Basic Plan

CAHP Health Benefits Trust

Preferred Provider Organization (PPO)

Combined Evidence of Coverage
and Disclosure Form

Effective January 1, 2017

Sponsored by California Association of Highway Patrolmen
Medical Claims Administered by Anthem Blue Cross (BC)
on Behalf of Anthem BC Life & Health Insurance Company

Contracted by the CalPERS Board of Administration Under the
Public Employees' Medical & Hospital Care Act (PEMHCA)

CalPERS

COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM

The CAHP Health Benefits Trust (the Plan) has a Memorandum of Agreement (the Agreement) with the California Public Employees' Retirement System (CalPERS). This Plan is a self-insured plan. The benefits of the Plan are provided while Medically Necessary for the Subscriber and enrolled Family Members for a covered illness, injury or condition, subject to all of the terms and conditions of the Evidence of Coverage

Medical, Hospital, mental disorders and chemical dependency, and health promotion program claims administration is provided by Anthem Blue Cross Life & Health Insurance Company in accordance with an Administrative Services Agreement between the CAHP Health Benefits Trust and Anthem Life. Prescription Drug benefits are administered by Express Scripts.

The benefits of the Plan shall be provided only to the extent that services are determined to be Medically Necessary, as defined herein. The determination of medical necessity shall be made by Blue Cross. The fact that a Physician or other provider prescribes or orders the services does not, of itself, make it Medically Necessary or a Covered Expense.

IMPORTANT

No person has the right to receive any benefits of this Plan following termination of coverage, except as specifically provided under the TERMINATION AND RELATED PROVISIONS section in this Evidence of Coverage.

Benefits of this Plan are available only for services and supplies furnished during the term the Plan is in effect and while the benefits you are claiming are actually covered by this Plan.

Reimbursement may be limited during the term of this Plan as specifically provided under the terms in this Evidence of Coverage. Benefits may be modified or eliminated upon subsequent years' renewals of this Plan. If benefits are modified, the revised benefits (including any reduction in benefits or the elimination of benefits) apply for services or supplies furnished on or after the effective date of modification. **There is no vested right to receive the benefits of this Plan.**

CAHP Health Benefits Trust

Plan year 2017

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REMEMBER, IT IS YOUR RESPONSIBILITY TO STAY INFORMED ABOUT YOUR HEALTH BENEFITS COVERAGE.

CLAIMS

For medical claims submission or inquiries, authorized referrals, benefit information, identification cards, or to obtain claim forms or a Prudent Buyer Plan Directory of Participating Providers, contact:

Anthem Blue Cross
Attn: CAHP Unit
P.O. Box 60007
Los Angeles, CA 90060-0007
1-800-759-5758
www.anthem.com/ca

MEDICAL MANAGEMENT PROGRAMS

For Utilization Review, Medical Necessity Review, and Personal Case Management contact:

Anthem Blue Cross
1-800-274-7767

HEALTH PROMOTION PROGRAM

For information regarding smoking cessation programs and products, and weight management as provided under HEALTH PROMOTION PROGRAM, contact:

Anthem Blue Cross
1-800-759-5758

DIRECT PAYMENT OF PREMIUMS

If you are eligible to continue your group membership while off pay status, send your payment, together with a completed Form HBD 21 to:

CAHP Health Benefits Trust
2030 V Street
Sacramento, CA 95818 1730

PRESCRIPTION DRUG PROGRAM

For information regarding Outpatient Prescription Drug Care Program (claims submission, claim forms, information, or for assistance in locating a Participating Pharmacy), contact:

Express Scripts
1-800-711-0917
www.express-scripts.com

For information regarding the Outpatient Prescription Drug Mail Order Program, contact:

Express Scripts
PO Box 747000
Cincinnati, OH 45274-7000
1-800-711-0917
www.express-scripts.com

ELIGIBILITY OR ENROLLMENT

For information regarding eligibility or enrollment, consult your health benefits officer in your agency (active Employees) or contact the Health Account Services (Annuitants), as follows:

CalPERS Member Account Management Division
P.O. Box 942714, Sacramento, CA 94229-2714
888 CalPERS (or **888-225-7377**)
(800) 959-6545 (fax)
TTY (877) 249-7442
www.calpers.ca.gov

NOTE: Important information pertaining to eligibility, enrollment, cancellation or termination of insurance, etc., is found in the CalPERS Health Program Guide You may request a copy of this booklet by writing or calling CalPERS at the address, telephone or Web site numbers listed above.

HEALTH PROMOTION PROGRAM

This Plan provides benefits for smoking cessation and weight management to help support your goal to develop and maintain a healthier lifestyle. Please refer to the HEALTH PROMOTION PROGRAM section page HEALTH PROMOTION PROGRAMS 61 for additional information.

ORGAN DONATION

Each year, organ transplantation saves thousands of lives. The success rate for transplantation is rising, but there are far more potential recipients than donors. More donations are urgently needed.

Organ donation is a singular opportunity to give the gift of life. Anyone age 18 or older and of sound mind can become a donor when he or she dies. Minors can become donors with parental or guardian consent.

Organ and tissue donations may be used for transplants and medical research. Today it is possible to transplant more than 25 different organs and tissues; this can save the lives of as many as eight people and improve the lives of another 50 people. Your decision to become a donor could someday save or prolong the life of someone you know, perhaps even a close friend or family member.

If you decide to become a donor, please discuss it with your family. Let your physician know your intentions as well. You may register as a donor by obtaining a donor card from the Department of Motor Vehicles. Be sure to sign the donor card and keep it with your driver's license or identification card. In California, you may also register online at www.donatelifecalifornia.org/.

While organ donation is a deeply personal decision, please consider making this profoundly meaningful and important gift.

ADVANCE HEALTH CARE DIRECTIVE

It is your RIGHT to make decisions concerning your own health, including the right to choose or refuse medical treatment.

Laws are designed to protect your health information and limit who can review it. Your treatment is between you and your physician, and you have the final decision on the course of treatment.

An Advance Health Care Directive (AHCD) is a document that instructs others about your care should you be unable to make decisions on your own. It provides a clear statement of wishes about your choice to prolong your life or to withhold or withdraw treatment.

Forms are available through community and senior services organizations, some physicians, hospitals and hospice programs. Specifically, the Californian Hospital Association has a form that can be downloaded at www.calhealth.org/download/advancedirective.doc.

Choices about the end of life are important for all adults – not just the older population. Not only does an advance directive let your voice be heard about what you want, but it also relieves others the burden of making these decisions for you.

PREVENTIVE MEDICAL MISTAKES

While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. By asking questions, learning more and understanding your risks, you can improve the safety of your own health care, and that of your family members. Take these simple steps:

Tell *all* your health-care providers if you have medication allergies or sensitivities.

Provide your doctor(s) with a written list of all the medications your take – including vitamins, herb or other over-the-counter drugs.

Bring an "advocate" with you to the doctor's office or hospital. If you can't ask questions or take notes, this person can do it for you. Take your list of medications along with you as well.

Ask questions about any new medications you are given. Pills should look the same each time. If they don't, you could be getting the wrong medication. If you get any injections, ask what they are and what they're for.

Immediately report any medication problems to your doctor.

Insist that all health-care providers wash their hands or wear sterile gloves. Have your advocate post a sign above your bed saying, "Please wash your hands before you touch me."

Be assertive if something seems wrong or different than usual.

Spend the *least* possible time in the hospital. The longer you stay, the greater your chances are of picking up a hospital-acquired infection.

Additional information on patient safety:

www.ahrq.gov/path/beactive.htm — The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but also to help choose quality health care providers and improve the quality of care you receive.

www.npsf.org — The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.

www.talkaboutrx.org/index.jsp — The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.

www.leapfroggroup.org — The Leapfrog Group is active in promoting safe practices in hospital care.

www.ahqa.org — The American Health Quality Association represents organizations and health care professionals working to improve patient safety.

www.quic.gov/report — Find out what federal agencies are doing to identify threats to patient safety and help prevent mistakes in the nation's health care delivery system.

STOP HEALTH CARE FRAUD

Fraud in our nation's health care system results in losses of millions of dollars every year. It increases the cost of health care for everyone including increases to your CAHP Health Benefits Trust Premiums.

Here are some things that you can do to prevent fraud:

Carefully review explanation of benefits (EOBs) that you receive from the Trust.

Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill the Plan to get it paid.

Do not ask your Physician to make false entries on certificates, bills or records in order to get the Plan to pay for an item or service.

If you suspect that a Physician has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

1. Call the Physician and ask for an explanation. There may be an error.
2. If the provider does not resolve the matter, call Anthem Blue Cross customer service and explain the situation.
3. If it is not resolved, contact the Department of Insurance:

CDI Fraud Division Intake Unit
PO Box 277320
Sacramento, CA 95827
www.insurance.ca.gov/0300-fraud/
(800) 927-HELP (4357)

Do not maintain ineligible family members on your policy. Former spouses, after a divorce decree or annulment is final (even if a court order stipulates otherwise), are not eligible to continue coverage as your dependent nor are children under the age of 26 who are not yours and for whom you have no legal or financial obligation. These dependents may be entitled to CONTINUATION OF COVERAGE (page 81).

LANGUAGE ASSISTANCE PROGRAM

Anthem Blue Cross introduced its Language Assistance Program to provide certain written translation and oral interpretation services to California Members with limited English proficiency.

The Language Assistance Program makes it possible for the Member to access oral interpretation services and certain written materials vital to understanding his or her health coverage at no additional cost to the Member.

Written materials available for translation include grievance and appeal letters, consent forms, claim denial letters, and explanations of benefits. These materials are available in the following languages:

- Spanish
- Chinese
- Vietnamese
- Korean
- Tagalog

Oral interpretation services are available in additional languages.

The Member may call the customer service number on his or her ID card to request a written or oral translation, to update his or her language preference, to receive future translated documents, or to request interpretation assistance. Anthem Blue Cross also sends/receives TDD/TTY messages at **866-333-4823** or by using the National Relay Service through 711.

For more information about the Language Assistance Program visit www.anthem.com/ca.

SUMMARY OF BENEFIT AND ADMINISTRATIVE CHANGES

The following is a brief summary of the benefit and administrative changes effective January 1, 2017. Be sure to refer to the appropriate benefit description sections of this Evidence of Coverage for additional information.

BENEFIT CHANGES

The Prescription Drug out-of-pocket maximum for an individual increased to $5,150.00 and for family (other than self-only) the amount increased to $10,300.00.

SUMMARY OF BENEFITS

The following chart is only a summary of benefits under your CAHP Health Benefits Trust Plan. Please refer to the Covered Medical Services and Supplies section beginning on page 36 for specific information and limitations.

Calendar Year Deductible		Maximum Calendar Year Copayment/Coinsurance Responsibility for Preferred Provider (PPO) Services	
For each Member	None	For each member	$2,000
For each family	None	For each family	$4,000
		(Non-Preferred Provider (non-PPO) coinsurance is not applied toward this amount and is the Member's responsibility. See page 31 for more information.)	

Important Note: In addition to the amounts shown below, you are required to pay any charges for services provided by a Non-Preferred Provider which are in excess of the allowable amount, plus all charges for non-covered services.

The following chart is only a summary of benefits under your CAHP Health Benefits Trust Plan. Please refer to the Covered Medical Services and Supplies section beginning on page 36 for specific information and limitations.		Member Pays		Contact Review Center
Benefits	Covered Services	PPO	Non-PPO	
Additional Services and Supplies p. 36	Ambulance services, surgical implants, artificial eyes and limbs, blood, the first pair of contact lenses or glasses when required as a result of eye surgery, and biofeedback services when medically necessary	20%	20%	No (unless listed on page 25)
Ambulatory Surgical Center p.36	Services and supplies provided by an Ambulatory Surgical Center	10%	40% (limited to $350)	No
Bariatric Surgery p. 37	Services and supplies provided for or in connection with a bariatric surgery performed in a CME	10% (CME only)	Not covered	Yes
Bariatric Surgery Travel Expense p. 37	Travel expenses in connection with a bariatric surgery. See page 37 for benefit limitations	None (CME only)	Not covered	Yes
Chiropractic and Acupuncture Services p. 38	Acupuncture and outpatient chiropractic care up to a maximum of 20 visits (combined) in a calendar year	10%	40%	No
Dental Care p. 38	Inpatient or outpatient hospital services for dental care or services of a physician solely to treat an accidental injury to natural teeth	20%	20%	No (unless listed on page 25)

The following chart is only a summary of benefits under your CAHP Health Benefits Trust Plan. Please refer to the Covered Medical Services and Supplies section beginning on page 36 for specific information and limitations.		Member Pays		Contact Review Center
Benefits	Covered Services	PPO	Non-PPO	
Diabetes Education Program p. 39	Services designed to teach Members and their family about the disease			
	Physician office visit	$15	40%	No
	Other provider services	10%	40%	
Diagnostic Services p. 39	Outpatient diagnostic imaging and laboratory services	10%	40%	No
Durable Medical Equipment p. 39	Rental or purchase of medically necessary durable medical equipment	10%	40%	Yes for DME over $5,000
Emergency Care p. 40	A medical emergency is an unexpected acute illness or injury which could permanently endanger health if immediate medical treatment is not received			No (unless listed on page 25)
	Emergency room services	10% + $50*	10% + $50*	
	Non-emergency use of emergency room	10% + $50	40% + $50	
	Emergency room physician services *If admitted a hospital inpatient, the $50 co-payment will be reduced to $25	10%	40%	
Family Planning p. 41	Sterilization, abortion, or services and supplies in connection with prescribing prescription contraceptives	10%	40%	No
Hearing Aid Services p. 41	Hearing aid services provided by or purchased as a result of a written recommendation by a physician certified as either an otologist, an otolaryngologist or a state-certified audiologist The benefit maximum is one audiological exam and one hearing aid, per ear, every 36 months	10%	40%	No

The following chart is only a summary of benefits under your CAHP Health Benefits Trust Plan. Please refer to the Covered Medical Services and Supplies section beginning on page 36 for specific information and limitations.		Member Pays		Contact Review Center
Benefits	Covered Services	PPO	Non-PPO	
Home Health Care p. 42	Services and supplies provided by a home health agency limited to a maximum of 90 visits for each period of disability	10%	40%	Yes
Home Infusion Therapy p. 43	Services and supplies provided by a home infusion therapy provider	10%	40%	Yes
Hospice Care p. 43	Services and supplies provided by a hospice provider. Bereavement counseling is limited to 2 visits per Member during the 12-month period following your death	None	None	No
Hospital p. 45 Inpatient	Services and supplies provided a hospital during an inpatient stay *Non-Prudent Buyer Plan Hospital inpatient services will be paid at 90% of the Scheduled Amount listed in the Table of Allowance on page 34. Plan payment shall not exceed $486 - $522 per day (based on Service Area)	10%	10%*	Yes
	Services and supplies provided by a hospital for outpatient care	10%	40%	No (unless listed on page 25)
Mastectomy p. 50	Mastectomy and lymph node dissection, complications from a mastectomy including lymphedema, reconstructive surgery to restore symmetry following a mastectomy, and breast prosthesis following a mastectomy	10%	40%	No
Mental Disorders or Chemical Dependency p. 46				

The following chart is only a summary of benefits under your CAHP Health Benefits Trust Plan. Please refer to the Covered Medical Services and Supplies section beginning on page 36 for specific information and limitations.		Member Pays		Contact Review Center
Benefits	Covered Services	PPO	Non-PPO	
Inpatient	Inpatient hospital services, services from a residential treatment center, and visits to a day treatment center *Non-Prudent Buyer Plan Hospital inpatient services will be paid at 90% of the Scheduled Amount listed in the Table of Allowance on page 34. Plan payment shall not exceed $486 - $522 per day (based on Service Area)	10%	10%*	Yes
Outpatient	Outpatient psychotherapy or psychological testing our outpatient rehabilitative care	10%	40%	No
	Physician office visits	$15	40%	No
	Other physician services	10%	40%	No
Organ and Tissue Transplants p. 47	Services and supplies incurred for or in connection with non-investigational human organ or tissue transplants	10%	40%	Yes
Physical and Occupational Therapy Services p. 48	Inpatient and outpatient physical and occupational therapy for the treatment of illness and injuries limited to 24 visit per calendar year	10%	40%	Yes (additional visits only)
Maternity Care p. 46	Services and supplies provided for maternity care, hospital routine nursery care, and services provided by an approved alternative birth center and/or certified nurse midwife	10%	40%	No (unless listed on page 25)
Professional Services p. 49	Physician office visit	$15	40%	No
	Other physician services	10%	40%	No
Routine Physical Exam (Members Age 7 and Over) p. 51	Preventive care services include routine examinations, screenings, tests, education, and immunizations administered with the intent of preventing future disease, illness, or injury	None	40%	No
Skilled Nursing Facility p. 52	Services and supplies provided by a skilled nursing facility up to maximum of 100 days per confinement period	10%	40%	Yes

The following chart is only a summary of benefits under your CAHP Health Benefits Trust Plan. Please refer to the Covered Medical Services and Supplies section beginning on page 36 for specific information and limitations.		Member Pays		Contact Review Center
Benefits	Covered Services	PPO	Non-PPO	
Speech Therapy Services p.53	Inpatient or outpatient speech therapy services if caused by or due to a non-congenital organic disease or illness, or accidental injury, or surgery resulting from illness, and services for treatment of a speech impediment due to congenital anomalies only after corrective surgery	10%	40%	No
Well Child Care (Members Under Age 7) p. 54	Routine examinations, including radiology and laboratory services, and immunizations	None	40%	No

EXCEPTIONS: Non-Prudent Buyer Plan Providers will be paid at 90% of Covered Expense for:

1. An approved Authorized Referral to a Non-Prudent Buyer Plan Provider (Authorized Referral is explained on page 101 of the DEFINITIONS section); or
2. Charges by a type of Physician not represented in the Prudent Buyer Plan Network at the time of service (for example, an audiologist, except as specifically stated under PRUDENT BUYER PLAN BENEFITS COVERED SERVICES AND SUPPLIES or
3. Charges by Non-Prudent Buyer Plan Emergency Room Physicians for services received at a Prudent Buyer Plan facility.

The following chart is only a summary of benefits under your CAHP Health Benefits Trust Plan. Please refer to the Outpatient Prescription Drug Benefits section beginning on page 18 for specific information and limitations.

Benefits	**Covered Services**	**Member Pays**	
		Initial and 1st refill	After 2nd refill
Prescription Drugs p. 64	Retail Pharmacy Program up to a 30-day supply	$5 Generic $20 Single-Source Brand Drug $25 Multi-Source Brand Drug*	$10 Generic $40 Single-Source Brand Drug $50 Multi-Source Brand Drug*
	Mail Order Program up to a 90-day supply *In addition to the co-payment, the Member is responsible for the difference in cost between the Brand Name Drug and its Generic equivalent	$10 Generic $40 Single-Source Brand Drug $50 Multi-Source Brand Drug*	$10 Generic $40 Single-Source Brand Drug $50 Multi-Source Brand Drug*
	Exception to the Prescription Drug Member Payment • The Member will not be required to pay for services provided under the Preventive Prescription Drug and Other Items provision in the section titled OUTPATIENT PRESCRIPTION DRUG BENEFITS.		

PREVENTIVE CARE GUIDELINES FOR HEALTHY CHILDREN, ADOLESCENT, ADULTS AND SENIORS

CAHP Health Benefits Trust wants to help you and your family stay healthy. Routine visits to the doctor are important. CAHP Health Benefits Trust has adopted the Preventive Care Guidelines for Healthy Children, Adolescents, Adults and seniors from the U.S. Preventive Services Task Force Guide to Clinical Preventive Services. Immunizations for infants and children are recommended in accordance with recommendations of the American Academy of Pediatrics, the American Academy of Family Physicians, and Anthem Blue Cross' adopted guidelines under Healthy Living. Visit www.anthem.com/ca for Anthem Blue Cross' adopted guidelines under Healthy Living. Please talk to your medical professional about recommended exams, screenings, vaccines and individual risk factors when making decisions about diagnostic tests. Benefits will be paid according to the Preventive Care benefits listed under the section Routine Physical Exam on page 51.

INTRODUCTION

The CAHP Health Benefits Trust (the Trust) is a self-insured health and welfare trust that is sponsored by the California Association of Highway Patrolmen (CAHP) and approved by the California Public Employees' Retirement System (CaIPERS), Board of Administration.

The Trust provides comprehensive health care coverage exclusively to members and Employees of the CAHP under a preferred provider arrangement that is annually negotiated with Anthem Blue Cross.

The Trust contracts directly with Anthem Blue Cross Life and Health Insurance Company (Anthem Blue Cross Life and Health), an affiliate of Anthem Blue Cross, as Claims Administrator of the medical and health promotion program benefits offered herein. As used in this Evidence of Coverage, the term "Anthem Blue Cross" shall be used for convenience to refer to both Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company.

The Trust maintains a separate administrative services agreement with Express Scripts, to administer and provide prescription drug benefits to eligible Plan Members. Express Scripts and Medco Health Solutions, Inc. have come together as one company to manage your prescription benefit.

- As a CAHP Health Benefits Trust Plan Member, you should understand that future health care premiums are directly determined by claims utilization. Any personal effort you can make to control costs will help keep your future monthly out of-pocket premium cost at a minimum.

IDENTIFICATION CARDS AND EVIDENCE OF COVERAGE BOOKLETS

Anthem Blue Cross, on behalf of the Trust, shall issue to the Member and Family Members an identification card. The Trust shall issue to the Member an Evidence of Coverage booklet setting forth a statement of the services and benefits to which the Member and Family Members are entitled. Possession of an identification card confers no right to services or other benefits of this Plan. To be entitled to services or benefits, the holder of the card must, in fact, be a Member on whose behalf applicable fees under this Plan have actually been paid. Any person receiving services or other benefits to which he or she is not then entitled pursuant to the provisions of this Plan is chargeable therefore at prevailing rates.

PRUDENT BUYER PLAN NETWORK

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED.

The Prudent Buyer Plan Network is subject to change. It is your obligation to be sure that the provider you choose has a Prudent Buyer Plan Agreement in effect.

Benefits for Non Prudent Buyer Plan Providers are strictly limited. Detailed information on how benefits are determined is found under PRUDENT BUYER PLAN BENEFITS, in the section titled DETERMINATION OF COVERED EXPENSE. Information on how providers are paid is found in the PAYMENT RATES section. Please read these sections carefully.

IMPORTANT NOTE: Please be aware that it is your responsibility and in your best financial interest to verify that the health care providers treating you have current Prudent Buyer Plan participating provider status for:

- The Hospital or other facility where care will be given. After verifying that the Hospital or their facility is a Prudent Buyer Plan Provider, you should not assume all providers at that Hospital are also Prudent Buyer Plan Providers. To receive the maximum benefits under this Plan, you should request that all your provider services (such as services by an anesthesiologist or emergency room Physician) be performed by Prudent Buyer Plan Providers whenever you enter a Hospital or other facility.
- The provider you select or to whom you are referred at the specific location at which you will receive care. Some providers participate at one location, but not at others.
- The Physician providing your care, especially anesthesiologists, emergency room Physicians, pathologists and radiologists.

Prudent Buyer Plan Providers may refer Members to Non-Prudent Buyer Plan Providers. If an Authorized Referral is not obtained prior to incurring services from a Non-Prudent Buyer Plan Provider, such services will be paid at the reduced Non-Prudent Buyer Plan rate specified in this Evidence of Coverage. Approved Authorized Referral services will be paid at the higher Prudent Buyer Plan Provider rate specified in this Evidence of Coverage. Authorized Referrals are explained on page 101 in the DEFINITIONS section of this Evidence of Coverage.

If you are in doubt about the status of any provider, call Anthem Blue Cross for a determination:

1-800-759-5758

It is important to know that when you enroll in the CAHP Health Benefits Trust Plan, services are provided through the Plan's delivery system, but the continued participation of any one doctor, Hospital or other provider cannot be guaranteed.

HOW TO USE YOUR PLAN

PRUDENT BUYER PLAN NETWORK

Your CAHP Health Benefits Trust Plan offers you the flexibility and freedom to select any provider of your choice. However, you will experience maximum savings when you choose a Prudent Buyer Plan Provider.

