic, two surfaces	\$55.00
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces	\$65.00
D6610	Retainer onlay - cast high noble metal, two surfaces	\$70.00
D6611	Retainer onlay - cast high noble metal, three or more surfaces	\$70.00
D6612	Retainer onlay - cast predominantly base metal, two surfaces	No Cost
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	No Cost
D6614	Retainer onlay - cast noble metal, two surfaces	\$60.00
D6615	Retainer onlay - cast noble metal, three or more surfaces	\$60.00
D6710	Retainer crown - indirect resin based composite	\$30.00
D6720	Retainer crown - resin with high noble metal	\$30.00
D6721	Retainer crown - resin with predominantly base metal	\$15.00
D6722	Retainer crown - resin with noble metal	\$20.00
D6740	Retainer crown - porcelain/ceramic*	\$70.00
D6750	Retainer crown - porcelain fused to high noble metal*	\$70.00
D6751	Retainer crown - porcelain fused to predominantly base metal	\$55.00
D6752	Retainer crown - porcelain fused to noble metal	\$60.00
D6780	Retainer crown - 3/4 cast high noble metal	\$70.00
D6781	Retainer crown - 3/4 cast predominantly base metal	\$55.00
D6782	Retainer crown - 3/4 cast noble metal	\$60.00
D6783	Retainer crown - 3/4 porcelain/ceramic*	\$70.00
D6790	Retainer crown - full cast high noble metal	\$70.00
D6791	Retainer crown - full cast predominantly base metal	\$50.00
D6792	Retainer crown - full cast noble metal	\$60.00
D6794	Retainer crown - titanium	\$70.00
D6930	Re-cement or re-bond fixed partial denture	No Cost
D6940	Stress breaker	No Cost
D6980	Fixed partial denture repair necessitated by restorative material failure	No Cost

D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY

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

D7111	Extraction, coronal remnants - primary tooth	No Cost
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	No Cost
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	\$10.00
D7220	Removal of impacted tooth - soft tissue	\$15.00
D7230	Removal of impacted tooth - partially bony	\$25.00
D7240	Removal of impacted tooth - completely bony	\$35.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	\$50.00
D7250	Removal of residual tooth roots (cutting procedure)	No Cost
D7251	Coronectomy - intentional partial tooth removal	\$50.00
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	\$35.00
D7280	Exposure of an unerupted tooth	\$25.00
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	\$25.00
D7283	Placement of device to facilitate eruption of impacted tooth	No Cost
D7286	Incisional biopsy of oral tissue - soft - <i>does not include pathology laboratory procedures</i>	No Cost
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	No Cost
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	No Cost
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	No Cost

D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	No Cost
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	No Cost
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	No Cost
D7471	Removal of lateral exostosis (maxilla or mandible)	No Cost
D7472	Removal of torus palatinus	No Cost
D7473	Removal of torus mandibularis	No Cost
D7510	Incision and drainage of abscess - intraoral soft tissue	No Cost
D7960	Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure	No Cost
D7970	Excision of hyperplastic tissue - per arch	No Cost
D7971	Excision of pericoronal gingiva	No Cost

D8000-D8999 XI. ORTHODONTICS

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

- The Retention Copayment includes adjustments and/or office visits up to 24 months.

Pre and post orthodontic records include:

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

D0210	Intraoral - complete series of radiographic images	
D0322	Tomographic survey	
D0330	Panoramic radiographic image	
D0340	2D cephalometric radiographic image - acquisition, measurement and analysis	
D0350	2D oral/facial photographic images obtained intraorally or extraorally	
D0351	3D photographic image	
D0470	Diagnostic casts	
	The benefit for post-treatment records includes:	\$70.00
D0210	Intraoral - complete series of radiographic images	
D0470	Diagnostic casts	
D8010	Limited orthodontic treatment of the primary dentition	\$725.00
D8020	Limited orthodontic treatment of the transitional dentition - child or adolescent to age 19	\$725.00
D8030	Limited orthodontic treatment of the adolescent dentition - adolescent to age 19	\$725.00
D8040	Limited orthodontic treatment of the adult dentition - adults, including covered dependent adult children	\$925.00
D8050	Interceptive orthodontic treatment of the primary dentition	\$725.00
D8060	Interceptive orthodontic treatment of the transitional dentition	\$725.00
D8070	Comprehensive orthodontic treatment of the transitional dentition - child or adolescent to age 19 ..	\$1,700.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition - adolescent to age 19	\$1,700.00
D8090	Comprehensive orthodontic treatment of the adult dentition - adults, including covered dependent adult children	\$1,900.00
D8660	Pre-orthodontic treatment examination to monitor growth and development	\$25.00
D8670	Periodic orthodontic treatment visit - included in comprehensive case fee	No Cost
D8680	Orthodontic retention (removal of appliances, construction and placement of removable retainers)	\$275.00
D8681	Removable orthodontic retainer adjustment	No Cost
D8693	Re-bond or re-cement fixed retainer - limited to 2 per 6 month period	No Cost
D8694	Repair of fixed retainers, includes reattachment - limited to 2 per 6 month period	No Cost
D8999	Unspecified orthodontic procedure, by report - includes treatment planning session	\$100.00

D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES

D9110	Palliative (emergency) treatment of dental pain - minor procedure	No Cost
D9211	Regional block anesthesia	No Cost
D9212	Trigeminal division block anesthesia	No Cost
D9215	Local anesthesia in conjunction with operative or surgical procedures	No Cost
D9219	Evaluation for 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 medical health care professional	No Cost
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	No Cost
D9440	Office visit - after regularly scheduled hours	\$20.00
D9450	Case presentation, detailed and extensive treatment planning	No Cost
D9932	Cleaning and inspection of removable complete denture, maxillary	No Cost
D9933	Cleaning and inspection of removable complete denture, mandibular	No Cost
D9934	Cleaning and inspection of removable partial denture, maxillary	No Cost
D9935	Cleaning and inspection of removable partial denture, mandibular	No Cost
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

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

SCHEDULE B**Limitations of Benefits**

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

Exclusions of Benefits

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

9. Consultations for non-covered benefits.
10. Dental services received from any dental facility other than the assigned Contract Dentist, a preauthorized dental specialist, or a Contract Orthodontist except for *Emergency Services* as described in the Contract and/or Evidence of Coverage.
11. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.
12. Prescription drugs.
13. Dental expenses incurred in connection with any dental or orthodontic procedure started before the Enrollee's eligibility with the DeltaCare USA Program. Examples include: teeth prepared for crowns, root canals in progress, full or partial dentures for which an impression has been taken and orthodontics unless qualified for the orthodontic treatment in progress provision.
14. Lost, stolen or broken orthodontic appliances.
15. Changes in orthodontic treatment necessitated by accident of any kind.
16. Myofunctional and parafunctional appliances and/or therapies, with the exception of procedures D9944, D9945, D9946 (occlusal guard).
17. Composite or ceramic brackets, lingual adaptation of orthodontic bands and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances.
18. Treatment or appliances that are provided by a Dentist whose practice specializes in prosthodontic services.
19. Orthodontic treatment must be provided by a licensed dentist. Self-administered orthodontics are not covered.
20. The removal of fixed orthodontic appliances for reasons other than completion of treatment is not a covered benefit.

Compare Plan Features¹

	Delta Dental PPO	DeltaCare USA
Can I go to any dentist?	You can visit any licensed dentist to receive coverage, but you'll save the most at an in-network dentist.	You must select a DeltaCare USA primary care dentist and visit this dentist to receive benefits. ²
What procedures are covered?	Your plan covers a wide range of services, with no exclusions for most pre-existing conditions. Preventive care, like routine cleanings and exams, is offered at low or no cost.	Your plan covers over 300 procedures, with no exclusions for most pre-existing conditions. Preventive care, like routine cleanings and exams, has low or no copayments.
Are there deductibles and maximums?	Yes, most plans have an annual deductible and maximum.	No, there are no annual deductibles or maximums. ³
Am I covered for treatment I began under a different employer-sponsored dental plan?	Coverage is provided only for treatment started and completed after your effective date. Orthodontic treatment may be an exception to this rule.	Coverage is provided only for treatment started and completed after your effective date. ⁴ Orthodontic treatment may be an exception to this rule.
What if I started orthodontic treatment under my previous dental plan?	Typically, Delta Dental pays the remaining benefit not paid by your prior dental plan.	You are responsible for the copayments and fees subject to the provisions of your prior dental plan.
What happens if I need to see a specialist?	You do not need a referral from your dentist.	Contact your DeltaCare USA primary care dentist to coordinate your referral. ⁵
What is my out-of-area coverage?	You can visit any licensed dentist.	You have a limited benefit to go out of network for emergency care.
How do I change my dentist?	You can change your dentist at any time without contacting us.	You can change your selected or assigned primary care dentist online or by telephone. ⁶
Do I need to fill out claims?	If you visit a Delta Dental dentist, the dental office will file the claim for you. If you go to a non-Delta Dental dentist, you may have to submit the claim yourself.	There are generally no claim forms under your plan. ⁷