Anthem Blue Cross has established and maintains a preferred provider arrangement with Physicians, Hospitals, Skilled Nursing Facilities, Home Health Agencies, Ambulatory Surgical Centers, chiropractors, physical therapists, acupuncturists, speech pathologists, Durable Medical Equipment Supply Outlets, Home Infusion Therapy Providers, Clinical Laboratories, and Diagnostic Imaging Facilities, known as the Prudent Buyer Plan Network.

The extensive network of Prudent Buyer Plan Providers includes more than 45,000 Physicians in private practice and over 400 Hospitals throughout California. (Also, providers in certain areas of Arizona, Nevada and Oregon may contract with the Prudent Buyer Plan Network).

Anthem Blue Cross has organized certain Prudent Buyer Plan Physicians to provide Urgent Care services to Members in the Physician's office without requiring a regular scheduled appointment. Members should be able to locate a Physician who is a Prudent Buyer Plan Provider in the Urgent Care Network by calling Anthem Blue Cross at 1-800-759-5758 or by visiting the Web site at **www.anthem.com/ca**.

Prudent Buyer Plan Providers have agreed to accept a reduced rate for the services they provide to Plan Members. Your co-payment is a lower percentage of these already discounted rates, so the amount you have to pay out of your pocket is less.

Utilizing the Prudent Buyer Plan Network

The Prudent Buyer Plan Network is subject to change. It is your responsibility to make sure that the Provider you choose or have been referred to is a Prudent Buyer Plan Provider, in case there have been any changes since your Prudent Buyer Plan Provider directory was published.

As a CAHP Health Benefits Trust Plan Member, when you receive services from a Prudent Buyer Plan Provider, no claim forms need to be completed by you. Your Prudent Buyer Plan Provider has agreed to bill Anthem Blue Cross directly.

To help ensure that your Prudent Buyer Plan Provider bills for you:

- When you schedule an appointment, confirm with the provider that he or she is a Prudent Buyer Plan Provider.
- Present your CAHP Health Benefits Trust identification card on the first visit to the provider.
- Ask your providers if they have on file an assignment of benefits for you (This assignment ensures that Anthem Blue Cross shall make direct payment to your provider).
- If your providers request that you pay for services at the time of your visit, remind them that as Prudent Buyer Plan Providers, they should bill Anthem Blue Cross for payment. However, you will be required to pay a $15 co-payment in advance for office visits provided by Prudent Buyer Plan Physicians who are licensed medical doctors (M.D.s), licensed doctors of osteopathy (D.O.s), licensed doctors of podiatry (D.P.M.s), and registered dietitians (R.D.s), and you may be asked to pay any other applicable co-payments in advance.

When you receive covered services from a Prudent Buyer Plan Provider, your required co-payment will be a percentage of the discounted Prudent Buyer Negotiated Rate. The Negotiated Rate is guaranteed to reduce your out-of-pocket costs for covered services and also saves your Trust fund valuable claims dollars, which helps to hold down the percentage of future premium increases. You may request a list of Prudent Buyer Plan Providers by calling Anthem Blue Cross at 1-800-759-5758.

Visit the Web site at **www.anthem.com/ca** to obtain a listing of Prudent Buyer Plan Providers and other valuable information about Anthem Blue Cross.

When you receive services from a Non-Prudent Buyer Plan Provider, allowable expense will be determined at the Customary and Reasonable Charge, Reasonable Charge, or the Scheduled Amount for Non-Prudent Buyer Plan Hospital inpatient services as stated under GENERAL DEFINITIONS page 101. This will result in a higher out-of-pocket cost to you, and shall also increase the claims expense paid by your Trust fund.

Non-Prudent Buyer Plan Provider Referrals

You will receive maximum Plan benefits when you receive health care services from a Prudent Buyer Plan Provider. Reimbursement for services received by a Non-Prudent Buyer Plan Provider is strictly limited. You may be required to pay for services in advance, and file your own claim.

A Prudent Buyer Plan Provider will use their best efforts, but is under no obligation to refer you to another Prudent Buyer Plan Provider. In order to maximize payment for Covered Expense and to receive the higher rate of payment, you may ask to be referred to a Prudent Buyer Plan Provider and should make sure that the provider you are referred to is a Prudent Buyer Plan Provider. Otherwise, unless you obtain an Authorized Referral prior to receiving services from a Non-Prudent Buyer Plan Provider, such services will be paid at the lower Non-Prudent Buyer Plan Provider rate stated under PAYMENT RATES. Authorized Referral is explained on page 101 in the DEFINITIONS section of this Evidence of Coverage.

Centers of Medical Excellence

Anthem Blue Cross has established a separate Centers of Medical Excellence (CME) bariatric facilities network. Hospitals included in this CME network have been organized to provide services for bariatric surgical procedures, such as gastric bypass and other surgical procedures for weight loss programs. Bariatric surgical procedures are covered only when performed at an approved CME. A Prudent Buyer Plan Provider is not necessarily a CME facility. Please refer to MEDICAL MANAGEMENT PROGRAMS section beginning on page 23 for information regarding obtaining advance authorization for Bariatric Surgery.

Providers Not Represented in the Prudent Buyer Plan Network

Although there is a large selection of Prudent Buyer Plan Providers, there are some specialties not fully represented in the network such as ambulance providers and audiologists.

If a Physician specialty is represented in the network but limited in geographical areas (i.e., rural areas), such specialty would not be included in the definition of Providers Not Represented in the Prudent Buyer Plan Network. However, services received from these Non-Prudent Buyer Plan Providers may be eligible for an Authorized Referral as stated under GENERAL DEFINITIONS on page 101.

Anthem BLUE CROSS WEB SITE

Information specific to your benefits and claims history are available on the Anthem Blue Cross Web site at **www.anthem.com/ca**. To access benefit information, claims payment status, benefit maximum status, and Prudent Buyer Plan participating providers or to order an ID card, simply log on to the Web site, select "Member," and click the "Register" button on your first visit to establish a User ID and Password to access the personalized and secure MemberAccess Web site. Once registered, simply click the "Login" button and enter your User ID and Password to access the MemberAccess Web site.

OUTPATIENT PRESCRIPTION DRUG BENEFITS

Benefits for outpatient Prescription Drugs are included in your comprehensive CAHP Health Benefits Trust Plan coverage. OUTPATIENT PRESCRIPTION DRUG BENEFITS (page 64 is administered by Express Scripts).

Although Generic Drugs are not mandatory, the Trust encourages you to purchase generics whenever possible in order to save valuable claims dollars that will help keep the cost of providing benefits for outpatient Prescription Drugs affordable. By law, Generic Drugs meet the same federal standards of purity, effectiveness, strength, and safety as their Brand Name equivalents. Utilizing Generic Drugs helps to manage the increasing cost of health care without compromising the quality of your pharmaceutical care.

Retail Pharmacy Benefits

To receive maximum Plan benefits, make sure you have your Prescription filled at a Participating Pharmacy. Express Scripts contracts with over 55,000 retail pharmacies within the United States. Information regarding Participating Pharmacies may be obtained by calling Express Scripts at 1-800-711-0917, or by logging on to **www.express-scripts.com**. Present your CAHP Health Benefits Trust identification card and prescription(s) to the pharmacist at the time of your purchase. Please refer to the section titled OUTPATIENT PRESCRIPTION DRUG BENEFITS for additional benefit information.

Mail Order Program

Another option that will result in extra savings to both you and the Trust is to purchase your ongoing maintenance medication through the mail order program administered by Express Scripts.

The mail order program offers the convenience of home delivery and the security of being able to order a larger supply of medication, which is ideal for Members who require maintenance medications for the treatment of such chronic conditions as arthritis, heart disease, diabetes or hypertension. Your order is usually filled within 48 hours of receipt and your medication will be sent to you via US Mail or UPS along with instructions for future refills, if applicable. After processing, please allow approximately one week for normal delivery. You may purchase up to a 90-day supply of medication.

NOTE: To assure the maximum amount of medication is dispensed through the Mail Order Program, the physician must indicate a 90-day supply along with the appropriate directions to fill a 90-day supply. If the Physician indicates a 30-day supply and your prescription is processed through the Mail Order Program, you will receive a 30-day supply at the Mail Order co-payment.

Please refer to OUTPATIENT PRESCRIPTION DRUG BENEFITS for additional benefit information.

WHEN YOU SUBMIT BILLS

Members filing claims for services received from a Non-Prudent Buyer Plan Provider, a Related Health Provider or a Non-Behavioral Health Access Provider must submit itemized bills attached to a CAHP claim form to the following address:

Anthem Blue Cross
Attn: CAHP Unit
P.O. Box 60007
Los Angeles, CA 90060-0007
1-800-759-5758

To obtain CAHP medical claim forms, please call Anthem Blue Cross at the telephone number listed above.

To obtain claim forms for the reimbursement for prescription drugs purchased from a Non-Participating Pharmacy, please call Express Scripts at 1-800-711-0917 or visit **www.express-scripts.com**.

NOTE: The Trust is not liable for the benefits of this Plan if claims are not filed within the periods listed below:

- Medical claims must be submitted to Anthem Blue Cross within 90 days of the date services are received. If it is not reasonably possible to submit the claim within that timeframe, an extension of up to 12 months will be allowed. Claim forms and itemized bills must be used; cancelled checks or receipts are not acceptable.
- Claims for outpatient Prescription Drugs purchased at a Non-Participating Pharmacy must be submitted to Express Scripts at the address listed under OUTPATIENT PRESCRIPTION DRUG BENEFITS within 90 days of the purchase date. If it is not reasonably possible to submit the claim within that timeframe, an extension of up to nine months will be allowed. Claim forms and itemized pharmacy receipts must be used; cancelled checks or receipts are not acceptable.
- HEALTH PROMOTION PROGRAM claims must be submitted to Anthem Blue Cross with the signed Certificate of Completion, Reimbursement Form and receipts within 90 days of the program completion. If it is not reasonably possible to submit the claims within that timeframe, an extension of up to 12 months will be allowed. Claim forms must be used; cancelled checks or receipts alone are not acceptable. Please refer to the HEALTH PROMOTION PROGRAMS section of this Evidence of Coverage.

WHEN YOU TRAVEL

Remember: Payment for medical and hospital services received outside of the Prudent Buyer Plan Network, including services received in a foreign country, for other than Emergency Care is strictly limited. Please refer to **PAYMENT RATES** under the **PRUDENT BUYER PLAN BENEFITS** section of this Evidence of Coverage.

Inside the United States. Anthem Blue Cross has a relationship with the Blue Cross and Blue Shield Association which administers a national program called “BlueCard Program”. When you travel outside California and receive covered health care services, you do not need to file a claim form. The BlueCard

program allows providers throughout the United States to file claims with the local Blue Cross and/or Blue Shield Plan.

Outside the United States. Your Plan benefits are provided for covered services received anywhere in the world. If you are in a foreign country and have services or supplies furnished and billed by a provider outside the United States, you may have to pay the bill and then send a completed claim form and itemized bill, written in English, to Anthem Blue Cross to be reimbursed.

WHEN YOU RESIDE OUT-OF-STATE

If you reside outside of California and require medical care or treatment, providers will submit claims for services to the on-site Blue Cross and/or Blue Shield Licensee ("Host Blue") under the Blue Cross and Blue Shield Association's BlueCard Program described above under WHEN YOU TRAVEL. Providers available to you through the BlueCard Program have not entered into contracts with Anthem Blue Cross. If you have any questions or complaints about the BlueCard Program, please call Anthem Blue Cross at 1-800-759-5758.

This Plan was designed primarily for California residents. If you receive services outside of California (other than for Emergency Care), your benefits will be significantly reduced; Covered Expense for providers outside of California will be determined as for Non-Prudent Buyer Plan Providers. Payment levels for such providers will also be determined at the Non-Prudent Buyer level of payment.

NOTE: For clarification, the Plan's payment for inpatient Hospital services (other than for Emergency Care or an Authorized Referral) received at a Non-Prudent Buyer Plan Hospital shall not exceed 90 percent of the daily amount listed in the Table of Allowances on page 34. Therefore, the Plan's payment shall be between $486 and $522 per day (based on Service Area). All charges in excess of the Scheduled Amount shall be the Member's responsibility and shall not apply to the maximum annual Out-of-Pocket Expense. Please refer to PAYMENT RATES and DETERMINATION OF COVERED EXPENSE under the PRUDENT BUYER PLAN BENEFITS section and also to the GENERAL DEFINITIONS section of this Evidence of Coverage.

EXCEPTIONS: Providers in certain areas of Arizona, Nevada and Oregon may contract with the Prudent Buyer Plan Network. During the plan year 2009, there was a significant reduction in the Prudent Buyer Plan Network in Nevada as compared to previous years.

MEDICAL NECESSITY

Except for the preventive benefits which are specifically listed in this Evidence of Coverage and benefits provided under HEALTH PROMOTION PROGRAM, benefits are provided only for services, procedures, equipment or supplies which are Medically Necessary and delivered with optimum efficiency.

The fact that a Physician or other provider may prescribe, order, recommend or approve a service or supply does not, in itself, make it Medically Necessary even though it is not specifically listed as an exclusion or limitation.

Medically Necessary shall mean health care services that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

1. In accordance with generally accepted standards of medical practice.
2. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or diseases; and
3. Not primarily for the convenience of the patient, Physician or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations and the views of physicians practicing in relevant clinical areas and any other relevant factors.

Hospital services, procedures, equipment and supplies which are generally not considered Medically Necessary on an inpatient basis include, but are not limited to:

- Diagnostic studies that could have been provided on an outpatient basis;
- Medical observation or evaluation;
- Removal of the patient from his or her customary work or home for rest, relaxation, personal comfort or environmental change;
- Pain management centers to treat or cure chronic pain;
- Pre-operative workups for the night before surgery;
- Rehabilitative services.
- Outpatient services may also be deemed to be not Medically Necessary.

Anthem Blue Cross reserves the right to review all medical claims to assure that services and supplies are Medically Necessary and whether any exclusions or limitations apply as specified in this Evidence of Coverage.

MEDICAL POLICY

Anthem Blue Cross reviews and evaluates new technology according to its technology evaluation criteria developed by its medical directors. Technology assessment criteria are used to determine the investigational status or medical necessity of new technology. Guidance and external validation of Anthem Blue Cross' medical policy is provided by their Medical Policy and Technology Assessment Committee (MPTAC) which consists of approximately 20 physicians from various medical specialties including Anthem Blue Cross' medical directors, physicians in academic medicine and physicians in private practice. Conclusions made are incorporated into medical policy used to establish decision

protocols for particular diseases or treatments and applied to Medical Necessity criteria used to determine whether a procedure, service, supply or equipment is covered.

Anthem Blue Cross has developed general medical policies that provide guidance and support for benefit determinations. These policies are considered guides and are not intended to imply benefit or coverage determination nor constitute medical advice. Anthem Blue Cross medical necessity guidelines and criteria for specific services are available for viewing by logging onto **www.anthem.com/ca**. Click on “Medical Policies and Clinical UM Guidelines.”

MEDICAL MANAGEMENT PROGRAMS

UTILIZATION REVIEW PROGRAM

Benefits are provided only for Covered Expense for Medically Necessary and appropriate services as provided in this Evidence of Coverage. Utilization review provides the Member with valuable information about the medical necessity of services, so that unexpected out-of-pocket costs can be avoided. When the utilization review program is properly used, the Member, in most cases, will know in advance whether the services are Medically Necessary and therefore, eligible for benefits.

IMPORTANT NOTE: Utilization review program requirements described in this section do not apply when coverage under this Plan is secondary to another plan providing benefits for a Subscriber or Family Member.

The utilization review program evaluates the medical necessity and appropriateness of care and the setting in which care is provided. Members and Physicians are advised when it is determined under the Plan that services can be safely provided in an ambulatory outpatient setting or when an inpatient Stay is recommended. Services that are Medically Necessary and appropriate are certified for an appropriate period and monitored so that Members know when it is no longer Medically Necessary and appropriate to continue those services.

It is the Member's responsibility to see that his or her Physician starts the utilization review process before scheduling the Member for any service subject to the utilization review program. If the Member receives any such service, and did not follow the procedures set forth in this section, benefits may be reduced as shown under How Benefits are Affected by Utilization Reviews.

Utilization Review Requirements of This Plan

Utilization reviews are conducted for the following services:

- All inpatient Hospital admissions*;
- All Skilled Nursing Facility admissions;
- Home Health Agency Services;
- Services provided by Home Infusion Therapy Providers; and
- Listed procedures/services under How to Obtain Utilization Reviews.

*EXCEPTIONS: Utilization review is not required for inpatient Hospital admissions for the following services:

- maternity care of 48 hours or less following a normal delivery or 96 hours or less following a cesarean section; and
- mastectomy and lymph node dissection.

The stages of utilization review are:

1. Preservice review determines in advance the medical necessity and appropriateness of scheduled, non-Emergency inpatient Hospital and Skilled Nursing Facility admissions, Home Infusion Therapy services, Home Health Care services, and procedures/services listed under How to Obtain Utilization Reviews.

2. Concurrent review determines whether services are Medically Necessary and appropriate when preservice review is not required or Anthem Blue Cross is notified while service is ongoing, for example, an Emergency admission to the Hospital.
3. Retrospective review is performed to review services that have already been provided. This applies in cases when preservice or concurrent review was not completed, or in order to evaluate and audit medical documentation subsequent to services being provided. Retrospective review may also be performed for services that continued longer than originally certified.

How Benefits Are Affected by Utilization Reviews

In order for the full benefits of this Plan to be payable, all of the following criteria must be met:

1. The appropriate utilization reviews must be performed in accordance with this Plan. Benefits will be provided for services subject to preservice authorization requirements only when the required authorization has been obtained as stated in this Evidence of Coverage.
2. When preservice review is performed and the admission, procedure or service is determined to be Medically Necessary and appropriate, benefits will be provided for the following:
    - Inpatient Hospital services and supplies.
    - Services provided in a Skilled Nursing Facility if the Member requires daily skilled nursing or rehabilitation, as certified by the Member's attending Physician.
    - Home Health Care services if (a) services can be safely provided in the Member's home, as certified by the Member's attending Physician, (b) the Member's attending Physician manages and directs the Member's medical care at home and (c) the Member's attending Physician has established a definitive treatment plan which must be consistent with the Member's medical needs and lists the services to be provided by the Home Health Agency.
    - Services of Home Infusion Therapy Provider if the Member's attending Physician has submitted both a prescription and a plan of treatment prior to services being rendered.
    - Reconstructive surgery.
    - Treatment of jaw joint.
    - Human organ and tissue transplants if the Physicians on the surgical team and the facility in which the transplant is to take place are approved for the transplant requested.
    - Positron emission tomography (PET scan).
    - Bariatric surgical procedures, such as gastric bypass and other surgical procedures for weight loss if (a) the services are to be performed for the treatment of morbid obesity, (b) the Physicians on the surgical team and the facility in which the surgical procedure is to take place are approved for the surgical procedure requested, and (c) the bariatric surgical procedure will be performed at a Centers of Medical Excellence (CME) facility.
    - A specified number of additional visits for physical therapy, physical medicine, speech therapy and occupational therapy if the Member needs more than 24 visits in a Year.
    - Select Durable Medical Equipment for which the purchase price is $5,000 or more.
3. Services that are not reviewed prior to or during service delivery will be reviewed retrospectively when the bill is submitted for benefit payment. If review results in the

determination that part or all of the services were not Medically Necessary and appropriate, benefits will not be paid for those services.

No benefits are payable, however, unless the Member's coverage is in force at the time services are rendered, and the payment of benefits is subject to all terms and requirements of this Evidence of Coverage.

If review results in the determination that part or all of the services were not Medically Necessary and appropriate, benefits will not be paid for those services. If the Member proceeds with any services that have been determined to be not Medically Necessary and appropriate at any stage of the utilization review process, benefits will not be provided for those services.

How to Obtain Utilization Reviews

A. Preservice Reviews

- Obtain Preservice Review Before Receiving Scheduled Services

For all scheduled services that are subject to the utilization review requirements of this Plan, the Member or the Member's Physician must initiate the preservice review by contacting Anthem Blue Cross at 1-800-274-7767 at least three working days prior to when the Member is scheduled to receive services.

Preservice review is performed for the following:

- Inpatient Hospital admissions;
- Skilled Nursing Facility admissions;
- Home Health Care services;
- Home Infusion Therapy;
- Reconstructive surgery;
- Jaw joint treatments;
- Human organ and tissue transplants;
- PET scans;
- Bariatric surgery;
- Physical and Occupational Therapy Services in excess of 24 visits per Year;
- Select durable medical equipment for which the purchase price is $5,000 or more; and
- Speech Therapy Services in excess of 24 visits per Year

The Member must tell his or her Physician that this Plan requires preservice review. Prudent Buyer Plan Providers will initiate the review on the Member's behalf. A Non-Prudent Buyer Plan Provider may initiate the review for the Member, or the Member may call Anthem Blue Cross directly. The Anthem Blue Cross toll-free telephone number is printed on the Member's CAHP Health Benefits Trust identification card.

If the Member does not receive the reviewed service within 60 days of the certification, or if the nature of the service changes, a new preservice review must be obtained by following the procedures described above.

Remember, it is always the Member's responsibility to confirm that the review has been performed.

Anthem Blue Cross will certify services that are Medically Necessary and appropriate. For inpatient Hospital Stays, Anthem Blue Cross will, if appropriate, specify a specific length of Stay for approved services. The Member, the Member's Physician and the provider of the services will receive a written confirmation showing this information.

However, if preservice review determines that the proposed services are not Medically Necessary and appropriate, the Member's provider will be notified immediately. Written notice then will be sent to the Member, the Member's Physician and the provider of the services.

If preservice review was not performed as required, or if the services the Member received exceed the originally certified period, the services are subject to concurrent review and retrospective review described below.

B. Concurrent Reviews

- If preservice review was not required or performed as required, the Member, the Member's Physician or the provider of service must contact Anthem Blue Cross for concurrent review. For Emergency Hospital admissions, Anthem Blue Cross must be notified within one working day of the admission.

When Prudent Buyer Plan Providers have been informed of the Member's need for utilization review, they will initiate the review on the Member's behalf. The Member may ask a Non-Prudent Buyer Plan Provider to call Anthem Blue Cross, or the Member may call Anthem Blue Cross directly. The Anthem Blue Cross toll-free telephone number is printed on the Member's CAHP Health Benefits Trust identification card.

Remember, it is always the Member's responsibility to confirm that the review has been performed.

If concurrent review determines that the service is Medically Necessary and appropriate, Anthem Blue Cross will, depending upon the type of treatment or procedure, specify the period of time that is medically appropriate for the type of treatment or procedure required. Concurrent review will also determine the medically appropriate setting.

If concurrent review determines that the service or continued treatment is not Medically Necessary and appropriate, the Member's Physician will be notified by telephone no later than 24 hours following the decision. Written notice will be sent to the Member, and the Member's Physician no later than two business days following the decision. However, care will not be discontinued until the Member’s Physician has been notified and a plan of care that is appropriate for the Member’s needs has been agreed upon.

C. Retrospective Reviews

Retrospective review is performed when Anthem Blue Cross has not been notified of the services the Member received, and is therefore unable to perform the appropriate review prior to the Member's discharge from the Hospital or completion of outpatient treatment. It is also performed when preservice or concurrent review has been done, but services continued longer than originally certified. It may also be performed for the evaluation and audit of medical documentation after services have been provided, whether or not preservice or concurrent review was performed.

Services that are retrospectively determined to have been not Medically Necessary and appropriate will be retrospectively denied certification.

DECISION AND NOTICE REQUIREMENTS

Anthem Blue Cross will review requests for medical necessity according to the timeframes listed below. The timeframes and requirements listed are based on state and federal laws. Where state laws are stricter than federal laws, the Plan will follow state laws. If you live in and/or get services in a state other than the state where your Plan was issued, other state-specific requirements may apply. You may call the phone number on the back of your identification card for more details.

Request Category	**Timeframe Requirement for Decision**
Pre-service urgent	72 hours from the receipt of the request
Pre-service non-urgent	5 business days from the receipt of the request
Concurrent care review when hospitalized at the time of the request and no previous authorization exists	72 hours from the receipt of the request
Concurrent care review urgent when request is received at least 24 hours before the end of the previous authorization	24 hours from the receipt of the request
Concurrent care review urgent when request is received less than 24 hours before the end of the previous authorization	72 hours from the receipt of the request
Concurrent care review non-urgent	5 business days from the receipt of the request
Retrospective	30 calendar days from the receipt of the request

If more information is needed to make a decision, Anthem Blue Cross will follow state and federal law and tell the requesting physician and send written notice to you or your authorized representative of the specific information needed to finish the review. If the Plan does not get the specific information it needs or if the information is not complete by the timeframe identified in the written notice, Anthem Blue Cross will make a decision based upon the information received.

Anthem Blue Cross will give notice of a decision as required by state and federal law. Notice may be given by the following methods:

- **Verbal:** Oral notice given to the requesting physician by phone or by electronic means if agreed to by the physician.

- **Written:** Mailed letter or electronic means including email and fax given to, at a minimum, the requesting physician and you or your authorized representative.

A determination of medical necessity does not guarantee payment or coverage. The determination that services are Medically Necessary is based on the clinical information provided. Payment is based on the terms of your coverage at the time of service. These terms include certain exclusions, limitations, and other conditions. Payment of benefits could be limited for a number of reasons, including:

- The information submitted with the claim differs from that given by phone;
- The service is excluded from coverage;
- You must not have exceeded any applicable limits under this *plan*; or
- You are not eligible for coverage when the service is actually provided.

Revoking or modifying an authorization. An authorization for services or care may be revoked or modified prior to the services being rendered for reasons including but not limited to the following:

- Your coverage under this Plan ends;
- The contract between Anthem Blue Cross and the Trust terminates;
- You reach a benefit maximum that applies to the services in question;
- Your benefits under the Plan change so that the services in question are no longer covered or are covered in a different way.

For a copy of the medical necessity review process, please contact customer service at the telephone number on the back of your identification card.

HEALTH PLAN INDIVIDUAL CASE MANAGEMENT PROGRAM

The health plan individual case management program enables the Plan to authorize Members to obtain medically appropriate care in a more economical, cost effective and coordinated manner during prolonged periods of intensive medical care.

Through a case manager an alternative plan of treatment, which may include services not otherwise covered under the Plan, may be recommended. It is not a Member's right to receive individual case management; no does the Plan have an obligation to provide it. Anthem Blue Cross, on behalf of the Trust, provides these services at the sole and absolute discretion of the Plan.

A. How the Health Plan Individual Case Management Program Works

1. The health plan individual case management program (Case Management) helps coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions. The programs coordinate benefits and educate Members who agree to take part in the Case Management program to help meet their health-related needs.
2. The Case Management programs are confidential and voluntary, and are made available at no extra cost to the Member. These programs are provided by, or on behalf of and at the request of, the Member's health plan case management staff. These Case Management programs are separate from any covered services you are receiving.
3. If you meet program criteria and agree to take part, then Anthem Blue Cross will help you meet your identified health care needs. This is reached through contact and team work with you and /or your chosen authorized representative, treating *physicians*, and other providers.

4. In addition, Anthem Blue Cross may assist in coordinating care with existing community-based programs and services to meet your needs. This may include giving you information about external agencies and community-based programs and services.

5. If Anthem Blue Cross determines that the Member's needs could be met more efficiently, an alternate treatment plan may be recommended. This may include providing benefits not otherwise covered under this Plan. An Anthem Blue Cross case manager will review the medical records and discuss the Member's treatment with the attending Physician, the Member and the Member's family.

6. Anthem Blue Cross makes treatment recommendations only; any decisions regarding treatment belong to the Member and the Member's Physician. Neither Anthem Blue Cross nor the Trust shall in any way prejudice or compromises the Member's freedom to make such decisions.

B. How Benefits Are Affected by the Health Plan Individual Case Management Program

1. Any alternative benefits paid are accumulated toward any lifetime maximums applicable under this Plan.
2. Benefits are provided for an alternative treatment plan on a case-by-case basis only. The Plan has absolute discretion in deciding whether or not to substitute benefits for any Member, which alternative benefits may be offered and the terms of the offer.
3. Authorization of substitution of benefits in a particular case in no way commits the Plan to do so in another case or for another Member.
4. The personal case management program does not prevent the expressed benefits, exclusions and limitations of this Plan from being strictly applied at any other time or for any other Member.

NOTE: Anthem Blue Cross reserves the right to use the services of one or more third parties in the performance of services outlined in the letter of agreement. No other assignment of any rights or delegation of any duties by either party is valid without the prior written consent of the other party.

QUALITY ASSURANCE

Utilization review programs are monitored, evaluated, and improved on an ongoing basis to ensure consistency of application of screening criteria and medical policy, consistency and reliability of decisions by reviewers, and compliance with policy and procedure including but not limited to timeframes for decision making, notification and written confirmation. Anthem Blue Cross' Board of Directors is responsible for medical necessity review processes through its oversight committees including the Strategic Planning Committee, Quality Management Committee, and Physician Relations Committee. Oversight includes approval of policies and procedures, review and approval of self-audit tools, procedures, and results. Monthly process audits measure the performance of reviewers and Peer Clinical Reviewers against approved written policies, procedures, and timeframes. Quarterly reports of audit results and, when needed, corrective action plans are reviewed and approved through the committee structure.

QUESTIONS ABOUT OR DISAGREEMENTS WITH MEDICAL MANAGEMENT DETERMINATIONS

A. If the Member or the Member's Physician disagrees with a decision or questions how it was reached, reconsideration may be requested. The request for reconsideration may be made by the Member, someone chosen to represent the Member or the Member's Physician. Requests for reconsideration may be made by telephone or in writing and must be directed to the reviewer making the determination within 60 days of issuance of the decision. The address and the telephone number of the reviewer are included on the Member's written notice of determination. Written requests must include medical information that supports the medical necessity of the services.

B. If the Member, Member's representative, or Member's Physician acting on the Member's behalf find the reconsidered decision is not satisfactory, a request for an appeal of the reconsidered decision may be submitted in writing to Anthem Blue Cross. Such request must be made within 60 days of issuance of the reconsidered decision. The appeal request may be made by the Member, the Member's representative or the Member's Physician.

C. In the event that the appeal decision still is unsatisfactory, the remedy is stated under GRIEVANCE/CLAIMS REVIEW PROCEDURE.

PAYMENT RATES

Covered Expense and the terms of this section do not include any amount payable under the sections entitled HEALTH PROMOTION PROGRAM and OUTPATIENT PRESCRIPTION DRUG BENEFITS.

FIRST LEVEL OF PAYMENT. The Plan will pay benefits for Covered Expense you incur up to the Plan Benefit Maximums when applicable.

SECOND LEVEL OF PAYMENT - OUT-OF-POCKET EXPENSE MAXIMUM

After you have made the following total Out-Of-Pocket Expense payments for Covered Expense you incur during a Calendar Year, payment will be provided at 100%† of Covered Expense for the remainder of that Year. You will remain responsible for costs in excess of Covered Expense, Prudent Buyer Plan Providers, Authorized Referrals, Centers of Medical Excellence, and Providers Not Represented in the Prudent Buyer Plan Network:

Per Member	$2,000
Per Family	$4,000

(Two or more Family Members, but not to exceed the $2,000 Out-of-Pocket Expense amount for any one Member)

Non-Prudent Buyer Plan Providers:

Payment to Non-Prudent Buyer Plan Providers will always be the FIRST LEVEL OF PAYMENT, (except for Authorized Referrals, Centers of Medical Excellence, Providers Not Represented in the Prudent Buyer Plan Network and Non-Prudent Buyer Plan Emergency Room Physicians for services received at a Prudent Buyer Plan Provider Hospital) regardless of how much Out-of-Pocket Expense has been incurred.

†EXCEPTION: Expense which is incurred for non-covered services or supplies, or which is in excess of the amount of Covered Expense, will not be applied toward your Out-of-Pocket Expense amount, and is always your responsibility.

PAYMENT RATES - ADDITIONAL EMERGENCY CARE INFORMATION

Emergency Care.* Payment for Emergency Care, including the initial treatment in a Physician's office, is provided at 90% of Covered Expense. This payment shall apply to both Prudent Buyer Plan Providers and Non-Prudent Buyer Plan Providers. Outpatient Emergency Care for an Accidental Injury must be provided within 72 hours of the injury date. NOTE: Ambulance services are covered under Additional Services and Supplies and Hospital Urgent Care or Emergency Room Services require the $50 co-payment shown below.

Inpatient Emergency Care provided by a Non-Prudent Buyer Plan Hospital will be paid at 90% of Reasonable Charges. If the Member is moved via ambulance, such ambulance expenses will be reimbursed at 100% of the Covered Expense.

Hospital Urgent Care or Emergency Room Services. Each time you visit a Hospital's urgent care facility or emergency room, payment will be provided at 90% (after the $50 co-payment) of Covered Expense for Emergency services. However, the $50 co-payment will be reduced to $25 if you are admitted as a Hospital inpatient from the urgent care/emergency room immediately following treatment. This co-payment shall apply to both Prudent Buyer Plan Providers and Non-Prudent Buyer Plan Providers.

Non-Emergency Hospital Urgent Care or Emergency Room Services. Payment is provided at 60% (after the $50 co-payment) of Covered Expense for non-Emergency outpatient services provided by a Non-Prudent Buyer Plan Provider for emergency room or urgent care, including all services rendered in connection with that treatment. This payment rate will also apply to any follow-up visits to the emergency room or to an urgent care facility of a Non-Prudent Buyer Plan Provider.

NOTE: All charges may not be billed by the Hospital and may be billed separately by the provider, such as an emergency room Physician. Although you may go to a Prudent Buyer Hospital, the Physician may be a Non-Prudent Buyer Plan Provider. You are responsible to pay, in addition to the dollar co-payments and percentage of Covered Expense remaining after the payment listed on page 34 any amount in excess of Covered Expense for the services of a Non-Prudent Buyer Plan Provider.

Urgent Care. If you need Urgent Care (defined on page 111), call your Physician. If treatment cannot reasonable be postponed until the earliest appointment time available with your Physician, but your illness, injury or condition is not severe enough to require Emergency Care, Urgent Care can be obtained from any physician. However, your out-of-pocket costs will be lower when covered services are provided by a Physician who is a Prudent Buyer Plan Provider in the Urgent Care Network.

Subject to the remaining paragraphs of this section, Covered Expense is the expense incurred for a covered service or supply. Expense is incurred on the date the Member receives the service or supply for which the charge is made. Please read the definitions of Negotiated Rate, Customary and Reasonable Charge, Reasonable Charge and Scheduled Amount under GENERAL DEFINITIONS to better understand this section.

Payment Example

Important Note: You are required to pay any charges for services provided by a Non-Preferred Provider or any other provider which are in excess of the allowable amount, plus all charges for non-covered services.

	Preferred Provider	**Non-Preferred Provider**
Billed Charge – the amount the Hospital charges for a two-day inpatient stay to a Member.	$100,000	$100,000
Allowable Amount – the allowance or negotiated amount under the Plan for a two-day inpatient stay. This is only an example. Allowable amount varies according to procedure and provider of service.	$20,000 (Prudent Buyer allowable amount)	$580 per day X 2 = $1,160 (Non-par allowance)
Plan Payment – the percentage of Allowable Amount the Plan pays.	$18,000 (90% of Allowable Amount)	$1,044 (90% of Non-par Amount)
Members Coinsurance – the percentage of Allowable Amount the Member pays	$2,000 (10% of Allowable Amount)	$116.00 (10% of Non-par Amount)
Remaining Balance – billed charges exceeding Allowable Amount that the Member is responsible to pay	$0 (Preferred Provider cannot bill the Member for the difference between Allowable Amount and Billed Charges)	$98,840 (Non-Preferred Provider can bill the Member for the difference between Allowable Amount and Billed Charges)
Total Amount the Member is Responsible To Pay	**$2,000.00**	**$98,956.00**

DETERMINATION OF COVERED EXPENSE

Covered Expense does not include:

A. Any charge in excess of the Negotiated Rate for services provided by a Prudent Buyer Plan Provider.

B. Any charge in excess of a Customary and Reasonable Charge or a Reasonable Charge for services provided by:

   1. A Non-Prudent Buyer Plan Hospital for outpatient care, Emergency Care* or an Authorized Referral, or

   2. A Non-Prudent Buyer Plan Provider (other than a Hospital), or

   3. A Provider not Represented in the Prudent Buyer Plan Network.
      NOTE: When you travel and obtain covered health care services outside of California, the claim for those services may be processed through the BlueCard Program. Detailed information on the usual calculation of Subscriber liability under the BlueCard Program and state law exceptions to such usual calculation are included in the Administrative Services Agreement the Trust has with Anthem Blue Cross.

C. Any charge in excess of the Scheduled Amounts shown in the Table of Allowances below for inpatient services provided by a Non-Prudent Buyer Plan Hospital for other than Emergency Care, or an Authorized Referral.

Anthem Blue Cross has the right to adjust these Scheduled Amounts listed in the Table of Allowances below in order to maintain the relationship between these amounts and the rates negotiated by Anthem Blue Cross with Prudent Buyer Plan Hospitals. Benefits are determined based on the Scheduled Amounts in effect at the time services are rendered. For a description of Service Area, please refer to GENERAL DEFINITIONS.

Table of Allowances*

Service Area	Non-Prudent Buyer Plan Hospital Inpatient Daily Maximum Scheduled Amounts (Other Area than for Emergency Care, an authorized bariatric surgery, or an Authorized Referral)
1	$540 for each day
2	$540 for each day
3	$540 for each day
4	$580 for each day
5	$540 for each day
6	$540 for each day
7	$540 for each day
8	$540 for each day
9	$540 for each day

*The Plan's payment shall not exceed 90% of the Scheduled Amounts listed above.

EXAMPLE: Non-Emergency Inpatient Hospital services are billed by a Non-Prudent Buyer Plan Hospital in San Francisco, which is located in Service Area 3. An Authorized Referral was not obtained. The maximum amount paid per day shall be 90 percent of $540.00, which is $486.00. Charges in excess of this amount are the Member's responsibility and also do not apply to the OUT-OF-POCKET EXPENSE MAXIMUM, since they are from a Non-Prudent Buyer Plan Hospital.

D. If covered services are received from a provider located outside of California who is a Non-Prudent Buyer Plan Provider, Covered Expense does not include the following:

1. For services received from a Hospital (other than for Emergency Care), any charge in excess of the amounts stated for Service Area 4 in the Table of Allowances on the previous page.
2. For services received from a Physician (other than for Emergency Care), Clinical Laboratory, Diagnostic Imaging Facility, chiropractor, physical therapist, acupuncturist, speech pathologist, Home Health Care Agency, Ambulatory Surgical Center, Home Infusion Therapy Provider, Skilled Nursing Facility; Durable Medical Equipment Supply Outlet or any charge in excess of the Customary and Reasonable Charge or Reasonable Charge in the California county of Los Angeles for like services.

EXCEPTION: If services are received from Prudent Buyer Plan Providers (which contract with the Prudent Buyer Plan Network in certain areas of Arizona, Nevada and Oregon), Covered Expense does not include any charge in excess of the Negotiated Rate.

E. If Medicare is the primary payer, Covered Expense does not include any of the following charges:

1. By a Hospital, in excess of the approved amount as determined by Medicare; or

2. By a Physician who is a Prudent Buyer Plan Provider who accepts Medicare assignment, in excess of the approved amount as determined by Medicare; or
3. By a Physician who is a Non-Prudent Buyer Plan Provider or a Provider not Represented in the Prudent Buyer Plan Network who accepts Medicare assignment, in excess of the lesser of maximum Covered Expense stated above, or the approved amount as determined by Medicare; or
4. By a Physician or a Provider not Represented in the Prudent Buyer Plan Network who does not accept Medicare assignment, in excess of the lesser of the maximum Covered Expense stated above, or the limiting charge as determined by Medicare.

NOTE: You are responsible to pay any amount in excess of Covered Expense, as described in items B, C, and D on the previous page, for the services of a Non-Prudent Buyer Plan Provider or a Provider Not Represented in the Prudent Buyer Plan Network.

COVERED MEDICAL SERVICES AND SUPPLIES

A. Additional Services and Supplies

1 Payment

80% PPO and non-PPO

2 Services

Benefits for Covered Expense incurred are provided for the services listed below.

a. The following ambulance services:
   (1) Base charge, mileage and non-reusable supplies of a licensed ambulance company for ground or airplane service to transport a Member to and from a Hospital or Skilled Nursing Facility.
   (2) Base charge, mileage and non-reusable supplies of a licensed air ambulance company to transport a Member from the area where the Member is first disabled to the nearest Hospital where appropriate treatment is provided.
   (3) Monitoring, electrocardiograms (EKGs or ECGs), cardiac defibrillation, cardiopulmonary resuscitation (CPR) and administration of oxygen and intravenous (IV) solutions in connection with ambulance service. An appropriately licensed person must render the services.
   NOTE: If it is Medically Necessary for the Member to be moved via ambulance from one facility to another, ambulance expenses will be reimbursed at 100% of the Covered Expenses.
b. Surgical implants. This includes Medically Necessary surgically implanted hearing devices (i.e. cochlear implants, audient bone conduction devices).
c. Artificial limbs or eyes. This includes services of an orthotist and prosthetist in connection with evaluation or fitting of an orthotic or prosthetic device when services are billed as part of the charge for the artificial limbs or eyes.
d. Blood transfusions, including blood processing and cost of unreplaced blood and blood products.
e. The first pair of contact lenses or the first pair of eyeglasses when required as the result of eye surgery, unless the surgery is specifically excluded under this Plan.
f. Biofeedback procedures.

B. Ambulatory Surgical Center

a. Payment
   90% PPO
   60% non-PPO – **maximum plan payment of $350 per surgical session**.
b. Services
   Benefits are provided for Covered Expense incurred for services and supplies provided by an Ambulatory Surgical Center in connection with outpatient surgery.

For the services of a Non-PPO facility only, the plan's maximum payment is limited to three hundred and fifty dollars ($350) each time you have outpatient surgery at an ambulatory surgical center.

C. Bariatric Surgery

1. Payment

90% Centers of Medical Excellence (CME)

2. Services

Authorization is required for bariatric surgery prior to services being rendered. Subject to the preservice review provisions stated under MEDICAL MANAGEMENT PROGRAMS, benefits are provided for Covered Expense for services and supplies provided in connection with Medically Necessary surgery for weight loss, only for morbid obesity and only when performed at an approved Centers of Medical Excellence (CME) facility.

3. Conditions of Service

a. Benefits are not payable for a bariatric surgical procedure for which prior authorization through preservice review was not obtained.

b. Charges for services provided for or in connection with a bariatric surgical procedure performed at a facility other than an approved CME are not covered.

D. Bariatric Surgery Travel Expense

1. Payment

100%

2. Services

Benefits may be provided for travel expense in connection with a covered bariatric surgery when the Member's home is outside the coverage area of the nearest designated Centers of Medical Excellence (CME). Coverage area is the area within the 50-mile radius surrounding a designated CME. Covered travel expense includes the following:

a. Transportation to and from the CME for the Member not to exceed $130 per trip for a maximum of three (3) trips, one pre-surgical visit, the initial surgery and one follow-up visit.
b. Transportation to and from the CME for one companion not to exceed $130 per trip for a maximum of two (2) trips, the Member's initial surgery and one follow-up visit.
c. Hotel accommodations for the Member and one companion not to exceed $100 per day for one room, double occupancy for a maximum of two (2) days per trip, up to two (2) trips, one pre-surgical visit and one follow-up visit.
d. Hotel accommodations for one companion during the Member's initial surgery stay not to exceed $100 per day for one room, double occupancy for a maximum of four (4) days.
e. Other reasonable expenses not to exceed $25 per day for a maximum of four (4) days per trip. Tobacco, alcohol and drug expenses are not covered.

3. Conditions of Service

a. All travel expenses must be authorized by Anthem Blue Cross prior to services being received. Customer service will confirm if the bariatric surgery travel expense benefit is provided in connection with access to the selected CME.

b. Legible copies of all applicable receipts must be submitted with a travel reimbursement form. You can obtain a travel reimbursement form by calling Anthem Blue Cross customer service.

E. Chiropractic and Acupuncture Services

1. Payment

90% PPO

60% non-PPO

2. Covered Services

Benefits are provided for Covered Expense for acupuncture and outpatient chiropractic care provided for a covered illness, injury or condition. This includes care which is customarily provided by acupuncturists, chiropractors and osteopaths.

3. Visits Covered

Benefits are limited to 20 visits in each Year for any combination of chiropractic or acupuncture services. For the purpose of this benefit, the term “visit" includes any visit to a Physician in the Physician's office or anywhere else during which one or more chiropractic care or acupuncture services covered by this benefit is received.

4. Conditions of Service

Services are limited to those which offer a reasonable expectation of improvement subject to the following:

a. Services rendered in the Member's home are provided under Home Health Care and are subject to the conditions of service, limitations and provisions applicable to that benefit.

b. Services rendered through a Hospice Care Program are provided under Hospice Care and are subject to the conditions of service, limitations and provisions applicable to that benefit.

c. Benefits are not payable for care provided to relieve general soreness or for conditions that may be expected to improve without treatment.

NOTE: Payment for subsequent chiropractic procedures and modalities billed on the same day shall be reduced.

F. Dental Care

1. Payment

80% PPO and non-PPO

2. Services

Benefits for Covered Expense incurred are provided for the services listed below.

a. Admissions for Dental Care

(1) Covered Services

Listed inpatient or outpatient Hospital services, subject to the conditions of service stated under Hospital, when a Hospital Stay or outpatient Hospital services for dental treatment is required due to an unrelated medical condition of the Member, and has been ordered by a Physician (M.D.) and a Dentist (D.D.S. or D.M.D.).

General anesthesia administered during a covered Hospital Stay or outpatient Hospital services for dental treatment will be payable under this Plan subject to the conditions of service under Professional Services below.

(2) Conditions of Service

- Anthem Blue Cross makes the final determination as to whether the dental treatment could have been safely rendered in another setting due to the nature of the procedure or the Member's medical condition.
- Hospital Stays for the purpose of administering general anesthesia are not considered Medically Necessary.

- General anesthesia and associated facility charges are payable only when:
  (a) The Member is less than seven years old, or
  (b) The Member is developmentally disabled, or
  (c) The Member's health is compromised and general anesthesia is Medically Necessary.
- Benefits are not payable for the dental procedure itself, including professional fees of a dentist.

b. Dental Injury
Services of a Physician (M.D.) or Dentist (D.D.S. or D.M.D.) solely to treat an Accidental Injury to natural teeth which occurs while the Member is covered under this Plan. Coverage shall be limited to only such services that are Medically Necessary to repair the damage done by Accidental Injury and/or restore function lost as a direct result of the Accidental Injury. Damage to natural teeth due to chewing or biting is not Accidental Injury unless the chewing or biting results from a medical or mental condition.

G. Diabetes Education Program

1. Payment
a. Physician Office Visit:
$15 office visit co-payment, 100% PPO
60% non-PPO
b. Other Provider Services:
90% PPO
60% non-PPO

2. Services
a. Designed to teach the Member who is the patient and covered Members of the patient's family about the disease process and the daily management of diabetic therapy;
b. Includes self-management training, education and medical nutrition therapy to enable the Member to properly use equipment, supplies and medications necessary to manage the disease; and
c. Is supervised by a Physician.

H. Diagnostic Services

1. Payment
90% PPO
60% non-PPO

2. Services
Covered Expense for outpatient diagnostic imaging and laboratory services.

I. Durable Medical Equipment

1. Payment
90% PPO
60% non-PPO

2. Services

Benefits for Covered Expense incurred are provided for rental or up to the purchase of dialysis equipment and dialysis supplies. Rental or costs up to the purchase of other Medically Necessary durable medical equipment and supplies which are:

a. Ordered by a Physician, and
b. Of no further use when medical need ends (but not disposable), and
c. Usable only by the patient, and
d. Not primarily for the Member's comfort or hygiene, and
e. Not for environmental control, and
f. Not for exercise, and
g. Manufactured specifically for medical use.

NOTE: Rental charges that exceed the Reasonable purchase price of the equipment are not covered. Anthem Blue Cross determines whether the item meets the above conditions.

3. Conditions of Service

Preservice review can be requested for select durable medical equipment for which the purchase price is $5,000 or more. Such equipment includes, but is not limited to, hospital beds, continuous positive airway pressure device (CPAP), and power wheelchairs. See MEDICAL MANAGEMENT PROGRAMS beginning on page 23.