¹ This comparison is based on the coverage of a typical plan. Please refer to your plan booklet for specific benefits, limitations, exclusions, waiting periods and other coverage details.

² In WY, you do not need to select a primary care dentist, but you must visit a network dentist to receive benefits. In the following states, you can maximize your savings when you visit a network dentist, although you may visit any licensed dentist and receive out-of-network coverage: AK, CT, LA, ME, MS, MT, NC, ND, NH, OK, SD, VT. Refer to your plan booklet for details about your out-of-network benefits.

³ In AK, CT, ND and SD, you have an out-of-network calendar year maximum of \$500 when you visit an out-of-network dentist.

⁴ Except in Texas; please refer to your plan booklet for details.

⁵ Most services not performed by your primary care dentist must be authorized by Delta Dental. In some states, specialty care benefits are only available for services performed by an in-network specialist. Refer to your plan booklet for details.

⁶ In the following states, you can change your dentist any time without contacting Delta Dental: AK, CT, LA, ME, MS, MT, NC, ND, NH, OK, SD, VT, WY.

⁷ You may have to complete a claim form if you visit an out-of-network dentist, such as for limited emergency treatment or in the following states: AK, CT, LA, ME, MS, MT, NC, ND, NH, OK, SD, VT.

Useful information once you're enrolled

Check out our SmileWay® Wellness program

Find oral health resources, including a risk self-assessment tool, quizzes, articles, videos and a subscription to *Grin!*, our free dental wellness e-magazine, at mysmileway.com.

Find a network dentist near you

Use our convenient "Find a Dentist" tool and select your network.

- Find a dentist near your home or office
- Narrow your search by location, specialty, languages spoken — and more

Sign up for an online account

Use your mobile device or desktop to sign up for a free, secure online account.

- Review your plan benefits
- Access your ID card

Go paperless

Save paper by viewing all your documents online instead of receiving them in the mail.

Once you've registered for an online account, visit your My Profile page to select "Online" for your document delivery preference.

NOTE: THIS IS ONLY A BRIEF SUMMARY OF YOUR PLAN. This brochure provides highlights about both dental plans to help you choose the best option for your needs. This brochure is not intended to replace your legally required plan booklet. Your Group Dental Service Contract or Evidence/Certificate of Coverage determines the exact terms and conditions of your coverage. Please refer to your plan booklet for a complete list of covered procedures, copayments, plan limitations and exclusions. Your Evidence/Certificate of Coverage will be mailed to you upon enrollment. If you wish to review an Evidence/Certificate of Coverage prior to enrollment, you may request a copy by calling the Customer Service number for each plan listed on the back page of this brochure.

PRODUCT ADMINISTRATION

DeltaCare USA is underwritten in these states by these entities: AL — Alpha Dental of Alabama, Inc.; AZ — Alpha Dental of Arizona, Inc.; CA — Delta Dental of California; AR, CO, IA, MA, ME, MI, MN, NC, ND, NE, NH, OK, OR, RI, SC, SD, 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 PPO is underwritten by Delta Dental Insurance Company in AL, DC, FL, GA, LA, MS, MT, NV and UT and by not-for-profit dental service companies in these states: CA - Delta Dental of California; PA, MD - Delta Dental of Pennsylvania; NY - Delta Dental of New York, Inc.; DE - Delta Dental of Delaware, Inc.; WV - Delta Dental of West Virginia, Inc. In Texas, Delta Dental Insurance Company provides a dental provider organization (DPO) plan.

Delta Dental is a registered mark of Delta Dental Plans Association.

Need help? Let us know

Online:

Visit deltadentalins.com/contact and select the company through which you receive benefits.

Call toll-free:

Customer Service agents are available Monday through Friday, during business hours. Or, use our interactive automated phone system, available 24/7.