J. Emergency Care

1. Payment

a. Emergency Room Services

$50 co-payment*, 90% PPO and Emergency Care by non-PPO
$50 co-payment, 60% non-emergency by non-PPO
*If admitted to the Hospital on an inpatient basis, the $50 co-payment will be reduced to $25.

b. Emergency Room Physician Services

90% PPO, Non-PPO at a PPO Hospital and Emergency Care by non-PPO
60% non-emergency by non-PPO

2. Services

Benefits for Covered Expense incurred are provided for the services listed under Hospital; refer to page 45.

3. Conditions of Service

a. Emergency room care must be for the first treatment of a medical Emergency. A medical Emergency is an unexpected acute illness or injury which could permanently endanger health if immediate medical treatment is not received.

b. Outpatient Emergency Care for an injury must be received within 72 hours of the injury date.

K. Family Planning

1. Payment

90% PPO
60% non-PPO

2. Services

Benefits for Covered Expense incurred are provided for the services listed below.

a. Physician services and supplies provided in a Physician's office in connection with prescribing prescription contraceptives as a method of contraception.

b. All PRUDENT BUYER PLAN BENEFITS when provided for abortions.

c. All PRUDENT BUYER PLAN BENEFITS when provided for sterilizations. In no event will benefits of this Plan be provided for or in connection with Infertility studies and treatment of Infertility, sterilization reversal, artificial insemination, in-vitro fertilization, gamete intrafallopian transfer and Prescription Drugs prescribed for Infertility.

Note: Certain services are covered under the Preventive Care Services benefit. See that benefit for further details.

L. Hearing Aid Services

1. Payment

90% PPO
60% non-PPO

2. Services

The Covered Expense for the hearing aid services listed below when provided by or purchased as a result of a written recommendation by a Physician certified as either an otologist, an otolaryngologist or a state-certified audiologist. The Hearing Aid Services benefit maximum is one audiological exam and one hearing aid per ear every 36 months.

a. Audiological evaluations to measure the extent of hearing loss and hearing aid evaluation to determine the most appropriate make and model of hearing aid.

b. Hearing aids (monaural or binaural) including ear mold(s), the hearing aid instrument, the initial battery, cords and other ancillary equipment. Includes visits for fitting, counseling, adjustments, repairs, etc. at no charge for a one-year period following the provision of a covered hearing aid.

3. Special Hearing Aid Services Exclusions: In addition to the PRUDENT BUYER PLAN EXCLUSIONS AND LIMITATIONS and GENERAL EXCLUSIONS AND LIMITATIONS elsewhere in this Evidence of Coverage, no benefits will be provided for the following:

a. Purchase of batteries or other ancillary equipment, except those covered under the terms of the initial hearing aid purchase.

b. Charges for a hearing aid which exceed specifications prescribed for the correction of hearing loss.

c. Replacement parts for hearing aids; repair of hearing aids after the covered one year warranty period.

d. Replacement of a hearing aid more than once in any period of thirty-six months.

e. Surgically implanted hearing devices. Medically Necessary surgically implanted hearing devices may be covered under the plan's benefits for surgical implants (see Additional Services and Supplies on page 36).

4. Audiology exams that exceed more than once in any period of thirty-six months.

M. Home Health Care

1. Payment

90% PPO
60% non-PPO

2. Covered Services

The Covered Expense for the following services and supplies are subject to the requirements stated under MEDICAL MANAGEMENT PROGRAMS:

a. Services of a registered nurse or licensed vocational nurse under the supervision of a registered nurse or a physician.

b. Services of a licensed therapist for physical, occupational, respiratory and speech therapy. NOTE: Please refer to Physical and Occupational Therapy Services and Speech Therapy Services for restrictions.

c. Services of a medical social service worker.

d. Services of a health aide who is employed by (or under arrangement with) a Home Health Agency. Services must be ordered and supervised by a registered nurse employed by the Home Health Agency as a professional coordinator. These services are only covered if the Member is also receiving the services listed in a. or b. above.

e. Medically Necessary supplies provided by the Home Health Agency.

3. Visits Covered

a. Benefits are limited to a combined number of 90 visits for all providers of service listed above per Period of Disability.

b. The 90-visit allowance renews 90 days after the Member no longer receives home health care services.

c. A home health visit is defined as a skilled nursing visit (R.N. or L.V.N.) or other professional visit (physical therapist, speech therapist, social worker or respiratory therapist) for a period of up to four hours of therapeutic service in any one day. A visit of four hours or less by the certified home health aide will be considered as one home health visit.

4. Conditions of Service

a. The Member must be confined at home under the active medical supervision of the Physician ordering Home Health Care and treating the illness or injury for which that care is needed.

b. Services must be provided and billed by the Home Health Agency.

c. Services must be consistent with the illness, injury, degree of Disability and medical needs of the Member. Benefits are provided only for the number of visits required to treat the Member's illness or injury.

d. Services must not be received while the Member is receiving Hospice Care benefits.

e. Custodial Care and maintenance therapy are not covered.

N. Home Infusion Therapy

1. Payment

90% PPO
60% non-PPO

2. Services

Authorization is required for home infusion therapy services prior to services being rendered. Subject to the preservice review provisions stated under MEDICAL MANAGEMENT PROGRAMS, the Covered Expense for the following services and supplies when provided by a Home Infusion Therapy Provider in the Member's home for the intravenous administration of a Member's total daily nutritional intake or fluid requirements, including but not limited to Parenteral Therapy and Total Parenteral Nutrition (TPN), medication related to illness or injury, chemotherapy, antibiotic therapy, aerosol therapy, tocolytic therapy, special therapy, intravenous hydration, or pain management:

a. Medication, ancillary medical supplies and supply delivery, (not to exceed a 14-day supply); however, medication which is delivered but not administered is not covered;

b. Pharmacy compounding and dispensing services (including pharmacy support) for intravenous solutions and medications;

c. Hospital and home clinical visits related to the administration of Home Infusion Therapy, including Skilled Nursing services provided for: (a) patient or alternative caregiver training; and (b) visits to monitor the therapy;

d. Rental and purchase charges for durable medical equipment; maintenance and repair charges for such equipment;

e. Laboratory services to monitor the patient's response to therapy regimen.

f. Total Parenteral Nutrition (TPN), Enteral Nutrition Therapy, antibiotic therapy, pain management, chemotherapy, and may also include injections (intra-muscular, subcutaneous, or continuous subcutaneous).

O. Hospice Care

1. Payment

100%

2. Covered Services

Benefits for Covered Expense are available for an approved Hospice that administers a Hospice Care Program providing home-based Hospice care, inpatient Hospice care, or both.

a. Inpatient Hospice care, including services and supplies.

b. Services of a Physician provided by or through a Hospice Care Program.

c. Services of a registered nurse, licensed practical nurse and licensed vocational nurse.

d. Services of a licensed therapist for physical, occupational, respiratory and speech therapy.

NOTE: Please refer to Physical and Occupational Therapy Services and Speech Therapy Services for restrictions.

e. Medical social services.

f. Services of a home health aide.

g. X-ray and laboratory services provided by or through a Hospice Care Program.

h. Nutritional support such as intravenous feeding or hyperalimentation.

i. Dietary and nutritional guidance.

j. Bereavement counseling provided by a Hospice Care Program for Family Members within one year of the Member's death. Bereavement counseling is limited to two visits.

k. Inpatient or outpatient respite care of the Member. Respite care means a short-term Hospice Stay which is necessary to provide relief to Family Members or others caring for the Member. Respite care is limited to a combined maximum of five days.

l. 24-hour home care in periods of crisis, to provide management of acute medical symptoms.

m. Medically Necessary supplies and Prescription Drugs provided by a Hospice Care Program.

n. Rental or purchase of medical equipment through a Hospice Care Program.

3. Conditions of Service

a. The Member must be suffering from a terminal illness for which the prognosis of life expectancy is six months or less, as certified to Anthem Blue Cross by the Member's Physician.

b. Palliative care (care which controls pain and relieves symptoms but does not cure) must be appropriate for the Member's illness.

c. The Member's Physician must consent to the Member's admission to a Hospice Care Program and must be consulted in the development of the Member's plan of care.

d. Services must be those which are regularly provided and billed by a Hospice Care Program.

e. The Hospice must notify Anthem Blue Cross at the time of the Member's admission into a Hospice Care Program and submit a written patient treatment plan to Anthem Blue Cross every 30 days.

f. Services must not be received while the Member is receiving Home Health Care benefits.

4. Special Hospice Care Exclusions
In addition to the PRUDENT BUYER PLAN EXCLUSIONS AND LIMITATIONS and GENERAL EXCLUSIONS AND LIMITATIONS listed elsewhere in this Evidence of Coverage, the following exclusions apply:

a. Homemaker and housekeeping services.

b. Food, home-delivered meals or housing charges.

c. Transportation charges.

d. Any volunteer service or services which would normally be provided free of charge.

e. Services provided in the areas of both legal and/or financial advice (preparation and execution of wills; estate planning and liquidation; financial investment, etc.).

f. Counseling by clergy or any volunteer group.

g. Personal comfort items.

h. Private duty nursing (a continuous bedside nursing service rendered by one nurse to one patient, either in a Hospital, Hospice Facility or the Member's home, as opposed to a general-duty nurse, who renders services to a number of Hospital or Hospice facility patients), except during periods of crisis to provide management of acute medical symptoms.

P. Hospital

1. Payment

a. Inpatient

90% PPO
90% of Scheduled Amounts non-PPO; refer to page 34

b. Outpatient

90% PPO
60% non-PPO

c. Emergency Care

$50 co-payment*, 90% PPO and Emergency Care by non-PPO
$50 co-payment, 60% non-emergency by non-PPO
*If admitted to the Hospital on an inpatient basis, the $50 co-payment will be reduced to $25.

2. Covered Inpatient Services

Benefits for Covered Expense for the following services and supplies, when provided by a Hospital, are subject to the requirements stated under MEDICAL MANAGEMENT PROGRAMS:

a. Accommodations.
b. Services in Special Care Units.
c. Operating, delivery and special treatment rooms.
d. Supplies and ancillary services including laboratory, cardiology, pathology, and radiology. Professional component fees for these services shall be covered only if a separate charge for professional interpretation is determined to be Medically Necessary.
e. Physical therapy, radiation therapy, chemotherapy and hemodialysis treatment.
f. Drugs and medicines approved for general use by the Food and Drug Administration which are supplied by the Hospital for use during the Member's Stay, including take-home drugs dispensed by the Hospital's pharmacy at the time of discharge.
g. Blood transfusions, including blood processing and the cost of unreplaced blood and blood products.

3. Covered Outpatient Services

a. Emergency room use, supplies, ancillary services, professional services, drugs and medicines as listed above.
b. Care received when outpatient surgery is performed. Covered services are operating room use, supplies, ancillary services, drugs and medicines as listed above.

c. Radiation therapy, chemotherapy and hemodialysis treatment.

d. Routine radiology and laboratory exams received within seven days prior to a covered Stay for inpatient or outpatient surgery. The exams must be needed for the illness, injury or condition necessitating the Stay, and must be provided and billed by the Hospital or Ambulatory Surgical Center where the surgery is to take place.

4. Conditions of Service

a. Services must be those which are regularly provided and billed by a Hospital.

b. Benefits are provided only for the number of days required to treat the Member's illness, injury or condition.

c. Emergency Care must be for the initial treatment of a medical Emergency as defined under GENERAL DEFINITIONS.

d. Outpatient Emergency Care for an injury must be received within 72 hours of the injury date.

e. Charges that are not billed by the Hospital and are sent separately by the provider, such as an emergency room Physician, are not covered under this Hospital benefit but may be covered under other benefits listed in this section.

Q. Maternity Care

1. Payment

90% PPO
60% non-PPO

2. Services

Benefits for Covered Expense incurred are provided for the services listed below.

a. All PRUDENT BUYER PLAN BENEFITS when provided for pregnancy and maternity care, including prenatal diagnosis of genetic disorders of the fetus in cases of high-risk pregnancy. The mother, at her option, may remain in the hospital up to 48 hours after a normal delivery and 96 hours after a cesarean delivery. Benefits for inpatient Stays will be extended if Medically Necessary.

b. Services listed under Hospital for routine nursery care of a newborn child that qualifies as an eligible dependent in accordance with the Act.

Note: Certain services are covered under the Preventive Care Services benefit. See that benefit for further details.

Services provided by an approved Alternative Birth Center and or a certified nurse midwife.

R. Mental Disorders or Chemical Dependency

1. Payment

a) Inpatient
90% PPO
90% of Scheduled Amounts non-PPO, refer to page 34

b) Outpatient

90% PPO

60% non-PPO

c) Emergency Care

$50 co-payment*, 90% PPO and Emergency Care by non-PPO
$50 co-payment, 60% non-emergency by non-PPO
*If admitted to the Hospital on an inpatient basis, the $50 co-payment will be reduced to $25.

d) Physician Office Visits:

$15 office visit co-payment, 100% PPO
60% non-PPO

e) Other Physician Services:

90% PPO
60% non-PPO

2. Services

Subject to the preservice review provisions stated under MEDICAL MANAGEMENT PROGRAMS, benefits are provided for Covered Expense for treatment of Mental Disorders or Chemical Dependency provided such services offer a reasonable expectation of improvement, and are the lowest level of care consistent with safe medical practice.

a. Inpatient Hospital services and services from a Residential Treatment Center as stated in the "Hospital" provision of this section, for inpatient services and supplies.

b. Partial hospitalization, including intensive outpatient programs and visits to a Day Treatment Center. Partial hospitalization is covered as stated in the "Hospital" provision of this section, for outpatient services and supplies.

c. Physician visits during a covered inpatient Stay.

d. Physician visits for outpatient psychotherapy or psychological testing or outpatient rehabilitative care for the treatment of Mental Disorders or Chemical Dependency. This includes nutritional counseling for the treatment of eating disorders such as anorexia nervosa and bulimia nervosa.

Treatment for Chemical Dependency does not include smoking cessation programs, or treatment for nicotine dependency or tobacco use.

S. Organ and Tissue Transplants

1. Payment

90% PPO
60% non-PPO

2. Services

Subject to the requirements stated under MEDICAL MANAGEMENT PROGRAMS, benefits are provided for Covered Expense incurred for or in connection with non-Investigational human organ or tissue transplants, such as skin, cornea or kidney transplants, that are commonly accepted medical practice in the United States. Benefits include all services provided elsewhere under this Plan for:

a. A Member who receives the organ or tissue, and

b. A Member who donates the organ or tissue, and

c. An organ or tissue donor who is not a Member, if the organ or tissue recipient is a Member. Benefits are reduced by any amounts paid or payable by the donor's own health plan.

EXCEPTIONS: Benefits for human heart, lung, heart-lung, liver, bone marrow and pancreas – kidney transplants will be provided only if benefits are authorized in advance according to the provisions stated under MEDICAL MANAGEMENT PROGRAMS. Such authorization will be provided through preservice review only if:

- Services are Medically Necessary and appropriate, and
- The Physicians on the surgical team and the facility in which the transplant is to take place are approved by Anthem Blue Cross for the type of transplant requested. Anthem Blue Cross will advise the Member and his/her Physician whether the facility in which the transplant is to take place is designated by Anthem Blue Cross as a transplant center.

Benefits for authorized services are subject to all other conditions, limitations, exclusions and provisions of this Plan. No benefits are provided for transplant procedures that are Experimental or Investigational. The Member may request an independent review of a coverage decision for services that Anthem Blue Cross has denied as being Experimental or Investigational if all of the following criteria have been met: (1) the Member has a terminal condition, and (2) the Member's Physician certifies that standard therapies have been ineffective or would be inappropriate, and (3) either the Member's Physician certifies in writing that the denied therapy is likely to be more beneficial to the Member than standard therapies, or the Member or the Member's Physician has requested a therapy that, based on documented medical and scientific evidence, is likely to be more beneficial than standard therapies. The Member will be notified in writing by Anthem Blue Cross of the opportunity to request this review when services are denied.

T. Physical and Occupational Therapy Services

1. Payment

90% PPO
60% non-PPO

2. Covered Services

Benefits for Covered Expense incurred are provided for the following services, subject to the provisions stated under MEDICAL MANAGEMENT PROGRAMS:

Inpatient and outpatient physical and occupational therapy for the treatment of illness and injuries. Physical and occupational therapy services include therapeutic use of heat, cold, exercise, electricity, ultraviolet radiation, or massage for the purpose of improving circulation, strengthening muscles or encouraging the return of motion. (This includes many types of care which are customarily provided by physical or occupational therapists.)

3. Visits Covered

Benefits are limited to the acute phase of the illness, injury or condition necessitating physical or occupational therapy services subject to the following:

a	An authorization is required for all physical and occupational therapy benefits in excess of 24 visits in a Year. Benefits may not be payable starting with the 25th visit if authorization is not obtained **before** services are received as stated under **MEDICAL MANAGEMENT PROGRAMS**.
b	For the purpose of this benefit, the term "visit" includes any visit to a Physician who is a licensed medical doctor (M.D.) in the Physician's office or anywhere else during which one or more physical or occupational therapy services covered by this benefit is received.

4. Conditions of Service

a. Services are limited to the acute phase of the illness, injury or condition necessitating physical or occupational therapy services.

b. Services rendered in the Member's home are provided under Home Health Care and are subject to the conditions of service, limitations and provisions applicable to that benefit.

c. Services rendered through a Hospice Care Program are provided under Hospice Care and are subject to the conditions of service, limitations and provisions applicable to that benefit.

d. Benefits are not payable for therapeutic treatment which is unlikely to result in long-term improvement of the patient's functional ability or status, or primarily for the purpose of maintaining the patient's current functional level.

NOTE: Payment for subsequent physical medicine procedures and modalities provided on the same day will be reduced.

U. Professional Services

1. Payment

a. Physician Office Visits:
$15 office visit co-payment, 100% PPO
60% non-PPO

b. Other Physician Services:
90% PPO
60% non-PPO

2. Services

Benefits for Covered Expense incurred are provided for the following, subject to the MEDICAL MANAGEMENT PROGRAMS requirements:

a. Surgery and surgical assistance.

(1) When two or more surgical procedures are performed during the same operation, Covered Expense will be calculated for all of the services combined by adding:

- The services with the highest maximum amount of Covered Expense; plus
- A reduced percentage of what the Covered Expense would have been for each of the additional surgical services if these services had been performed alone.

(2) Covered Expense for the services of an assistant surgeon will be a reduced percentage of the Covered Expense for the primary surgeon performing that procedure.

b. Anesthesia during surgery (provided by a M.D. or C.R.N.A.).

c. Physician's visits during a covered inpatient Hospital Stay are limited to one visit per physician or specialist per day unless additional visits are needed to treat a Member in critical condition who requires constant care.

d. Radiation therapy, chemotherapy and hemodialysis treatment.

e. Physician's care includes acupuncture, allergy treatment, physical therapy, speech therapy, chiropractic care, occupational therapy and Urgent Care.

   NOTE: Please refer to Physical and Occupational Therapy Services, Chiropractic and Acupuncture Services and Speech Therapy Services for restrictions.

f. Services of a special duty nurse (R.N., L.P.N., L.V.N.).

g. Outpatient Drugs and medicines approved for general use by the Food and Drug Administration, including intravenous Drugs, that are available only if prescribed by a Physician. The Drug or medicine must be:

   (1) Dispensed by a Physician in his or her office, or

   (2) Administered by a Physician or an individual licensed to administer Drugs and medicines under the supervision of a Physician.

   EXCEPTIONS:

   - Drugs which are sold by a retail pharmacy and prescribed for the Member to self-administer.
   - Intravenous Drugs in a setting other than a Physician's office or the outpatient department of a Hospital.

h. Medically Necessary supplies and injections provided by a Physician during a covered office visit.

i. Professional services provided at a Hospital, such as emergency room Physician, which are not included in the Hospital bill and are submitted separately by the provider.

V. Reconstructive Surgery

1. Payment

100% PPO
60% non-PPO

Precertification from the utilization review program must be obtained as soon as possible, but no later than three (3) business days before services are provided. Failure to obtain precertification within the specified time frame may result in increased coinsurance responsibility and/or denial of benefits.

Hospital and physician services provided in connection with reconstructive surgery are a benefit only to the extent that surgery is coincident with and necessary to the repair or alleviation of bodily damage caused by illness, congenital anomaly, or accidental injury. However, dental surgery, including dental implants (materials implanted into or on bone or soft tissue), is not covered even if related to emergency care services or treatment of injury.

Reconstructive surgery performed to restore symmetry following a mastectomy for documented medical pathology, such as cancer, is covered. Prosthetic devices and services provided in connection with a mastectomy are a benefit regardless of when the mastectomy was performed.

Benefits are also payable for medically necessary services provided in connection with complications arising from reconstructive surgery.

Benefits are not payable for services provided in connection with complications arising from a non-authorized or cosmetic procedure.

W. Routine Preventive Care Services (for Members age 7 and over)

1. Payment
100% PPO
60% non-PPO

2. Covered Services

Screening services and supplies provided in connection with Preventive Care Services as shown below. No co-payment will apply to these services or supplies when they are provided by a Prudent Buyer Plan Provider.

a. A Physician's services for routine physical examinations.

b. Immunizations prescribed by an examining Physician.

c. Radiology and laboratory services and tests ordered by the examining Physician in connection with a routine physical examination, excluding any such tests related to an illness or injury. Those radiology and laboratory services and tests related to an illness and injury will be covered as any other medical service available under the terms and conditions of the provision "Diagnostic Services".

d. Health screenings as ordered by the examining Physician for the following: breast cancer, cervical cancer, including human papillomavirus (HPV), prostate cancer, colorectal cancer, and other medically accepted cancer screening tests, blood levels, high blood pressure, type 2 diabetes mellitus, cholesterol, and obesity.

e. Human immunodeficiency virus (HIV) testing, regardless of whether the testing is related to a primary diagnosis.

f. Counseling and risk factor reduction intervention services for sexually transmitted infections, human immunodeficiency virus (HIV), contraception, tobacco use, and tobacco use-related diseases.

g. Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the follow:

(1) All FDA-approved contraceptive methods for women, including over-the-counter items, if prescribed by a Physician. In order to be covered as preventive care, contraceptive prescription drugs must be either a Generic or Single Source Brand Drug. Also covered are sterilization procedures and counseling. Multi-Source Brand Name Drugs (those with a Generic equivalent) will be covered as preventive care Services when medically necessary, otherwise they will be covered under your Plan's prescription drug benefits.

(2) Breast feeding support, supplies, and counseling. One breast pump will be covered per pregnancy under this benefit.

(3) Gestational diabetes screening.

(4) Preventive prenatal care.

h. Preventive services for certain high-risk populations as determined by your Physician, based on clinical expertise.

This list of Preventive Care Services is not exhaustive. Preventive tests and screenings with a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF), or those supported by the Health Resources and Services Administration (HRSA) will be covered with no copayment.

See the definition of "Preventive Care Services" in the DEFINITIONS section for more information about services that are covered by this Plan as routine Preventive Care Services.

NOTE: Employment related physical exams are not covered under this Plan.

X. Skilled Nursing Facility

1. Payment

90% PPO
60% non-PPO

2. Covered Services

Benefits for Covered Expense for the following services and supplies, when provided by a Skilled Nursing Facility, are subject to the requirements stated under MEDICAL MANAGEMENT PROGRAMS:

a. Accommodations in a room of two or more beds, or the prevailing charge for two-bed room accommodations in that facility if a private room is used.

b. Special treatment rooms.

c. Laboratory exams.

d. Physical, occupational and speech therapy. Oxygen and other gas therapy.

NOTE: Please refer to Physical and Occupational Therapy Services and Speech Therapy Services for restrictions.

e. Drugs and medicines approved for general use by the Food and Drug Administration which are used in the facility.

f. Blood transfusions, including blood processing and the cost of unreplaced blood and blood products.

3. Days Covered

a. Skilled Nursing Facility services are provided up to 100 days in each confinement period.

b. The 100-day allowance renews 90 days after the Member is no longer confined in a Skilled Nursing Facility.

4. Conditions of Service

a. The Member must be referred to the Skilled Nursing Facility by a licensed medical doctor (M.D.).

b. Services must be those which are regularly provided and billed by a Skilled Nursing Facility.

c. The services must be consistent with the illness, injury, degree of Disability and medical needs of the Member. Benefits are provided only for the number of days required to treat the Member's illness or injury.

d. The Member must remain under the active medical supervision of a Physician. The Physician must be treating the illness or injury for which the Member is confined in the Skilled Nursing Facility.

e. Custodial Care is not covered.

Y. Speech Therapy Services

1. Payment

90% PPO
60% non-PPO

2. Covered Services

Benefits will be provided for Covered Expense incurred for the following services:

a. Inpatient and outpatient speech therapy services if caused by or due to:

(1) A non-congenital organic disease or illness, or

(2) Accidental Injury, or

(3) Surgery resulting from illness.

b. Services for the treatment of a speech impediment due to congenital anomalies are included only after corrective surgery.

3. Conditions of Service

a. Services must be ordered by a Physician.

b. Speech therapy services are limited to the acute phase of the illness, injury or condition necessitating the therapy services.

c. Services rendered in the home are provided under Home Health Care benefits and are subject to the conditions of service, limitations and provisions applicable to those benefits.

d. Services rendered through a Hospice Care Program are provided under Hospice Care benefits and are subject to the conditions of service, limitations and provisions applicable to those benefits.

e. Speech therapy services are provided only following surgery for the correction of functional disorders, injury or non-congenital organic disease.

f. An authorization is required for all speech therapy benefits in excess of 24 visits in a Year. Benefits may not be payable starting with the 25th visit if authorization is not obtained **before** services are received as stated under **MEDICAL MANAGEMENT PROGRAMS**.

g. For the purpose of this benefit, the term “visit” includes any visit to a Physician who is a licensed medical doctor (M.D.) in the Physician’s office or anywhere else during which one or more speech therapy services covered by this benefit is received.

Refer to page 58 for Benefit Limitations, Exceptions and Exclusions related to this benefit.

Z. Well-Child Care (for Members under age 7)

1. Payment

100% PPO
60% non-PPO

2. Services

The Covered Expense for the following services is covered when rendered to a Member who is a dependent child under age 7:

a. Physician's services including radiology and laboratory services in connection with routine physical examinations are covered under this benefit. The definition of Preventive care services is added to reflect more information about services covered under this Plan as Preventive Care Services.

b. Immunizations for children in accordance with recommendations of the American Academy of Pediatrics.

MEDICAL EXCLUSIONS AND LIMITATIONS

The title of each exclusion is not intended to be fully descriptive of the exclusion; rather, it is provided solely to assist the Member to easily locate particular items of interest or concern. Additional exclusions or limitations which clarify a specific benefit are listed under that benefit. Remember, a particular condition may be affected by more than one exclusion. Benefits are subject to review for medical necessity before, during and/or after services have been rendered. Please refer to the provisions stated under MEDICAL NECESSITY and under MEDICAL MANAGEMENT PROGRAMS. Benefits of this Plan are not provided for or in connection with the following:

1. **After Coverage Ends.** Services received after the Member's coverage ends, except as specifically stated under **TERMINATION AND RELATED PROVISIONS.**

2. **Aids and Environmental Enhancements.** The rental or purchase of aids, including but not limited to ramps, elevators, stair lifts, swimming pools, spas, hot tubs, air filtering and conditioning systems, or car hand controls, whether or not their use or installation is for purposes of providing therapy or easy access.

3. **Amounts Over Maximums.** Any amounts in excess of the maximum amounts stated in the **PRUDENT BUYER PLAN BENEFIT MAXIMUMS, HEALTH PROMOTION PROGRAM,** and **OUTPATIENT PRESCRIPTION DRUG BENEFITS.**

4. **Before Coverage Begins.** Services received before the Member's Effective Date, or during a continuous period of hospitalization which began before the Member's Effective Date. However, in the case of a person covered under this Plan by reason of transfer from another CalPERS plan, the exclusion for hospitalization beginning prior to the Member's Effective Date shall apply only during the first 90 days of enrollment under this Plan unless the prior carrier provides coverage for the condition causing the Hospital confinement beyond the 90th day following the Member's Effective Date under this Plan.

5. **Caffeine Addiction.** Any expense incurred in connection with treatment for caffeine addiction.

6. **Chronic Conditions.** Chronic conditions not reasonably expected to improve with short-term, intensive symptom-focused treatment.

7. **Clinical Trials.** Services and supplies in connection with clinical trials.

8. **Commercial Weight Loss Programs**. Weight loss programs, whether or not they are pursued under medical or Physician supervision, unless specifically listed as covered in this plan. This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs. This exclusion does not apply to Medically Necessary treatments for morbid obesity or dietary evaluations and counseling, and behavioral modification programs for the treatment of anorexia nervosa or bulimia nervosa. Surgical treatment of morbid obesity will be covered as stated in **Bariatric Surgery** under **PRUDENT BUYER PLAN BENEFITS COVERED SERVICES AND SUPPLIES.**

9. **Cosmetic Services.** Cosmetic surgery and other services and supplies determined to be furnished primarily to improve appearance rather than physical function or control of organic disease. This exclusion does not apply to reconstructive surgery preformed to correct deformities caused by

congenital or developmental abnormalities illness, or injury for the purpose of improving bodily function or symptomatology or to create a normal appearance. Improvement of physical function does not include improvement of self-esteem, personal concept of body image, or relief of social, emotional or psychological distress. Procedures not covered include, but are not limited to: face lifts; liposuction; procedures for the treatment of sagging eyelids, prominent ears, skin scars and baldness; and correction of breast size, asymmetry or shape, except surgery performed to restore symmetry following mastectomy.

10. **Custodial Care or Rest Cures.** Custodial Care or domiciliary care or rest cures. Any services furnished by an institution which is primarily a place of rest, a place for the aged, a nursing home, or any institution of like character. Any services furnished by a Skilled Nursing Facility; a Home Health Care, or a Hospice Care Program, except as specifically stated under **PRUDENT BUYER PLAN BENEFITS-COVERED SERVICES AND SUPPLIES.**
11. **Dental Implants.** Dental Implants and any related services.
12. **Donor Search.** Any services and supplies for donor searches, related or unrelated, for organ or tissue transplants.
13. **Donor Sperm/Eggs.** Any services relating to donation of a Member's sperm/egg.
14. **Durable Medical Equipment.** The following are examples of items which are not covered under this benefit: dental braces and other orthodontic appliances; hearing aids (except as specifically stated under **Hearing Aid Services**); orthopedic shoes (except when joined to braces) or non-custom molded and cast shoe inserts; air conditioners, humidifiers, dehumidifiers or air purifiers, exercise equipment, or any other equipment not primarily medical in nature; and supplies for comfort, hygiene or beautification. Prosthetic, orthotic and durable medical equipment replacement and repair resulting from loss, misuse, abuse and/or accidental damage are not covered.
15. **Excess Amounts.** Any expense incurred in excess of Covered Expense.
16. **Experimental or Investigational**. Experimental or Investigational procedures.
17. **Facial Asymmetry.** Diagnosis or treatment (including surgery) to correct facial asymmetry including, but not limited to mandibular and maxillary procedures, unless Medically Necessary.
18. **Foot Care.** Procedures affecting the feet: callus or corn paring or excision, or toenail trimming. Any manipulative procedure for weak or fallen arches, flat or pronated foot, or foot strain.
19. **Fraud.** Any service provided in connection with an attempt to commit fraud, or a material misrepresentation of the facts.
20. **Free Services.** Services for which the Member is not legally obligated to pay. Services for which no charge is made to the Member. Services for which no charge is made to the Member in the absence of insurance coverage, except services received at a non-governmental charitable research Hospital. Such a Hospital must meet the following guidelines:
    a. It must be internationally known as being devoted mainly to medical research, and
    b. At least ten percent of its yearly budget must be spent on research not directly related to patient care, and
    c. At least one-third of its gross income must come from donations or grants other than gifts or payments for patient care, and

d. It must accept patients who are unable to pay, and

e. Two-thirds of its patients must have conditions directly related to the Hospital's research.

21. **Government Services.** Any services you actually received that were provided by a local, state or federal government agency, or by a public school system or school district, except when payment under this Plan is expressly required by federal or state law. The Plan will not cover payment for these services if the Member is not required to pay for them or they are given to the Member for free.

22. **Hearing Aids and Tests.** Furnishing or replacement of hearing aids and routine hearing tests, except as specifically stated under **Hearing Aid Services.**

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

24. **Hospital Admissions.** Inpatient room and board charges in connection with a Hospital Stay primarily for diagnostic tests which could have been performed safely on an outpatient basis.

25. **Infertility Treatment.** Any services or supplies furnished in connection with the diagnosis and treatment of Infertility, including but not limited to diagnostic tests, medication, surgery; artificial insemination, in-vitro fertilization, sterilization reversal, and gamete intrafallopian transfer, or any complications that result from such treatment.

26. **Learning Disorders, Retardation, Autism.** Learning disabilities, behavior problems, mental retardation or autistic disease of childhood, except as specifically stated under MENTAL DISORDERS AND CHEMICAL DEPENDENCY BENEFITS.

27. **Mental Disorders or Chemical Dependency.** Services primarily for conditions not attributable to chemical dependence, or to a mental disorder (V code) in the international Classification of Diseases, including but not limited to marital, parent-child, occupational, interpersonal and antisocial behavior problems or for uncomplicated bereavement, learning disabilities, behavior problems, mental retardation or autistic disease of childhood, except as specifically stated under **PRUDENT BUYER PLAN BENEFITS-COVERED SERVICES AND SUPPLIES.** Marriage and family counseling for the sole purpose of resolving conflicts between a subscriber and his or her family members. Personal development programs for or incident to vocational, educational, recreational, art, dance, music, reading therapy, or exercise programs (formal or informal).

    Psychiatric or psychological care:

    a. for treatment of personality disorders, sexual deviations and disorder, abuse of drugs, except as specifically stated under PRUDENT BUYER PLAN BENEFITS-COVERED SERVICES AND SUPPLIES, conduct disorders, mental retardation and developmental delays, conditions of abnormal behavior which are not directly attributed to a mental disorder which is the focus of attention or treatment, and attention deficit disorders;

    b. In connection with telephone consultations;

    c. for psychological testing or testing for intelligence or learning disabilities unless medically necessary to assess brain function suspected to be impaired due to trauma, or organic dysfunction;

d. during inpatient treatment for eating disorders unless the inpatient stay is necessary for the treatment of anorexia nervosa or bulimia nervosa;

e. for services on court order or as a condition of parole or probation unless the services are determined to be medically necessary and appropriate for the condition being treated and otherwise covered by the Plan; and for non-therapeutic treatment, custodial care and educational programs.

NOTE; Any dispute regarding a psychiatric condition will be resolved with reference to the American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), Fourth Edition, Washington, DC, American Psychiatric Association, 1994. Use of DSM-IV to resolve disputes is subject to change as new editions are published.

28. **Nicotine Addiction.** Services for smoking cessation or reduction, nicotine use or addiction, except as provided under HEALTH PROMOTION PROGRAM or under the section titled OUTPATIENT PRESCRIPTION DRUG BENEFITS.

29. **Non-Licensed Provider.** Treatment or services rendered by non-licensed health care providers and treatment or services for which the provider of services is not required to be licensed. This includes treatment or services from a non-licensed provider under the supervision of a licensed Physician, except as specifically provided or arranged by Anthem Blue Cross.

30. **Not Medically Necessary.** Services or supplies that are not Medically Necessary as defined in this Evidence of Coverage.

31. **Not Specifically Listed.** Services not specifically listed in this Plan as covered services.

32. **Orthodontic or Dental Care.** Braces, other orthodontic appliances or orthodontic services. Dental plates, bridges, crowns, caps or other dental prostheses, dental services, extraction of teeth or treatment to the teeth or gums, except as specifically stated under **Additional Services and Supplies** under **PRUDENT BUYER PLAN BENEFITS-COVERED SERVICES AND SUPPLIES.** Cosmetic dental surgery or other services for beautification.

33. **Outpatient Drugs.** Outpatient Drugs prescribed for self administration by the Member, except as specifically stated under OUTPATIENT PRESCRIPTION DRUG BENEFITS.

34. **Outpatient Speech Therapy.** Charges for speech therapy due to functional nervous disorders are not covered. No benefits are provided for:

    a. the correction of stammering, stuttering, lisping, tongue thrust;

    b. the correction of speech impediments caused by functional nervous disorders;

    c. the correction of developmental speech delays;

    d. functional maintenance using routine, repetitious, and/or reinforced procedures that are neither diagnostic nor therapeutic (e.g., practicing word drills for developmental articulation error);

    e. procedures that may be carried out effectively by the patient, family, or caregivers (e.g., maintenance therapy);

    f. inpatient charges in connection with a hospital stay solely for the purpose to receiving speech therapy.

Outpatient speech therapy, speech correction or speech pathology services are not covered except as provided in the Speech Therapy benefit description on page 53 .

35. **Pathological Gambling or Co-dependency.** Services for pathological gambling or co-dependency.
36. **Personal Comfort Items.** Personal comfort items, including cosmetics, dietary supplements, health or beauty aids.
37. **Personality Restructuring.** Personality restructuring, self-discovery, self-realization, pr psychoanalysis.
38. **Private Contracts.** Services or supplies provided pursuant to a private contract between the Member and a provider, for which reimbursement under the Medicare program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act.
39. **Professional Interpretation of Laboratory Services.** Any expense incurred for professional interpretation of laboratory services. This exclusion does not apply to pathology services.
40. **Property or Vehicle Modification.** Any modification made to dwellings, property or motor vehicles, whether or not their use or installation is for purposes of providing therapy or easy access.
41. **Rehabilitative Care.** Inpatient charges in connection with a Hospital Stay primarily for environmental change, physical therapy or treatment of chronic pain.
42. **Relatives**. Professional services received from a person who ordinarily resides in the Member's home or who is related to the Member by blood or marriage.
43. **Routine Exams and Tests.** Routine physical exams or tests which do not directly treat an actual illness, injury or condition, including those required by employment or governmental authority, except as specifically stated under Well Child Care (for Members under age 7) and Routine Physical Exam (for Members age 7 and over) under **PRUDENT BUYER PLAN BENEFITS-COVERED SERVICES AND SUPPLIES.**
44. **Gender Reassignment.** Procedures or treatments to change characteristics of the body to those of the opposite sex.
45. **Surgical Modification of Jaws.** Services incident to vestibuloplasty (surgical modification of the jaws, gums and adjacent tissues) unless related to or in connection with bone disease, or unless necessary for the repair or alleviation of bodily damage caused solely by Accidental Injury sustained while covered under this Plan.
46. **Surrogate Mother Services.** For any services or supplies provided to a person not covered under the plan in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).
47. **Trainee Services.** Services performed in a Hospital by house officers, residents, interns and others in training.
48. **Vision Services or Supplies.** Eye exercises, including orthoptics or vision training. Any eye surgery solely for the purpose of correcting refractive defects of the eye such as near-sightedness (myopia) and astigmatism. Optometric services, dispensing optician's services, eyeglasses, contact lenses, routine eye examinations for the fitting of glasses.
49. **War or Nuclear Energy.** Conditions caused by an act of war. Conditions caused by the release of nuclear energy, whether or not the result of war, when government funds are available for treatment of illness or injury arising from such release of nuclear energy.

50. **Waived Cost-Shares Non-Participating Provider.** For any service for which you are responsible under the terms of this *plan* to pay a co-payment or deductible, and the co-payment or deductible is waived by a Non-Participating Provider.
51. **Work-Related.** Work-related conditions if benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation, employer's liability law or occupational disease law even if the Member does not claim those benefits.

HEALTH PROMOTION PROGRAMS

INTRODUCTION

With the objective of encouraging CAHP members to maximize their commitment and efforts to establish and maintain healthy lifestyles, the CAHP Health Benefits Trust (the Trust) provides a Health Promotion Program.

This Health Promotion Program includes reimbursement for approved smoking cessation programs (including prescription nicotine patches, Chantix or Zyban) and/or weight management programs. Benefits are provided in accordance with Anthem Blue Cross' health promotion policies. Claims are administered by Anthem Blue Cross on behalf of the Trust.

SMOKING CESSATION PROGRAM

Behavior modification programs utilize methods to identify your smoking habit and to modify behavior to successfully quit smoking. Behavior modification **does not** consist of hypnosis, shock therapy, acupressure, acupuncture or other similar methods to alter behavior.

1. **Benefit Reimbursement**

   The Plan will provide 100% reimbursement for an approved behavior modification smoking cessation program.

2. **Approved Programs**

   Benefits are provided when verification of completion of one of the following approved programs is submitted to Anthem Blue Cross:

   a. American Lung Association - "Freedom From Smoking." Call 1-800-586-4872 or your local lung association office or visit the Web site at **www.lungusa.org** for information.

   b. Medical clinic or Hospital-based programs. Consult your family Physician or local community Hospital for information.

SMOKING CESSATION PRODUCTS

Many individuals find the use of nicotine replacement therapies helpful with their attempt to combat nicotine addiction. However, the use of most of these products has only been shown to be successful when used in conjunction with a smoking cessation program which works with individuals to understand their smoking habits. The combination of a nicotine patch or a prescription medication such as Zyban or Chantix, to help alleviate withdrawal symptoms, with a smoking cessation program, to assist with the behavioral aspect of the smoking habit, and the desire to quit generally leads to success.

Benefit Reimbursement

When you successfully complete one of the approved smoking cessation programs specified in this Evidence of Coverage and submit a Certificate of Completion, the Plan will provide 50% of the total cost of a 90-day supply of nicotine patches or a 90-day supply of the prescription medication Zyban or a 90-day supply of the prescription medication Chantix per Member.

WEIGHT MANAGEMENT PROGRAM

1. **Benefit Reimbursement**

   The Plan will provide 80% reimbursement up to $125 payment per Member per lifetime for an approved weight management program.

2. **Approved Programs**

   Benefits are provided when verification of completion of one of the following approved programs is submitted to Anthem Blue Cross:

   a. Weight Watchers - Call 1-800-651-6000 or your local Weight Watchers Center or visit the Web site at www.weightwatchers.com for information.

   b. Medical clinic or Hospital-based programs. Consult your family Physician or local community Hospital for information.

HOW TO FILE A CLAIM

To qualify for reimbursement, you must complete the following steps:

1. Enroll in an approved smoking cessation and/or weight management program as specified in this Evidence of Coverage. Retain your payment receipts for claims reimbursement.
2. Request a CAHP Health Promotion Program Reimbursement Form and a Certificate of Completion from Anthem Blue Cross at 1-800-759-5758.
3. Obtain instructor's signature on the Certificate of Completion, verifying that you have completed the program, attended every session and, for the smoking cessation program, that you are smoke free at the time of the program's completion.
4. Mail a copy of the signed Certificate of Completion and Reimbursement Form with your receipts to:

   Anthem Blue Cross
   Attn: CAHP Unit
   11030 White Rock Road
   Rancho Cordova, CA 95670

5. To qualify for reimbursement of covered smoking cessation products, submit the pharmacy receipt, Certificate of Completion for one of the approved smoking cessation programs specified in this Evidence of Coverage, your receipt for the program cost and a completed Reimbursement Form to Anthem Blue Cross at the address listed under 4. above.
6. You must submit your Reimbursement Form and all required information for the smoking cessation program, covered smoking cessation products and/or the weight management program to Anthem Blue Cross **within 90 days** of the program completion. If it is not reasonably possible to submit the claims within that timeframe, an extension of up to 12 months will be allowed.

EXCLUSIONS AND LIMITATIONS

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

1. Reimbursement of Covered Expense in excess of the maximum amounts stated in this Evidence of Coverage.

NOTE: Member co-payments and charges in excess of maximum Plan benefits are not included in the **OUT-OF-POCKET EXPENSE MAXIMUM** calculations under **PRUDENT BUYER PLAN BENEFITS.**

2. Services not specifically listed in this Evidence of Coverage as covered services. This includes any smoking cessation and/or weight management program not specifically listed as an approved program, and any smoking cessation products other than the nicotine patch, Chantix or Zyban.
3. Reimbursement of Covered Expense without verification of completion of an approved smoking cessation and/or weight management program.
4. Benefits of this Plan may be modified or eliminated upon subsequent years' renewals. There is no vested right to receive the benefits of this Plan.
5. Food, dietary supplements, health or beauty aids.

SELF-CARE TOOLS

WebMD

Anthem Blue Cross offers online access to health-related resources and information to assist you in making informed health care decisions. Members can access this information on the Anthem Blue Cross Web site at www.anthem.com/ca; access your personal information and then click on *WebMD*.

Anthem Blue Cross has joined with WebMD to offer our members a web-based tool that will help them achieve their health goals.

WebMD allows you to:

- Identify and understand personal health risks.
- Receive reliable health information and news tailored to your needs.
- Communicate more effectively with doctors.
- Manage your specific conditions or concerns.
- Stay on track with preventive screenings.
- Improve your lifestyle, including fitness, nutrition and stress.
- Keep family health records in one secure place.

Express Scripts

Health topics, including information on specific diseases and conditions, as well as prescription drug information, can be located on the Express Scripts Web site www.espress-scripts.com. Under the Health and Wellness section, Member's can do further research by selecting:

Health Toolbox allows you to assess, track and plan your medication and health activities.

The **Drug Information** section allows you to research specific drug information.

Health News shares updated information specific conditions and product alerts.

The **Diseases and Conditions** section provider's health topics for specific medical conditions

OUTPATIENT PRESCRIPTION DRUG BENEFITS

Benefits for Prescription Drugs are determined by the type of pharmaceutical provider the Member chooses and the type of Drug provided. A Member can choose to have his or her Prescription filled by Participating Retail Pharmacies, Non-Participating Retail Pharmacies, or through the mail order program. The Member can also choose between Generic Drugs, Single Source Brand Drugs (Brand Name Drugs with no Generic Drug equivalent), or Multi-Source Brand Drugs (Brand Name Drugs with a Generic Drug equivalent). However, the amount the Member will pay for his or her Prescription is affected by these choices.

Although Generic Drugs are not mandatory, the Trust encourages you to purchase generics whenever possible in order to save valuable claims dollars that will help keep the cost of providing benefits for outpatient Prescription Drugs affordable. By law, Generic Drugs meet the same federal standards of purity, effectiveness, strength, and safety as their Brand Name equivalents. Utilizing Generic Drugs helps to manage the increasing cost of health care without compromising the quality of your pharmaceutical care.

RETAIL PHARMACY BENEFITS

Co-Payments

1. The Member is responsible for a **$5** co-payment for the initial Generic Drug and first refill. After the second prescription drug fill, the Member is responsible for a **$10** co-payment.
2. The Member is responsible for a **$20** co-payment for the initial Single-Source Brand Drug and first refill. After the second prescription drug fill, the Member is responsible for a **$40** co-payment.
3. The Member is responsible for a **$25** co-payment for the initial Multi-Source Brand Drug and first refill, plus the difference in cost between the Brand Name Drug and its Generic equivalent.
4. After the second prescription drug fill for Multi-Source Brand Drugs, the Member is responsible for a **$50** co-payment, plus the difference in cost between the Brand Name Drug and its Generic equivalent.
5. The Member will receive up to a 30-day supply of medication per applicable co-payment as specified in A., B. and C. above.

   NOTE: Prescription Drugs subject to the increased co-payment amount after the second prescription drug fill are for medications taken on a long-term basis (3 months or more).

Reimbursement

1. When the Member has a Prescription filled at a Participating Retail Pharmacy, the Member pays only the applicable co-payment amount as specified above under **Co-Payments.**
2. When the Member has a Prescription filled at a Non-Participating Retail Pharmacy, the Member will be reimbursed the amount the drug would have cost at a Participating Retail Pharmacy minus the applicable co-payment as specified above under **Co-Payments**.
3. When the Member has a Compound Prescription filled at a Non-Participating Retail Pharmacy and covered by the plan, the Member will be reimbursed based on the covered Prescription ingredient for a Participating Pharmacy minus the applicable co-payment as specified above under **Co-Payments**.

When You Use a Participating Pharmacy

Approximately 55,000 Participating Retail Pharmacies are located within the United States. The Member may contact Express Scripts Member Services at 1–800-711-0917 or access online at **www.express-scripts.com** for assistance in locating a Participating Retail Pharmacy.