Delta Dental PPO: 888-335-8227

DeltaCare USA: 800-422-4234

Write to:

Delta Dental PPO:

Delta Dental Customer Service
P.O. Box 997330
Sacramento, CA 95899-7330

DeltaCare USA:

DeltaCare USA Customer Service
P.O. Box 1803
Alpharetta, GA 30023

A LOOK AT YOUR VSP VISION COVERAGE



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

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

VALUE AND SAVINGS YOU LOVE.

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

PROVIDER CHOICES YOU WANT.

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



Like shopping online? Go to eyeconic.com and use your vision benefits to shop over 50 brands of contacts, eyeglasses, and sunglasses.

QUALITY VISION CARE YOU NEED.

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

PROVIDER NETWORK:

VSP Choice

EFFECTIVE DATE:

01/01/2022

BENEFIT	DESCRIPTION	COPAY
YOUR COVERAGE WITH A VSP PROVIDER		
WELLVISION EXAM	<ul style="list-style-type: none"> Focuses on your eyes and overall wellness Every 12 months 	\$10
PRESCRIPTION GLASSES		
FRAME	<ul style="list-style-type: none"> \$170 featured frame brands allowance \$150 frame allowance 20% savings on the amount over your allowance \$80 Costco® frame allowance Every 24 months 	Included in Prescription Glasses
LENSES	<ul style="list-style-type: none"> Single vision, lined bifocal, and lined trifocal lenses 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"> \$150 allowance for contacts; copay does not apply Contact lens exam (fitting and evaluation) Every 12 months 	Up to \$60
PRIMARY EYECARESM	<ul style="list-style-type: none"> Retinal screening for members with diabetes Additional exams and services for members with diabetes, glaucoma, or age-related macular degeneration. Treatment and diagnoses of eye conditions, including pink eye, vision loss, and cataracts available for all members. Limitations and coordination with your medical coverage may apply. Ask your VSP doctor for details. As needed 	\$0 \$20 per exam
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 WITH OUT-OF-NETWORK PROVIDERS

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

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

Contact us:

800.877.7195 or **vsp.com**

Classification: Restricted

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BOARD OF DIRECTORS

STEVE BRANDAU
NATHAN MAGSIG
BUDDY MENDES
LARRY MICARI
BRIAN PACHECO
AMY SHUKLIAN
PETE VANDER POEL

Exhibit B

County of Fresno

**Plan Year 2022
Rates**

County of Fresno Rates to be remitted to SJVIA	Monthly Rates Effective January 1, 2022				Bi-Weekly Rates Effective December 13, 2021			
	EE	ES	EC	FA	EE	ES	EC	FA
Anthem PPO \$250	\$1,187.65	\$2,493.10	\$2,258.71	\$3,444.21	\$548.15	\$1,150.66	\$1,042.48	\$1,589.64
Anthem PPO \$1000	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Anthem PPO \$1,500 Active	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Anthem PPO \$1,500 Retiree	\$914.24	\$1,618.51	\$1,428.18	\$2,130.68	N/A	N/A	N/A	N/A
Anthem PPO \$3,000	\$653.08	\$1,383.36	\$1,240.23	\$1,889.95	\$301.42	\$638.47	\$572.41	\$872.28
Anthem EPO 500 (includes VSP Vision)	\$846.99	\$1,534.09	\$1,344.79	\$2,021.28	\$390.92	\$708.04	\$620.67	\$932.90
Anthem EPO 1000 (includes VSP Vision)	\$798.26	\$1,445.81	\$1,267.49	\$1,905.07	\$368.43	\$667.30	\$585.00	\$879.26
Anthem EPO 0 (includes VSP Vision)	\$931.49	\$1,689.48	\$1,481.09	\$2,227.05	\$429.92	\$779.76	\$683.58	\$1,027.87
Kaiser HMO (includes EPO parity)	\$931.49	\$1,689.48	\$1,481.09	\$2,227.05	\$429.92	\$779.76	\$683.58	\$1,027.87
Delta Dental PPO	\$50.29	\$80.19	\$69.88	\$102.58	\$23.21	\$37.01	\$32.25	\$47.34
Delta Dental DHMO	\$27.38	\$47.51	\$47.83	\$68.95	\$12.64	\$21.93	\$22.08	\$31.82
VSP Vision	\$7.89	\$14.18	\$13.90	\$20.35	\$3.64	\$6.54	\$6.42	\$9.39