When the Member presents his or her CAHP Health Benefits Trust identification card to a Participating Retail Pharmacy, the Member will pay only the applicable co-payment amount as specified under **RETAIL PHARMACY BENEFITS Co-Payments** for each covered Prescription and each refill.

Generic Drugs will be dispensed by Participating Retail Pharmacies when the Prescription indicates a Generic Drug. When a Brand Name Drug is specified, but a Generic Drug equivalent exists, the Generic Drug will be substituted unless the Member or Physician specifically requests a Brand Name Drug to be dispensed. Brand Name Drugs will be dispensed by Participating Retail Pharmacies when the Prescription specifies a Brand Name and states "dispense as written" or no Generic Drug equivalent exists.

When You Use a Non-Participating Retail Pharmacy

When the Member goes to a Non-Participating Retail Pharmacy, the Member must pay the full cost of the Drug and submit a claim to the address below:

Express Scripts
ATTN: Commercial Claims
PO Box 14711
Lexington, KY 40512800-711-0917

Non-Participating Retail Pharmacies have not agreed to the Prescription Drug Negotiated Rate. The amount that will be covered as Prescription Drug Covered Expense is significantly lower than what these providers customarily charge.

Claim forms and customer service are available by calling 1-800-711-0917 or by accessing online at **www.express-scripts.com**. The Member must mail the claim form to **Express Scripts within 90 days** of the date of purchase. If it is not reasonably possible to submit the claim within that timeframe, an extension of up to nine months will be allowed. The Member will be reimbursed according to the procedures described under the provision entitled **Reimbursement** on the previous page.

Note: Coordination of Benefits provisions do not apply to the Outpatient Prescription Drug Program.

MAIL ORDER PROGRAM

Co-Payments

1. The Member is responsible for a **$10** co-payment for each Generic Drug or refill ordered through the mail order program.
2. The Member is responsible for a **$40** co-payment for each Single Source Brand Drug or refill ordered through the mail order program.
3. The Member is responsible for a **$50** co-payment for each Multi-Source Brand Drug plus the difference in cost between the Brand Name Drug and its Generic equivalent for each Multi-Source Brand Drug or refill ordered through the mail order program.
4. The Member will receive **up to** a 90-day supply of medication per applicable co-payment as specified in A., B. and C. above.

Out-of-Pocket Maximum

Out of Pocket limit is the maximum dollar amount for which an individual or a family unit is responsible during a defined period of time. The co-pay amounts associated with each claim are accumulated and when these amounts exceed the specified out of pocket limit, all subsequent claims will be reimbursed at 100% with no co-pay taken. Your maximum calendar year copayment is $5,150.00 for individual or $10,300.00 per family.

Prescription costs that do not apply towards the Out-Of-Pocket Maximum

1. If the member selects a brand name drug when a generic was available and medically appropriate the cost difference between the brand and generic drug will not be applied towards the out-of-pocket maximum.
2. Non-covered items will not apply towards the out-of-pocket maximum.

When You Use the Mail Order Program

For any Prescription Drugs ordered through the mail order program (not all Drugs are available through the mail order program), the Member will pay only the applicable co-payment amount. Mail order Prescriptions can be filled for **up to** a 90-day supply. The Prescription must state the dosage, the patient's name and address and be signed by a Physician. The Member must submit the Prescription with the copayment amount and a properly completed order form. Order forms can be obtained by contacting Express Scripts Member Services at 1-800-711-0917 or by accessing online at **www.express-scripts.com**.

Generic Drugs will be dispensed through the mail order program when the Prescription indicates a Generic Drug. When a Brand Name Drug is specified, but a Generic Drug equivalent exists, the Generic Drug may be substituted with approval from your Physician.

PREVENTIVE PRESCRIPTION DRUGS AND OTHER ITEMS

Co-Payments

- The Member will not be required to pay for services provided under this benefit.

Your prescription drug benefit include certain preventive Drugs, medications, and other items as listed below that may be covered under this Plan as Preventive Care Services. In order to be covered as a Preventive Care Services, these items must be prescribed by a Physician and obtained from Participating Retail Pharmacy or through the mail order programs. This includes items that can be obtained over the counter for which a Physician's prescription is not required by law.

1. All FDA-approved contraceptives for women, including oral contraceptives, diaphragms, patches and over-the-counter contraceptives. In order to be covered as a Preventive Care Service, in addition to the requirements state above, in general contraceptive prescription Drugs must be Generic Drugs or Single Source Brand Drugs. *If an individual's attending provider recommends a particular service or FDA-approved item based on a determination of medical necessity with respect to that individual, the service or item is covered without cost sharing.
2. Vaccinations prescribed by a Physician and obtained from a Participating Pharmacy
3. Prescription Drugs to eliminate or reduce dependency on, or addiction to, tobacco and tobacco products.
4. Tobacco cessation drugs, medications, and other items for members age 18 an older as recommended by the United States Preventive Services Task Force including:

- Prescription drugs to eliminate or reduce dependency on, or addiction to, tobacco and tobacco products.
- FDA-approved smoking cessation products including over-the-counter (OTC) nicotine gum, lozenges and patches when obtained with a Physician's prescription and you are at least 18 year old.

Prescription Drugs and OTC items are limited to a no more than 180 day supply per year.

5. Aspirin to reduce the risk of heart attack or stroke, for men ages 45-79 and women ages 55-79.
6. Aspirin after 12 weeks of gestation in pregnant women who are at high risk for preeclampsia.
7. Folic acid supplementation for women age 55 years and younger (folic acid supplement or a multivitamin).
8. Vitamin D for women over age 65.
9. Medications for risk reduction of primary breast cancer in women (such as tamoxifen or raloxifene) for women who are at increased risk for breast cancer and at low risk for adverse medication effects.
10. Bowel preparations when prescribed for a preventive colon screening.
11. Iron supplements for children from birth through 12 months old.
12. Fluoride supplements for children from birth through 6 years old (drops or tablets).
13. Dental fluoride varnish to prevent tooth decay of primary teeth for children from birth to 5 years old.

DETERMINATION OF COVERED EXPENSE

Covered Expense for Prescription Drugs is determined as follows. Expense is incurred on the date the Member receives the service or supply for which the charge is made.

1. For Prescription Drugs dispensed by a Participating Retail Pharmacy, the amount Express Scripts considers Covered Expense is the Prescription Drug Negotiated Rate.

2. For Prescription Drugs dispensed by a Non-Participating Retail Pharmacy, the amount Express Scripts considers Covered Expense is derived as defined in A. above. The Member is responsible for any amount exceeding the schedule.

PRESCRIPTION DRUG CONDITIONS OF SERVICE

To be covered, the Drug or medication must satisfy **all** of the following requirements:

1. It must be prescribed by a Physician and be dispensed within one year of being prescribed, subject to federal and state laws.

2. It must be approved for general use by the State of California Department of Health Services or the Food and Drug Administration.

3. It must be for the direct care and treatment of the Member's illness, injury or condition.

4. It must be dispensed from a licensed retail Pharmacy, a Home Health Agency or through the mail order program.

5. It must not be used while the Member is an inpatient in any facility. Also, it must not be dispensed or administered in an outpatient facility.

6. For a retail Pharmacy, the Prescription must not exceed a 30-day supply.
7. For the mail order program, the Prescription must not exceed a 90-day supply.
8. Drugs for the treatment of impotence and/or sexual dysfunction are limited to eight tablets/units for a 30-day period at retail or 24 tablets/unit for a 90-day period at mail order.
9. The pharmacy data system will track for 180 days usage: refills can be obtained when 75% of the drug has been used.

PRESCRIPTION DRUGS AND CHANGES TO THE FORMULARY

The Plan includes a list of preferred drugs that are either more effective at treating a particular condition than other drugs in the same class of drugs, or as effective as and less costly than similar medications. Non-preferred drugs may also be covered under the prescription drug program, but as a higher cost-sharing tier. Collectively, these lists of drugs make up the Plan's Formulary. The Plan's Formulary is updated periodically and subject to change, so to get the most up-to-date list go online to **www.express-scripts.com**. Drugs that are excluded from the Plan's Formulary are not covered under the Plan unless approved in advance through a Formulary exception process managed by Express Scripts on the basis that the drug requested is (1) medically necessary and essential to the Covered Person's health and safety and/or (2) all Formulary drugs comparable to the excluded drug have been tried by the Covered Person. If approved through that process, the applicable Formulary co-pay would apply for the approved drug based on the Plan's cost share structure. Absent such approval, Covered Persons selecting drug excluded from the Formulary will be required to pay the full cost of the drug without any reimbursement under the Plan. If the Covered Person's Physician believes that an excluded drug meets the requirements described above, the Physician should take the necessary steps to initiate a Formulary exception review.

The Formulary will continue to change from time to time. For example:

- A drug may be moved to a higher or lower cost-sharing Formulary tier.
- Additional drugs may be excluded from the Formulary.
- A restriction may be added on coverage for a Formulary-covered drug (e.g. prior authorization).
- A formulary-covered brand name drug may be replaced with a Formulary-covered generic drug.

Please be sure to check before the drug is purchased to make sure it is covered on the Formulary, as you may not have received notice that a drug has been removed from the Formulary. Certain drugs even if covered on the Formulary will require prior authorization in advance of receiving the drug. Other Formulary-covered drugs may not be covered under the Plan unless an established protocol is followed first; this is known as Step-Therapy. As with all aspects of the Formulary, these requirements may also change from time to time.

PRESCRIPTION DRUG SERVICES AND SUPPLIES THAT ARE COVERED

1. Outpatient Drugs and medications which the law restricts to sale by Prescription.
2. Insulin, Insulin Needles and Syringes; and niacin for lowering cholesterol.
3. Injectable Drugs which are self-administered by the subcutaneous route (under the skin) by the patient or family member (except immunizing agents and allergy serum).
4. Compound Prescription Drugs in which all ingredients are covered under the plan.

5. Prescription Drugs for the treatment of impotence and/or sexual dysfunction are limited to organic (non-psychological) causes.

PRESCRIPTION DRUG SERVICES AND SUPPLIES THAT ARE NOT COVERED

In addition to the items listed in this Evidence of Coverage under **PRUDENT BUYER PLAN EXCLUSIONS AND LIMITATIONS** and **GENERAL EXCLUSIONS AND LIMITATIONS,** Prescription Drug benefits are **not** provided for or in connection with the following:

1. Immunizing agents, allergy desensitization products or allergy serum, biological sera, blood, blood products or blood plasma.*
2. Hypodermic syringes and/or needles.*
3. Contraceptive medications, materials or devices, except as covered under the provision PREVENTIVE PRESCRIPTION DRUGS AND OTHER ITEMS.
4. While not covered under this prescription drug benefit, contraceptive devices are covered as specified under the **Routine Preventive Care Services** provision of **PRUDENT BUYER PLAN BENEFITS - COVERED SERVICES AND SUPPLIES** on page 51, subject to all terms of this plan that apply to those benefits.
5. Drugs and medications dispensed or administered in an outpatient facility, including, but not limited to, outpatient Hospital facilities and Physicians' offices.*
6. Drugs and medications dispensed by or while the Member is confined in a Hospital or Skilled Nursing Facility, rest home, sanatorium, convalescent hospital or similar facility.*
7. Professional charges in connection with administering, injecting or dispensing of Drugs.*
8. A Non-Prescription patent or proprietary medicine or medication not requiring a Prescription, except insulin or niacin for cholesterol reduction.

   Note: Vitamins, supplements, and certain over-the-counter items as specified under the provision PREVENTIVE PRESCRIPTION DRUGS AND OTHER ITEMS are covered under this Plan only when obtained with a Physician's Prescription, subject to all terms of this Plan that apply to those benefits.
9. Durable medical equipment, devices, appliances and supplies, even if prescribed by a Physician.*
10. Services or supplies for which the Member is not charged.
11. Oxygen.*
12. Cosmetics, dietary supplements and health or beauty aids.
13. Any Drug labeled "Caution, Limited By Federal Law to Investigational Use" or non-FDA approved Investigational Drugs. Any Drug or medication prescribed for experimental indications.
14. Any expense for a Drug or medication incurred in excess of the Prescription Drug Negotiated Rate for Drugs dispensed by Non-Participating Retail Pharmacies, Participating Retail Pharmacies or through the mail order program.
15. Non-medicinal substances or items (for example, dextroamphetamine for weight loss).
16. Drugs used primarily for cosmetic purposes (for example, Retin-A for wrinkles).
17. Any Drug which has not been approved for general use by the State of California Department of Health Services or the Food and Drug Administration.

18. Drugs and medications prescribed for the treatment of male or female infertility (including, but not limited, to Clomid, Pergonal and Metrodin).

19. Anorexiants (for example, diet pills and appetite suppressants).

20. Drugs obtained outside of the United States, unless such Drugs would be covered under this section if obtained within the United States.

21. Infusion Drugs, except Drugs that are self-administered subcutaneously.*

22. Any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after one year from the date of the physician's prescription.

23. Any drugs prescribed solely for the treatment of an illness, injury or condition that is excluded under the Plan.

24. Any charges for special handling and/or shipping cost incurred through a Participating Retail Pharmacy, a Non-Participating Retail Pharmacy, or through the mail order program.

25. Any quantity of dispensed medications that are deemed inappropriate as determined through Express Scripts utilization review.

26. Compound medications which have been deemed inappropriate for use and have commercially available FDA approved alternatives are excluded. Typically, these will be compounds used for pain management, inflammation and scarring.

NOTE: Items marked by an asterisk (*) are covered as stated under **PRUDENT BUYER PLAN BENEFITS - COVERED SERVICES AND SUPPLIES.**

PRESCRIPTION DRUG PROGRAM UTILIZATION REVIEW, PRIOR AUTHORIZATION AND STEP THERAPY PROGRAMS

These Prescription Drug benefits include utilization review of Prescription Drug usage for the Member's health and safety. Certain Drugs may require prior authorization (e.g. Multiple Scelrosis, Rheumatoid Arthritis and Cancer Therapy, etc.). Certain drugs may also require Step Therapy (Migraine Agents, Sleep Agents and Topical Acne therapy, etc.) to promote use of generics and preferred brand name therapies. A Participating Retail Pharmacy will advise you if the prescribed Drug requires prior authorization or step therapy and then will initiate the review on your behalf or in the case of step therapy provide names of preferred agents. In most cases, the review will be processed within 72 hours.

SPECIALTY PHARMACY SERVICE

The specialty pharmacy service is designed to help Member's meet the particular needs and challenges of using certain medications, many of which require injection or special handling. These medications are taken to treat conditions such as anemia/neutropenia, cancer, cystic fibrosis, deep vein thrombosis, Gaucher's disease, erectile dysfunction, growth hormone deficiency, hepatitis C, immune deficiency, multiple sclerosis (MS), osteoarthritis, rheumatoid arthritis, and respiratory syncytial virus (RSV).

The Specialty Pharmacy Service includes:

- Support from Express Scripts nurses and pharmacist who are trained in specialty medications, their side effects and the conditions they treat.
- Expedited delivery to your home or your doctor's office of all your specialty prescription medications.

- Some supplemental supplies, such as needles and syringes, required to administer the medications will be included at no additional charge.
- Scheduling of refills and coordination of services with home care providers, case managers, and doctors or other healthcare professionals.

Additional information regarding the Specialty Pharmacy Service can be obtained by calling **1-800-803-2523** or accessing online at **www.express-scripts.com**.

SERVICES COVERED BY OTHER BENEFITS

When expense incurred for a service or supply is covered under another benefit section of this Plan, that expense is not included as Covered Expense under this **OUTPATIENT PRESCRIPTION DRUG BENEFITS** section of this Evidence of Coverage.

PRESCRIPTION DRUG REVIEW PROCESS

You may request a second level of appeal for each medication denied through Coverage Management Programs within one-hundred eighty (180) days from the postmark date of initial Benefit Denial sent by Express Scripts. Appeals should be directed to:

Express Scripts
PO Box 66588
St. Louis, MO 63166-6587
Attn: Clinical Appeals Department

FLU AND SHINGLES VACCINATIONS

The flu and shingles*vaccinations are available to you at a participating retail pharmacies. To locate a participating pharmacy,

- Sign in at Express-Scripts.com and click **Locate a Pharmacy** to search for in-network pharmacies convenient for you.
- Call the number on your Express Scripts member ID card to find a participating pharmacy near you.

Vaccines administered at your retail pharmacy typically do not require an appointment and are the same effective medications as your physician's office.

*Note: The Shingles vaccination is covered for individuals age 50 and over.

Contact your network pharmacy in advance to inquire about vaccine availability, age restrictions, and current vaccination schedules. Also, don't forget to present your member ID card to the pharmacist.

CREDITABLE COVERAGE

MEDICARE PART D

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) added a new prescription drug program (known as Part D).

The word "Member" is a term used for "Person Enrolled in Medicare", which could mean the (retired) employee or a dependent of an active or retired employee.

Members with Medicare coverage can enroll in Part D. However, the CAHP Health Benefits Trust is recommending that Members do **not** enroll in Part D because the Trust prescription drug coverage is as good as – or better than – the coverage that will be available under Part D.

Important Legislation

AB 587 was signed by the Governor on October 5, 2005 (Stats.2005, Ch 527, §1), which states CalPERS Medicare-eligible members who enroll in Medicare Part D other than a CalPERS Board-approved Medicare Advantage Prescription Drug Plan may not be enrolled in a CalPERS health plan. Therefore by enrolling in Part D, you may jeopardize your CalPERS health coverage.

Enrolling in Part D

Member's that are considered low income with limited resources may want to enroll in Part D. Extra help paying for Part D is available for people with limited income and resources. Information about this extra help is available from the Social Security Administration (SSA) online at **www.socialsecurity.gov**, or call **1-800-772-1213** (TTY 1-800-325-0778).

More detailed information about Part D is also available by:

• Reviewing the "Medicare & You" handbook, which is available from Medicare,

• Visiting **www.medicare.gov**,

• Calling your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number) and/or

• Calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Before enrolling in Part D, you should compare your current coverage, including which drugs are covered, with the coverage and cost of Part D. Remember, the Trust Plan pays for other health expenses (i.e. office visits, hospital charges), in addition to your prescription drugs.

Lose and/or Drop Coverage

If you are eligible for Medicare and do not enroll in Part D (upon entitlement) and you drop or lose your CalPERS Health Benefits coverage, you must enroll in Part D within 63 days. If you don't enroll in Part D within 63 days or longer without proof of *Creditable Coverage,* your monthly premium will go up at least 1% per month for every month after you were eligible for Part D. For example, if you go 19 months without *Creditable Coverage*, your premium always will be at least 19% higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare Part D coverage. In addition, you may have to wait until next November to enroll.

A copy of "Notice of Creditable Coverage" is available by calling the Trust at **1-800-734-2247** or visiting the website at www.thecahp.org**.**

GENERAL EXCLUSIONS AND LIMITATIONS

THIRD PARTY LIABILITY

Under some circumstances a Member may need services under this Plan for which a third party may be liable or legally responsible by reason of negligence, an intentional act or breach of any legal obligation. In that event, the benefits of this Plan will be provided subject to the following:

1. The Trust shall automatically have a lien, to the extent of benefits advanced, upon any recovery, whether by settlement, judgment or otherwise, that the Member receives from the third party, the third party's insurer or the third party's guarantor or any insurer. The lien shall be in the amount of benefits paid by the Trust under this Plan for the treatment of the illness, disease, injury or condition for which the third party is liable, but not more than the amount allowed by California Civil Code Section 3040. Also see Government Code section 22945 et. Seq.
2. **The Member agrees to advise Anthem Blue Cross, in writing, within 60 days of his or her filing a claim against the third party and to take such action, furnish such information and assistance, and execute such papers as Anthem Blue Cross may require to facilitate enforcement of the Trust's rights. The Member also agrees to make no action which may prejudice the rights or interests of the Trust under this Plan.**
   Failure of the Member to give such notice to Anthem Blue Cross, or cooperate with Anthem Blue Cross, or actions of the Member that prejudice the rights or interests of the Trust shall be a material breach of the Member's obligations hereunder and shall result in the Member being <u>personally responsible</u> for reimbursing the Trust.
3. The Trust shall be entitled to collect on its lien even if the amount the Member or any person recovered for the Member (or the Member's estate, parent or legal guardian) from or for the account of such third party as compensation for the injury, illness or condition is less than the actual loss the Member suffered. This would also include, but is not limited to any monies recovered by means of an uninsured or under insured motorist policy.
4. The Plan's right to recover shall apply regardless of whether the Member is made whole.

WORKERS' COMPENSATION INSURANCE

This Plan is not in lieu of and does not affect any requirement of coverage by workers' compensation insurance.

If, pursuant to any workers' compensation or employers' liability law or other legislation of similar purpose or import, a third party is responsible for all or part of the cost of health services provided by the Trust, and such third party disputes that responsibility, the Trust shall provide the benefits of this Plan and the Trust shall automatically acquire thereby, by operation of law, a lien to the extent of the reasonable value of the services provided by the Trust.

It is the Member's responsibility to notify Anthem Blue Cross when the Member or a Family Member has filed a claim for workers' compensation insurance by calling Anthem Blue Cross at 1-800-759-5758.

The Trust shall provide the benefits of this Plan **<u>only</u>** on condition that the Member shall agree in writing to provide the Trust with a lien to the extent of the reasonable value of the services provided by the Trust.

The Member agrees to take no action that may prejudice the Trust's right under such lien. The lien may be filed with the responsible third party, his or her agent, or the court and the Trust may exercise all other rights available to it as a lienholder. For purposes of this subsection, reasonable value shall be determined to be the Customary or Reasonable Charge for services in the geographic area where the services are rendered.

IMPORTANT NOTE:

In those cases where the Member or Family Member has filed a claim with his or her employer, with State Compensation Insurance Fund, or filed an Application for Adjudication of Claim with the Workers' Compensation Appeals Board, and there is an adjudication and/or settlement of the claim under circumstance in which the work-related nature of the illness or injury is accepted, the Trust shall not provide any further benefits or services for the condition or illness which gave rise to the Member's or Family Member's workers' compensation claim unless the illness or injury is later disputed by the State Compensation Insurance Fund, the Workers' Compensation Appeals Board or the employer.

BENEFITS FOR MEMBERS ENROLLED IN MEDICARE

When Medicare is the primary payer for a Member, Covered Expense for covered services is determined as stated in **DETERMINATION OF COVERED EXPENSE** under **PRUDENT BUYER PLAN BENEFITS.**

The Member's benefits will be reduced so that the benefits that the Member receives in a Year under this Plan and from Medicare Parts A (hospital insurance) and B (medical insurance) do not exceed 100 percent of the Covered Expense.

Please refer to the **ENROLLMENT PROVISIONS** section of this Evidence of Coverage for Medicare eligibility requirements; refer to page 79.

COORDINATION OF BENEFITS

If a Member is covered under one or more other plans, the benefits of this Plan will be coordinated with the benefits payable by such other plans in accordance with the following provisions:

1. **Definitions**

   a. **Allowable Expense** is any necessary, reasonable and customary item of expense which is at least partially covered by any plan covering the person for whom a claim is made. When a plan provides benefits in the form of services rather than cash reimbursement for services, the reasonable cash value of each service rendered shall be deemed to be both an Allowable Expense and a benefit paid. An expense that is not covered by any plan covering the person for whom a claim is made is not Allowable Expense.

      The following are not Allowable Expense:

      - Use of a private hospital room is not an Allowable Expense unless the patient's stay in a private hospital room is Medically Necessary in terms of generally accepted medical practice, or one of the plans routinely provides coverage for hospital private rooms.
      - If you are covered by two plans that calculate benefits or services on the basis of a reasonable and customary amount or relative value schedule reimbursement method or some other similar reimbursement method, any amount in excess of the higher of the reasonable and customary amounts.

- If a person is covered by two plans that provide benefits or services on the basis of negotiated rates or fees, an amount in excess of the lower of the negotiated rates.
- If a person is covered by one plan that calculates its benefits or services on the basis of a reasonable and customary amount or relative value schedule reimbursement method or some other similar reimbursement method and another plan provides its benefits or services on the basis of negotiated rates or fees, any amount in excess of the negotiated rate.
- The amount of any benefit reduction by the Principal Plan because you did not comply with the plan's provisions is not an Allowable Expense. Examples of these types of provisions include second surgical opinions, utilization review requirements, and network provider arrangements.
- If you advise us that all plans covering you are high deductible health plans as defined by Section 223 of the Internal Revenue Code, and you intend to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code, any amount that is subject to the primary high deductible health plan's deductible.

b. This **Plan** means the CAHP Health Benefits Trust Prudent Buyer Plan.

c. The **other plan** means any plan providing benefits or services for or by reason of Hospital or medical care or treatment, which benefits or services are provided by any group, group service, group practice or any other prepayment coverage on a group basis or any coverage under labor management trustee plans, or group coverage sponsored by or provided through a school or educational institution, or Medicare.

d. **Primary Carrier** means a plan which, according to the Order of Benefit Determination provisions (below), has primary responsibility for the provision of benefits.

e. **Secondary Carrier** means a plan which, according to the Order of Benefit Determination provisions (below), has secondary responsibility for the provision of benefits after the Primary Carrier determines its benefits.

2. Order of Benefit Determination

The rules for establishing the Order of Benefit Determination are:

(1) A plan which has no coordination of benefits provision pays before a plan which has a coordination of benefits provision.

(2) A plan which covers the Member as other than a dependent shall have primary responsibility for the provision of benefits before a plan which covers the Member as a dependent. However, if the Member is an Annuitant and eligible for Medicare, Medicare pays (a) after the plan covering the Member as a dependent of an active employee, but (b) before the plan covering the Member as a Subscriber, than the plan covering the Member as an Annuitant.

For example: The Member is covered as an Annuitant under the Plan and eligible for Medicare (Medicare would normally pay first). The Annuitant is also covered as a dependent of an active employee under another plan (in which case Medicare would pay second). In this situation, the plan covering the Member as a dependent would pay first and the plan covering the Member as an Annuitant would pay last.

(3) When a plan covers the Member as a dependent child and the parents are not separated or divorced, and each parent is covered by a group plan which covers the Member as a dependent, the plan of the parent with the earliest birth date in the Year shall have primary responsibility for the provision of benefits. If, however, either of the plans does not include the birthday rule provisions of this paragraph, primary responsibility for the provision of benefits shall be determined by the plan which does not include this provision.

(4) When a plan covers the Member as a dependent child and the parents are separated or divorced, and the parent with custody of the Member has not remarried, the plan which covers the Member as a dependent of the parent with custody of the Member shall have primary responsibility for the provision of benefits before the plan which covers the Member as a dependent of the parent without custody.

(5) When a plan covers the Member as a dependent child, and the parents are separated or divorced and the parent with custody of the Member has remarried, the plan which covers the Member as a dependent of the parent with custody shall have primary responsibility for the provision of benefits before then the plan which covers the Member as a dependent of the step-parent married to the parent with custody. In addition, the plan which covers the Member as a dependent of the step-parent married to the parent with custody will determine its benefits before the plan which covers the Member as a dependent of the parent without custody.

(6) When a plan covers the Member as a dependent child, and the parents are separated or divorced and there is a court decree which would otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to such Member, notwithstanding paragraphs 4. and 5. above, the plan which covers the Member as a dependent of the parent with such financial responsibility shall have primary responsibility for the provision of benefits before any other plan which covers the Member as a dependent.

(7) When a plan covers an individual as a laid-off or retired employee, or an individual who is a dependent of a laid-off or retired employee, such plan shall determine its level of responsibility after any other plan covering that individual as other than a laid-off or retired employee or the dependent of such person.

(8) A plan which has no provision regarding laid-off or retired employees or their dependent shall have primary responsibility for their benefits, if the lack of this provision would result in each plan determining its level of responsibility after the other.

(9) The plan covering the Member under a continuation of coverage provision in accordance with state or federal law pays after a plan covering the Member as a Subscriber, a dependent or otherwise, but not under a continuation of coverage provision in accordance with state or federal law. If the order of benefit determination provisions of the other plan do not agree under these circumstances with the order of benefit determination provisions of this Plan, this rule will not apply.

(10) When rules 1. through 9. do not establish an order of benefit determination, the plan which has covered the Member for the longer period of time will have primary responsibility for the provision of benefits before a plan which has covered the Member the shorter period of time.

3. Effect on Benefits

a. Primary Carrier

If this Plan is the Primary Carrier with respect to a Member, then this Plan will provide its services and benefits regardless of the benefits available to that Member from any other plan.

b. Secondary Carrier

If this Plan is a Secondary Carrier with respect to a Member, then this, Plan will provide its benefits in accordance with the following procedure:

In the event that the total amount of Allowable Expense incurred by that Member in any Calendar Year is exceeded by the sum of:

(1) The amount of benefits that would be provided for such Allowable Expense under this Plan in the absence of these provisions, and

(2) The amount of benefits that would be provided or would be payable for such Allowable Expense under all other plans in the absence therein of the same or any similar provisions.

The services and benefits that would be provided under this Plan in the absence of these provisions shall be reduced to the extent necessary so that the sum of such reduced benefits when added to the benefits payable under all other plans shall not exceed the total of such Allowable Expense. Benefits payable under another plan include those benefits that would have been payable had a claim been duly made therefore.

4. Provision of Benefits by Secondary Plan

With respect to the provisions of Section 2, the Secondary Carrier shall provide the services and benefits of this Plan as if it were the Primary Carrier. Members who receive services and benefits from the Secondary Carrier are hereby deemed to have assigned the benefits to the Secondary Carrier which they would have otherwise received from the Primary Carrier. By virtue of the provisions of this Plan, Members (a) agree to cooperate fully with Anthem Blue Cross in completing the necessary assignments to enable this Plan to obtain payment of benefits from the Primary Carrier, and (b) agree to reimburse this Plan from the benefits paid to the Member by the Primary Carrier for the services and benefits also provided by this Plan.

5. Optional Payment of Benefits

Whenever services which should have been provided under this Plan in accordance with these provisions have been paid as benefits under any other plan, this Plan shall have the right to pay to such other plan any amounts that it determines to be necessary in order to satisfy the intent of these provisions. Such amounts shall be considered to be benefits provided under this Plan and, to the extent of such payments, the Trust shall be fully discharged from liability under this Plan.

6. Right of Recovery

Whenever this Plan has made payments, or has provided covered services in excess of the amount determined in accordance with these Coordination of Benefits provisions, this Plan shall have the right to recover such payments or the reasonable cash value of such covered services, to the extent of such excess, from one or more of the following, as this Plan shall determine: 1) any person(s) to or for or with respect to whom such payments were made or services provided, 2) any other plans, 3) insurers, 4) service plans, or 5) any other organization. If a Member is covered under any other

plan and the contract or plan documents of such other plan contain Coordination of Benefits provisions, this Plan shall be deemed a third party beneficiary of such provision.

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ENROLLMENT PROVISIONS

ELIGIBILITY FOR ENROLLMENT

1. All Members who are eligible in accordance with the Act may enroll hereunder. Enrollment is restricted to eligible, dues-paying members and eligible permanent Employees and vested Annuitants of the California Association of Highway Patrolmen and their eligible Family Members.
2. An Employee, Annuitant or a Family Member shall not be eligible for enrollment with this Plan while enrolled under any of the Board's alternative medical and hospital benefit programs (i.e. PERSCare, PERS Choice, Kaiser, etc).

MEDICARE ELIGIBILITY

Under the Public Employee's Medical and Hospital Care Act (PEMHCA), if you are Medicare-eligible and do not enroll in Medicare Parts A and B and a CalPERS Medicare health plan, you and your enrolled dependents will be excluded from coverage under the CalPERS program.

Annuitants and their Family Members who become eligible for and are enrolled in both Part A (Hospital) and Part B (Medical) Medicare Insurance, on or after January 1, 1985, are no longer eligible to continue coverage in this CAHP Health Benefits Trust Basic Plan, but may apply for coverage under the CAHP Health Benefits Trust Supplement to Original Medicare Plan. To enroll in the Supplement to Original Medicare Plan, the Annuitant or their Family Members must send a copy of their Medicare card and a letter requesting the change to the CalPERS Member Account Management Division P.O. Box 942714, Sacramento, CA 94229-2714.

Supplement to Original Medicare coverage cannot be offered to active Employees or their Family Members, regardless of age, unless they are eligible for Medicare because of permanent kidney failure.

CONDITIONS OF ENROLLMENT

1. Each Employee or Annuitant who is eligible to become a Subscriber according to the provisions stated under this **ENROLLMENT PROVISIONS** section, and who files an application for membership for himself or herself and his or her eligible Family Members on forms provided by the Employer with the Employer during an Open Enrollment Period or period of initial eligibility, as specified in the Act, shall have fulfilled the Conditions of Enrollment.
2. Prior to the annual CalPERS Open Enrollment Period, the Trust will issue an affidavit titled "CAHP Health Benefits Trust Affirmation of Plan Limitations and Out-of-State Health Benefits Options" to all Annuitant Members who reside outside of California and are enrolled in the Basic Plan. This affidavit shall also be mailed to all Annuitant Members residing outside of California, upon the Trust's receipt of request for enrollment in the Basic Plan.

   As a condition of enrollment in the Basic Plan, Annuitant Members who reside outside of California must complete and return the affidavit to the Trust. Failure to return the affidavit to the Trust within the required time-frame shall result in administrative transfer to the PERS Choice Basic plan.
3. If an Employee or Annuitant fails to enroll himself or herself or his or her eligible Family Members during an Open Enrollment Period or the period of initial eligibility as specified in the Act, the Employee or Annuitant may apply for late enrollment for himself or herself and any eligible Family Members in accordance with the Act. Contact your Employer (Employees) or the CalPERS Customer

Account Services Division – Health Account Services (Annuitants) for information regarding late enrollment.

IMPORTANT NOTE: It is the Subscriber's responsibility to request additions, deletions or changes in enrollment in a timely manner and to stay informed about the eligibility requirements in the Act and Regulations. The Subscriber shall be held liable retroactively for any services provided to ineligible Members.

COMMENCEMENT OF COVERAGE

After fulfilling the **CONDITIONS OF ENROLLMENT** as stated above, coverage shall commence for a Subscriber and his or her Family Members at 12:01 a.m. on the date set forth in the Act.

TERMINATIONS AND RELATED PROVISIONS

VOLUNTARY CANCELLATION

A Member may cancel his or her enrollment in this Plan established in accordance with the provisions of Section 599.505 of the Regulations, and shall cease to be covered without notice from the Trust or Anthem Blue Cross, at midnight on the day on which such cancellation of enrollment becomes effective, under Section 599.506 of the Regulations.

REENROLLMENT

Members who have voluntarily cancelled enrollment from this Plan may apply for reenrollment during the Open Enrollment Period.

TERMINATION OF ENROLLMENT AND COVERAGE

The enrollment in this Plan of a Member shall be terminated in accordance with the provisions of Section 599.506 of the Regulations, or by the Trust's or Anthem Blue Cross' termination of the Agreement, subject, however, to the extensions of coverage required by Section 599.508 (a) (5) of the Regulations, and the continuation benefits provided under **CONTINUATION OF COVERAGE** below.

CONTINUATION OF COVERAGE (COBRA and CalCOBRA)

COBRA

COBRA (Consolidated Omnibus Budget Reconciliation Act) group continuation coverage is provided through federal legislation and allows an enrolled Employee or Annuitant or his or her enrolled Family Members, other than a domestic partner and a child of a domestic partner, who loses their regular group coverage under this Plan because of certain events to continue coverage for 18 or 36 months.

1. **Eligibility for Continuation - Qualifying Events**

   Subscribers or Family Members may choose to continue coverage under the Plan if it would otherwise end for any of the reasons shown below. These are called qualifying events, and they are:

   For Subscriber and Family Members.

   a. The Subscriber's termination, for any reason other than gross misconduct;

   b. Loss of coverage under an employer’s health plan due to a reduction in the Subscriber's work hours;

   c. For Members who may be covered as retirees, cancellation of that retiree coverage due to the Trust's filing for protection under the bankruptcy law (Chapter 11), provided the Member was covered prior to the filing of bankruptcy.

   For Family Members.

   d. The death of the Subscriber;

   e. The Spouse's divorce or legal separation from the Subscriber, or if the Spouse vacates the residence shared with the Subscriber;

   f. The end of a child's status as a Family Member, in accordance with the Act or Regulations;

   g. The Subscriber’s entitlement to Medicare.

A Subscriber or Family Member is not eligible to continue coverage if, at the time of the qualifying event, ineligible to continue coverage for these reasons, the other eligible Family Members may still choose to continue their coverage. Also, eligibility for Medicare will not preclude a person from continuing coverage if the qualifying event is 3. above.

2. Requirements for Continuation

a. Notice

For qualifying events 1., 2., and 3. on the previous page, the Subscriber's Employer will notify the Subscriber of the right to continue coverage. For qualifying events 4., and 7., a Family Member will be notified of the continuation right. Anyone choosing to continue coverage must so notify CalPERS/Employer **within 60 days** of the date they receive notice of their continuation right.

In the event of an Annuitant's death, it is the Family Member's responsibility to notify CalPERS/Employer **within 60 days** of the date of such qualifying event.

The Member must inform CalPERS/Employer of qualifying events 5. or 6. listed above within 60 days of such event if the Family Member wishes to continue coverage. If the Subscriber or Family Member fails to provide such timely notice to CalPERS/Employer, then such person shall not be entitled to elect continuation coverage.

Within 14 days of receipt of timely notice of a qualifying event, CalPERS/Employer shall provide written notice to eligible Subscribers and Family Members of their continuation right at the address of such persons on the records of the CalPERS/Employer. Such notice to an Employee or Annuitant or his or her Spouse shall be deemed notice to all other eligible Family Members residing with such Employee, Annuitant or Spouse at the time such notification is made.

The continuation coverage may be chosen for all Members within a family, or only for selected Members. However, if a Member fails to elect the continuation when first eligible, that person may not elect the continuation at a later date.

Once an Employee, Annuitant or Family Member elects the COBRA continuation, the Trust shall provide written notice of their rights to continuation of coverage. In addition to the written notice, an Evidence of Coverage will be sent to the enrolled Subscriber at his or her address on enrollment document(s) and shall be deemed notice to such Subscriber and his or her Spouse.

b. Family Members Acquired During Continuation

A Spouse or child newly acquired during the continuation period is eligible to be enrolled as a Family Member. The standard enrollment provisions of the Plan apply to enrollees during the continuation period. A Family Member acquired and enrolled during the period of continuation coverage which resulted from the original qualifying event is not eligible for a separate continuation if a subsequent qualifying event results in the person's loss of coverage.*

***EXCEPTION:** A child who is born to, or placed for adoption with the Subscriber during the COBRA continuation period will be eligible for a separate continuation if a subsequent qualifying event results in the person's loss of coverage.

c. Cost of Coverage

The benefits of continuation coverage are identical to the benefits in this Evidence of Coverage. The required monthly contribution for continuation coverage may not exceed 102 percent of the prepayment fees specified for coverage under this Plan or any amendment, renewal or replacement of this Plan. An eligible Subscriber or his or her eligible Family Member(s) electing continuation coverage shall pay to the Trust the required monthly contribution for continuation coverage **no later than the following dates:**

(1) If such election is made before the qualifying event, the required monthly contribution may be paid with the written election, in the amount required for the first month of continuation coverage.

(2) If such election is made after coverage is terminated due to a qualifying event, the required monthly contribution for the period of continuation of coverage preceding the election shall be made **within 45 days** of the election together with the required monthly contribution for the period beginning with the date of election and ending on the last day of the month in which the required monthly contribution is paid for the period preceding the election. It is the intention of this provision to require that the initial required monthly contribution payment include the required monthly contributions due for continuation coverage from the date coverage terminates under the group Plan to the end of the month in which the initial required monthly contribution is paid.

Thereafter, the required monthly contribution shall be paid on or before the first day of each month for which continuation coverage is to be provided. If any required monthly contribution for continuation coverage is not paid when due, the Trust may issue a notice of cancellation of continuation of coverage. If payment is not received within 15 days of issuance of such notice of cancellation, the Trust may cancel the continuation coverage on the sixteenth day following issuance of notice of cancellation. Termination of coverage shall be retroactive to the first day of the month for which the required monthly contribution has not been received.

For a Subscriber who is eligible for an extension of continuation coverage due to the Subscriber or a Family Member having been determined by the Social Security Administration to be totally and permanently disabled, the Trust shall charge 150 percent of the Subscriber's required monthly contribution prior to the Disability for the length of time the disabled member remains covered. The Trust must receive timely payment of the required monthly contribution each month in order to maintain the coverage in force.

If a second qualifying event (as shown below) occurs during this extended continuation, the total COBRA continuation may continue for up to 36 months from the date of the first qualifying event. The required monthly contribution shall then be 150 percent of the applicable rate for the 19th through the 36th months if the disabled member remains covered. The cost will be 102 percent of the applicable rate for any periods of time the disabled member is not covered following the 18th month.

For purposes of determining the required monthly contribution payable for continued coverage, a person originally covered as a Spouse will be treated as the Subscriber if coverage is continued for him/herself alone. If such Spouse and his or her child(ren) enroll, the required monthly contribution payable will depend upon the number of persons covered. Each child continuing coverage other than as a dependent of a Subscriber will pay

the required monthly contribution applicable to a Subscriber. (If more than one child is so enrolled, the required monthly contribution shall be the two-party or three-party rate, depending upon the number of children enrolled.)

d. Subsequent Qualifying Events

Once covered under the continuation plan, it's possible for a secondary qualifying event to occur. If that happens, a Family Member may be entitled to a second continuation period. This period shall in no event continue beyond 36 months from the date the Member's coverage terminated due to the first qualifying event. Except for newborn or newly adopted children as described above, only a Member covered prior to the original qualifying event is eligible to continue coverage again as the result of a later qualifying event. A Family Member acquired during the continuation coverage is not eligible to continue coverage as the result of a later qualifying event, with the exception of newborns and adoptees as described above.

For Example: Continuation may begin due to termination of employment. During the continuation, if a child reaches the proper age limit of the Plan, the child is eligible for a second continuation period. This second continuation would end no later than 36 months from the date coverage was terminated due to the first qualifying event - the termination of employment.

e. When Continuation Coverage Begins

When continuation coverage is elected and the required monthly contribution paid, coverage is reinstated back to the date the Member's coverage was terminated due to the qualifying event, so that no break in coverage occurs. Coverage for Family Members acquired and properly enrolled during the continuation begins in accordance with the enrollment provisions of the Act and Regulations.

f. When the Continuation Ends

This continuation will end on the earliest of:

(1) The end of 18 months from the date the Member's coverage terminates, if the qualifying event was termination of employment or reduction in work hours. For a Member whose continuation coverage began under a prior plan, this term will be dated from the time the Member's coverage terminates under that prior plan due to the qualifying event.

EXCEPTION: A qualified beneficiary whose coverage is continued may extend that continuation coverage for up to an additional 11 months, provided that the disabled Member has been determined by the Social Security Administration to be totally and permanently disabled according to the statutory requirements of either Title II or Title XVI of the Social Security Act. The extension applies to all covered Members as well as the disabled Member. The Member is required to furnish proof of the Social Security Administration's determination of disability to his or her Employer during the first 18 months of the COBRA continuation period **but no later than 60 days** after the later of the following events: (1) the date of the Social Security Administration's determination of the disability; (2) the date on which the original qualifying event occurs; (3) the date on which the qualified beneficiary loses coverage; or (4) the date on which the qualified beneficiary is informed of the obligation to provide the disability notice. The period of continuation shall in no event

continue beyond (1) the period of disability, or (2) a maximum of 29 months after the date the Subscriber's coverage terminated due to the loss of employment, whichever occurs first.

(2) The end of 36 months from the date the Member's coverage terminates, if the qualifying event was the death of the Subscriber; divorce, legal separation or if the Spouse vacates the residence shared with the Subscriber; or the end of dependent child status. For a Member whose continuation coverage began under a prior plan, this term will be dated from the time the Member's coverage terminated under that prior plan due to the qualifying event.

(3) The end of 36 months from the date the Subscriber became entitled to Medicare, if the qualifying event was the Subscriber's entitlement to Medicare;

(4) The date the Plan terminates.

(5) The end of the last period for which the final required monthly contribution was paid.

(6) The date after the effective date of the COBRA election that the Member first becomes eligible for Medicare.

(7) The date after the effective date of the COBRA election that the Member first becomes covered under any other group health plan, except that if the Member's coverage under a group health plan contains any exclusion or limitation relating to a pre-existing condition, the Member's coverage will remain effective until the exclusions or limitations of the group health plan for preexisting conditions no longer apply to the Member.

(8) In the event that the Member is eligible for both continuation coverage and coverage under any other group health plan, the continuation benefits may be reduced so that the benefits and services the Member receives from all group coverage's do not exceed 100 percent of the Covered Expense incurred.

Subject to the Plan remaining in effect, a retired Subscriber whose coverage began due to a Chapter 11 bankruptcy may continue coverage for the remainder of his or her life; that person's covered Family Members may continue coverage for 36 months after their coverage terminates due to the Subscriber's death. However, coverage could terminate prior to such time for either the Subscriber or Family Member in accordance with items d., e., f., or g. above.

If a person's COBRA continuation under this Plan began on or after January 1, 2003 and ends in accordance with item "a" above, the person may further elect to continue coverage for medical benefits only under CalCOBRA for the balance of 36 months (COBRA and CalCOBRA combined). All COBRA eligibility must be exhausted before a person can be eligible to further continue coverage under CalCOBRA.

Other Coverage Options Besides COBRA Continuation Coverage. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan). Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

CalCOBRA

CalCOBRA provides for an additional period of continuation of coverage following federal COBRA if federal COBRA lasts for LESS than 35 months. The incremental period give Members a total of 36 months of continuation coverage between the two programs.

1. Eligibility for Continuation - Qualifying Events

If the Member's continuation coverage under federal COBRA began on or after January 1, 2003, the Member has the option to further continue coverage under CalCOBRA for medical benefits only if the Member's federal COBRA ended following: (a) 18 months after the qualifying event, if the qualifying event was termination of employment or reduction in work hours; or (b) 29 months after the qualifying event, if the Member qualified for the extension of COBRA continuation during total disability.

All federal COBRA eligibility must be exhausted before the Member is eligible to further continue coverage under CalCOBRA. The Member is not eligible to further continue coverage under CalCOBRA if the Member (a) is entitled to Medicare; (b) have other coverage or become covered under another group plan, as long as the Member is not subject to a pre-existing condition limitation under that coverage; or (c) is eligible for or covered under federal COBRA. Coverage under CalCOBRA is available for medical benefits only.

2. Requirements for Continuation

a. Notice.

Within 180 days prior to the date federal COBRA ends, the Member will be notified of their rights to further elect coverage under CalCOBRA. If the Member chooses to elect CalCOBRA coverage, the Member must notify CalPERS/Employer in writing within 60 days of the date the Member's coverage under federal COBRA ends or when the Member is notified of their right to continue coverage under CalCOBRA, whichever is later. If the Member does not give CalPERS/Employer written notification within this time period the Member will not be able to continue their coverage.

The Member should examine their options carefully before declining this coverage. The Member should be aware that companies selling individual health insurance typically require a review of their medical history that could result in higher cost or the Member could be denied coverage entirely.

b. Family Members Acquired During Continuation

A Spouse or child newly acquired during the CalCOBRA continuation period is eligible to be enrolled as a Family Member. The standard enrollment provisions of the Plan apply to enrollees during the CalCOBRA continuation period.

c. Cost of Coverage

The Member may be required to pay the entire cost of CalCOBRA continuation coverage. This cost will be

(1) 110% of the required monthly contribution if coverage under federal COBRA ended after 18 months; or

(2) 150% of the required monthly contribution if coverage under federal COBRA ended after 29 months.

The Member must make payment to CalPERS/Employer. CalPERS/Employer must receive payment of the required monthly contribution each month to maintain coverage.

d. CalCOBRA Continuation Coverage Under the Prior Plan

If the Member was covered through CalCOBRA continuation under a prior Plan, the Member's coverage may continue under this Plan for the balance of the continuation period. However the Member's coverage shall terminate if he/she does not comply with the enrollment requirements and required monthly contribution payment requirements of this Plan within 30 days of receiving notice that their continuation coverage under the prior Plan will end.

e. When Continuation Coverage Begins

When the Member elects CalCOBRA continuation coverage and pay the required monthly contribution, coverage is reinstated back to the date federal COBRA ended, so that no break in coverage occurs. For a Family Member properly enrolled during the CalCOBRA continuation, coverage begins according to the enrollment provisions of the Plan.

f. When the Continuation Ends

This CalCOBRA continuation will end on the earliest of:

(1) The date that is 36 months after the date of the Member's qualifying event under federal COBRA (if the Member's CalCOBRA continuation coverage began under a prior Plan, this term will be dated from the time of the qualifying event under that prior Plan);

(2) The date the Plan terminates;

(3) The date the Plan no longer provides coverage to the class of Employees to which the Subscriber belongs;

(4) The end of the period for which the required monthly contribution is last paid;

(5) The date the Member becomes covered under any other health plan, unless the other health plan contains an exclusion or limitation relating to a pre-existing condition that the Member has. In this case, this continuation will end at the end of the period for which the pre-existing condition exclusion or limitation applied;

(6) The date the Member becomes entitled to Medicare; or

(7) The date the Member becomes covered under a federal COBRA continuation.

CalCOBRA continuation will also end if the Member moves out of the service area or if the Member commits fraud.

BENEFITS AFTER TERMINATION

There is no coverage for the treatment of any condition, including pregnancy, beyond the effective date of termination of this Plan, or of coverage offered by this Plan, except as follows:

1. If a Member is Totally Disabled when coverage ends and is under the treatment of a licensed medical doctor (M.D.), the benefits of this Plan shall continue to be provided for services treating the totally disabling illness or injury, and for no other condition not reasonably related to the condition causing the total Disability, illness or injury or arising out of such totally disabling illness or injury. This extension of benefits is not available if the Member becomes covered under another group health plan that provides coverage without limitation for the disabling condition.

2. A Member confined as an inpatient in a Hospital or Skilled Nursing Facility is considered Totally Disabled as long as the inpatient Stay is Medically Necessary, and no written certification of the total Disability is required.

3. A Member not confined as an inpatient who wishes to apply for total Disability benefits must submit written certification by his or her Physician of the total Disability. Anthem Blue Cross, on behalf of the Trust, must receive this certification **within thirty (30) days** of the date coverage ends under this Plan. At least once every sixty (60) days while benefits are extended, Anthem Blue Cross, on behalf of the Trust, must receive proof that the Member's total Disability is continuing.

4. Benefits are provided until one of the following occurs:

a. The Member is no longer Totally Disabled, or

b. The maximum benefits of this Plan are paid, or

c. The Member becomes covered under another group health plan that provides coverage without limitation for disabling illness or injury, or

d. A period of 12 consecutive months has passed since the date coverage ended.

GENERAL PROVISIONS

EVIDENCE OF COVERAGE

The Trust shall issue to the Subscriber an Evidence of Coverage. This Evidence of Coverage is not the Agreement. It does not change the coverage under the Agreement in anyway. This Evidence of Coverage, which is evidence of coverage under the Agreement, is subject to all of the terms and conditions of the Agreement.

WORKERS' COMPENSATION INSURANCE

The Agreement does not affect any requirement of coverage by workers' compensation insurance. It also does not replace that insurance.

Nondiscrimination. No person who is eligible to enroll will be refused enrollment based on health status, health care needs, genetic information, previous medical information, disability, sexual orientation or identity, gender, or age.

PROTECTION OF COVERAGE

Neither the Trust nor Anthem Blue Cross has the right to cancel the coverage of any Member under this Plan while:

a. The Administrative Services Agreement between Anthem Blue Cross and the Trust is still in effect, and

b. The Member is still eligible, and

c. The Member's required monthly contributions are paid according to the terms of the Administrative Services Agreement between Anthem Blue Cross and the Trust.

PROVIDING OF CARE

The Trust and Anthem Blue Cross are not responsible for providing any type of Hospital, medical or similar care. Also, the Trust and Anthem Blue Cross are not responsible for the quality of any type of Hospital, medical or similar care received.

NON-REGULATION OF PROVIDERS

Benefits provided under this Plan do not regulate the amounts charged by providers of medical care, except to the extent that rates for covered services are regulated with Prudent Buyer Plan Providers.

AREA OF SERVICE

The benefits of this Plan are provided for covered services received anywhere in the world.

INDEPENDENT CONTRACTORS

All providers are independent contractors. Neither the Trust nor Anthem Blue Cross is liable for any claim or demand for damages connected with any injury resulting from any treatment.

IDENTIFICATION CARDS AND EVIDENCE OF COVERAGE BOOKLETS

Anthem Blue Cross, on behalf of the Trust, shall issue to the Member and Family Members an identification card. The Trust shall issue to the Member an Evidence of Coverage booklet setting forth a

statement of the services and benefits to which the Member and Family Members are entitled. Possession of an identification card confers no right to services or other benefits of this Plan. To be entitled to services or benefits, the holder of the card must, in fact, be a Member on whose behalf applicable fees under this Plan have actually been paid. Any person receiving services or other benefits to which he or she is not then entitled pursuant to the provisions of this Plan is chargeable therefore at prevailing rates.

PAYMENT TO PROVIDERS

Anthem Blue Cross, on behalf of the Trust, pays the benefits of this Plan directly to Contracting Hospitals, Prudent Buyer Plan Providers, Behavioral Health Access Providers, Centers of Medical Excellence (CME) and licensed ambulance companies. Also, other providers of service may be paid directly when the Member assigns benefits in writing. These payments fulfill the obligation of the Trust to the Member for those services.

Express Scripts on behalf of the Trust, pays the prescription drug benefits of this Plan, as stated under **OUTPATIENT PRESCRIPTION DRUG BENEFITS,** directly to contracting Express Scripts Participating Pharmacies. These payments fulfill the obligation of the Trust to the Member for those services.

FREE CHOICE OF PROVIDER

This Plan in no way interferes with the right of any person entitled to Hospital benefits to select the Hospital of his or her choice. That person may choose any Physician who holds a valid Physician and surgeon's certificate and who is a member of, or acceptable to, the attending staff and board of directors of the Hospital where services are received. You may also choose any other health care professional or facility which provides care covered under this Plan, and is properly licensed according to appropriate state and local laws. However, that person's choice may affect the benefits payable according to the terms of the Agreement.

RIGHT TO RECEIVE AND RELEASE INFORMATION

a. For the purpose of enforcing or interpreting this Plan, or participating in resolving any matter in dispute in regard to this Plan, the Trust, Anthem Blue Cross, the Board, or any person covered under this Plan agrees, subject to statutory requirements, to share all relevant information with any other party. Such information may only be used in determining the disputed matter, and shall not be further disclosed without the consent of the person(s) to whom the information pertains. Any exchange of information pursuant to this section, for the limited purposes of this section, shall not be deemed a breach of any person's right of privacy.

b. For the purposes of enforcing, determining the applicability of, and implementing the Coordination of Benefits provisions of this Plan or any similar provisions of any other plan, the Plan may release to, or obtain from, any other plan, health care provider, insurance company, organization or person, any information, with respect to any person, which the Plan deems to be necessary for such purposes. Members shall furnish such information as may be necessary to implement these provisions.

LIABILITY OF MEMBER FOR CERTAIN CHARGES

a. In the event the Plan fails to pay a provider for covered services (for example due to the Plan's filing for bankruptcy), the Member will be required to pay the provider any amounts not paid to them by the Plan. However, a Member is not required to pay to a Prudent Buyer Plan Provider any amount of expense for a covered service that exceed the negotiated rate.

b. The Member is liable for all expenses in excess of the benefits of this Plan.

EXPENSE IN EXCESS OF BENEFITS

Anthem Blue Cross and the Trust are not liable for any expense the Member incurs in excess of the benefits of this Evidence of Coverage.

RIGHT OF RECOVERY

When the amount paid by Anthem Blue Cross, on behalf of the Trust, exceeds the amount for which the Trust is liable under this Plan, the Trust has the right to recover the excess amount. This amount may be recovered from the Member, the person to whom payment was made or any other plan. The Trust may reduce subsequent benefit payments to offset overpayments.

BENEFITS NON-TRANSFERRABLE

Only eligible Members are entitled to receive benefits under this Plan. The right to benefits cannot be transferred.

CLERICAL ERROR

No clerical error on the part of the Employer, the Trust or Anthem Blue Cross shall operate to defeat any of the rights, privileges or benefits of any Member.

TERMS OF COVERAGE

a. In order for a Member to be entitled to benefits under the Agreement, both the Agreement and the Member's coverage under the Agreement must be in effect on the date the expense giving rise to a claim for benefits is incurred.

b. The benefits to which a Member may be entitled will depend on the terms of coverage in effect on the date the expense giving rise to a claim for benefits is incurred. An expense is incurred on the date the Member receives the service or supply for which the charge is made.

c. The Agreement is subject to amendment, modification or termination according to the provisions of the Agreement without the consent or concurrence of Members.

MEMBER COOPERATION

By virtue of the Agreement with CalPERS, Members agree to: (a) take action, furnish help and information and execute instruments required to enforce the Trust's rights as set forth in the Agreement; (b) take no action to harm the Trust's rights or interests; and (c) notify the Trust or Anthem Blue Cross, on behalf of the Trust, of circumstances that may give rise to its rights.

PROVIDER REIMBURSEMENT

Physicians and other professional providers are paid on a fee-for-service basis, according to an agreed upon schedule for Prudent Buyer Plan Providers and to the Customary and Reasonable Charge or the Reasonable Charge for Non-Prudent Buyer Plan Providers, and providers not represented in the Prudent Buyer Plan Network. Hospitals and other health care facilities may be paid either a fixed fee or on a discounted fee-for-service basis.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The California Association of Highway Patrolmen's Health Benefits Trust (CAHP-HBT) is dedicated to protecting your medical information. We are required by law to maintain and protect the privacy of your medical information and provide this notice of our legal duties and privacy practices. The CAHP-HBT is required by law to abide by the terms of this notice.

HOW YOUR MEDICAL INFORMATION WILL BE USED AND DISCLOSED

As administrator of the CAHP-HBT plan, we will use your medical information in the following ways.

As Required By Law

We will disclose medical information about you when required to do so by federal, state or local law or regulation. Medical information can also be shared for certain reasons with organ donation groups, for research, and to avoid a serious threat to health or safety. It can be shared for special government functions or to respond to requests from the U.S. Department of Health and Human Services.

Business Associates

We may disclose your health information to a business associate with whom we contract to provide services on our behalf. For your protection, we require our business associates to appropriately safeguard all members' health information.

Health Oversight Activities

We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and licensure, and are necessary in order for the government to monitor the health care system and compliance with civil rights laws.

Health Plan Operations

We may use and disclose medical information about you for CAHP-HBT operations. These uses and disclosures are necessary to manage the CAHP-HBT plan. For example, we may use and disclose medical information about you to confirm your eligibility or to resolve an appeal, complaint or grievance.

We also may combine medical information about many CAHP-HBT plan members to evaluate health plan performance, assist in rate-setting, measure quality of care provided, or for other health care operations. In some cases, we may obtain medical information about you from a provider or third-party administrator.

Health-Related Benefits and Services

We may use and disclose medical information to tell you about health-related benefits or services such as treatment alternatives, disease management or wellness programs that may be of interest to you.

Lawsuits and Disputes

If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if you have been given proper notice and an opportunity to object.

Law Enforcement

We may release medical information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, and to coroners, funeral directors or medical examiners (about decedents).

Policy Holder

If you are enrolled in the CAHP-HBT plan as a dependent, we may release medical information about you to the policyholder.

Relations

Unless you object, we may disclose your medical information to family members, or other relative or close personal friends, when the medical information is directly relevant to that person's involvement with your care.

Serious Threat to Health or Safety

We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Workers' Compensation

We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

AUTHORIZATIONS

We will not use and disclose your medical information for any other purpose without your written authorization. Once given, you may revoke your authorization in writing at any time. If medical information has already been provided as authorized by you, the action cannot be undone if you decide to revoke your authorization.

To request a Revocation of Authorization form, you may contact:

The CAHP Health Benefits Trust
Attn: Privacy Officer
2030 V Street
Sacramento, CA 95818

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

You have the following rights regarding your medical information:

Right to Inspect, Copy and Amend

You have the right to inspect and copy protected medical information about you that is maintained by the CAHP-HBT. In most cases, this consists solely of information concerning your health plan enrollment or an appeal, complaint or grievance.

If you are denied access to medical information, we will provide you with a written explanation for the denial and information regarding further rights you may have at that point.

If you feel that protected medical information we have about you is incorrect or incomplete, you may ask us to amend the information. To request an amendment, your request must be made in writing and you must provide a reason that supports your request.

Any request to inspect, copy or appeal any of your protected medical information must be submitted in writing to the CAHP-HBT at 2030 V Street, Sacramento, CA 95818, Attn: Privacy Officer. We may charge a fee for the costs of copying, mailing or other supplies associated with your request.

Right to an Accounting of Disclosures

You have the right to request an "accounting of disclosures." This is a list of the disclosures we have made about your medical information.

To obtain an accounting of disclosures, you must submit your request in writing to the CAHP-HBT. Your request must include a specific period, within a maximum six-year time frame, and may not include dates before April 14, 2003.

Right to Request Restrictions

You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health-care procedures. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide emergency treatment for you. You must make any request in writing to the CAHP-HBT at 2030 V Street, Sacramento, CA 95818, Attn: Privacy Officer. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply. (For example, disclosures to your spouse.)

Right to Request Confidential Communications

You have the right to request that we communicate with you about medical matters in a specific manner or location. For example, you can ask that we only contact you at work or by mail to a specific address.

To request confidential communications, you must make your request in writing to the CAHP-HBT at 2030 V Street, Sacramento, CA 95818, Attn: Privacy Officer. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice

You have the right to a paper copy of this notice and you may ask us to give you a copy at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy.

To obtain a paper copy of this notice contact the CAHP-HBT.

Right to Complain

If you believe your privacy rights have been violated, you may file a complaint with CAHP-HBT or with the Secretary of the Department of Health and Human Services. If you choose to file a complaint, **you will not be retaliated against in any way.** To complain to us, please contact the CAHP-HBT at 2030 V Street, Sacramento, CA 95818, Attn: Privacy Officer. All complaints must be submitted in writing.

REVISION OF NOTICE OF PRIVACY PRACTICES

We reserve the right to change this Notice, making any revision applicable to all the protected health information we maintain. If we revise the terms of this Notice, we will post a revised Notice at the

California Association of Highway Patrolmen's Health Benefits Trust and on the CAHP Web site at www.thecahp.org. Paper copies of the revised Notice to Privacy Practices will be available upon request.

If you would like further information regarding your rights or regarding the uses and disclosures of your medical information, you may contact:

The CAHP Health Benefits Trust
2030 V Street
Sacramento, CA 95818
(800) 734-2247

GRIEVANCE/CLAIMS REVIEW PROCEDURES

STEP 1: DISAGREEMENTS WITH Anthem BLUE CROSS' CLAIMS DETERMINATIONS

The Plan provides that treatment or service must be Medically Necessary and be covered by this Plan. The fact that your attending Physician may prescribe, order, recommend or approve a service or treatment does not, of itself, make it Medically Necessary or make the service or treatment an allowable expense, even if it is not specifically listed in this Evidence of Coverage as an exclusion. Anthem Blue Cross has the responsibility for determining whether claims are payable. A practicing physician-consultant retained by Anthem Blue Cross must agree if the denial is based on the lack of medical necessity.

Action on your claim, including any denial, will be given in writing by Anthem Blue Cross, including the reason for any denial. If you do not agree, either you or your attending Physician, acting as your authorized representative, may request reconsideration. **This request must be made in writing to Anthem Blue Cross within 60 days** of the denial of your claim and must give the reasons you believe the claim should be paid and should include any additional information that would affect the decision. To request reconsideration you may write to Anthem Blue Cross at P.O. Box 60007, Los Angeles, CA 90060-0007, Attn: CAHP Unit or file online through the Anthem Blue Cross Web site at **www.anthem.com/ca**. Anthem Blue Cross will acknowledge receipt of a reconsideration request by written notice to the complainant within 20 days. Anthem Blue Cross will then either affirm or resolve the denial within 30 days.

If Anthem Blue Cross affirms the denial or fails to respond within 30 days after receiving the written request for review and you still disagree, you may proceed to **STEP 2, STEP 3, STEP 4, STEP 5.**

NOTE: You should follow Anthem Blue Cross' grievance procedure listed above for disputes over coverage and/or benefits, or if you are dissatisfied with the quality of care or your access to care. For matters of eligibility, you should contact the CalPERS Member Account Management Division at P.O. Box 942714, Sacramento, CA 94229-2714.

Procedures for grievances not resolved after completing **STEP 1**:

1. **Covered grievances:** If you have followed Anthem Blue Cross' grievance procedure listed above and are still dissatisfied, you may proceed to **STEP 2: SPECIAL REVIEW PROCEDURES FOR DENIAL OF EXPERIMENTAL OR INVESTIGATIONAL TREATMENT; STEP 3: INDEPENDENT EXTERNAL REVIEW; STEP 4: ADMINISTRATIVE APPEAL PROCESS** or **STEP 5: BINDING ARBITRATION (OR SMALL CLAIMS COURT).** If your coverage/benefit dispute is within the jurisdictional limits of small claims court, you must proceed through that court.

   NOTE: CalPERS has no authority to rule over issues of medical malpractice or allegations of bad faith.

2. **Eligibility grievances:** These issues should always and only be referred directly to CalPERS at the address noted above.
3. **Malpractice grievances:** Claims of malpractice must be taken up directly with the provider(s) of medical care.
4. **Bad faith grievances:** You must proceed to **STEP 5: BINDING ARBITRATION (OR SMALL CLAIMS**
5. **COURT)** for claims for benefits involving charges of bad faith.

STEP 2: SPECIAL REVIEW PROCEDURES FOR DENIAL OF EXPERIMENTAL OR INVESTIGATIONAL TREATMENT

The Member may request an independent review of a coverage decision for services that Anthem Blue Cross has denied as being Experimental or Investigational if **all** of the following criteria have been met: (1) the Member has a terminal condition, **and** (2) the Member's Physician certifies that standard therapies have been ineffective or would be inappropriate, **and** (3) either the Member's Physician certifies in writing that the denied therapy is likely to be more beneficial to the Member than standard therapies, or the Member (or the Member's Physician) has requested a therapy that, based on documented medical and scientific evidence, is likely to be more beneficial than standard therapies. The Member will be notified in writing by Anthem Blue Cross of the opportunity to request this review when services are denied.

This review may be requested in place of or in addition to a reconsideration request made of Anthem Blue Cross as set forth in **STEP 1** on the previous page.

If the independent review affirms the denial and you still disagree, you may proceed to **STEP 3, STEP 4, STEP 5.**

STEP 3: INDEPENDENT EXTERNAL REVIEW

If the Plan Member remains aggrieved by a decision of Anthem Blue Cross after reconsideration of a denied claim he/she may request further review by an independent external reviewer. Such request must be in writing, unless Anthem Blue Cross determines that it is not reasonable to require a written statement. You do not have to re-send the information that was submitted under Step 1 or Step 2 of the grievance procedures. However, you are encouraged to submit any additional information that you think is important for review.

For pre-service claims involving urgent/concurrent care, you may proceed with an expedited external review without filing an internal appeal or while simultaneously pursuing an expedited appeal through the internal appeal process. You or your authorized representative may request it orally or in writing. All necessary information, including Anthem Blue Cross' decision, can be sent between Anthem Blue Cross and you by telephone, facsimile or other similar method. To proceed with an expedited external review, you or your authorized representative must contact Anthem Blue Cross at the phone number listed on your ID card and provide at least the following information.

- The date (s) of the medical service;
- The identity of the claimant:;
- The specific medical condition or symptom;
- The provider's name;
- The service or supply for which approval of benefits was sought; and
- Any reasons why the appeal should be processed on a more expedited basis.

All other requests for external review should be submitted in writing unless Anthem Blue Cross determines that it is not reasonable to require a written statement. Such requests should be submitted by you or your authorized representative to:

Anthem Blue Cross Life and Health Insurance Company
ATTN: Appeals
P.O. Box 4310
Los Angeles, CA 91365-4310

You must include your Member Identification Number when submitting an appeal.

Such request must be submitted to Anthem Blue Cross no later than 4 months following Anthem Blue Cross' final determination of payment under Step 1 or Step 2 of the grievance procedures.

This is not an additional step that you must take in order to fulfill your appeal procedure obligations described above. Your decision to seek external review will not affect your rights to any other benefits under this health care Plan. There is no charge for you to initiate an independent external review. The external review decision is final and binding on all parties except for any relief available through applicable state laws or ERISA (if applicable).

If the independent external reviewer affirms Anthem Blue Cross' denial and you still disagree, you may proceed to STEP 4 or STEP 5.

STEP 4: ADMINISTRATIVE APPEAL PROCESS

If you remain dissatisfied after exhausting the Internal Review process for benefit decisions and the independent External Review in cases involving Medical Judgment, you and/or your Authorized Representative may request a CalPERS Administrative Review. The California Code of Regulations, Title 2, Section 599.518 requires that you exhaust Anthem Blue Cross' internal grievance process, and the independent External Review process, when applicable, prior to submitting a request for CalPERS Administrative Review.

CalPERS staff will conduct an administrative review upon your appeal of Anthem Blue Cross' denial of coverage. **NOTE:** Your written appeal must be submitted to CalPERS **within 30 days** of the postmarked date of Anthem Blue Cross' of denial following your grievance. Not every dispute may be appealed to CalPERS. For example, you must proceed directly to **STEP 5** for issues involving quality of care, access to care, or allegations of bad faith.

If the dispute remains unresolved during the administrative review process, the matter may then proceed to an Administrative Hearing. The hearing will be conducted in a formal manner, with evidence and testimony presented to an Administrative Law Judge. **NOTE: You must choose between the ADMINISTRATIVE HEARING** and **BINDING ARBITRATION (OR SMALL CLAIMS COURT). You may not take the same grievance through both procedures**. You may withdraw your appeal at any time, and proceed to **STEP 5.**

To file an administrative appeal, please contact CalPERS Health Plan Administration Division Health Appeals Coordinator, P.O. Box 1953, Sacramento, CA 95812-1953.

STEP 5: BINDING ARBITRATION (OR SMALL CLAIMS COURT)

If you do not use **STEP 3** or **STEP 4,** or if they do not apply, binding arbitration is the final step in resolving your grievance, except any dispute regarding a claim for damages within the jurisdictional limits of the small claims court must be resolved in such court. **A small claims court judgment cannot be appealed.**

By enrolling in this Plan, you agree to waive your constitutional right to have any such claim decided in a court of law or before a jury and instead accept the use of binding arbitration.

The steps for binding arbitration are as follows:

1. Binding arbitration is begun by you making written demand on Anthem Blue Cross.

2. The arbitration will be conducted by Judicial Arbitration and Mediation Services (JAMS) according to its applicable Rules and Procedures. If, for any reason, JAMS is unable to conduct the arbitration, the arbitration will be conducted by another neutral arbitration entity, by mutual agreement of you and Anthem Blue Cross or by order of the court, if you and Anthem Blue Cross cannot agree. The arbitration shall be held in the State of California. Copies of such arbitration rules are available from Anthem Blue Cross.
3. **THE ARBITRATION FINDINGS ARE FINAL AND BINDING, except to the extent that California or Federal law provides for the judicial review of arbitration proceedings.**

Questions about your right of appeal, all notices required of you to initiate these rights and any demand for arbitration not available through the local medical society should be directed to Anthem Blue Cross, P.O. Box 60007, Los Angeles, CA 90060-0007, Attn: Claims Appeal Department.

REQUIRED MONTHLY CONTRIBUTIONS

Type of Enrollment	Enrollment Code	Cost*
Subscriber Only	2301	$620.79
Subscriber and One Family Member	2302	$1,205.17
Subscriber and Two or More Family Members	2303	$1576.26

State Employees and Annuitants

*The required monthly contributions shown above are effective January 1, 2017 and will be reduced by the amount the State of California contributes toward the cost of your health benefits plan. These contribution amounts are subject to change by legislative action. Any such change resulting in a change in the amount of your contribution will be accomplished automatically by the State Controller or affected retirement system without action on your part. For current contribution information contact your Employer or Retirement System Health Benefits Officer.

Required Monthly Contribution

The required monthly contribution may be changed as of January 1, 2018, following at least sixty (60) days' written notice to the Board prior to such change.

GENERAL DEFINITIONS

When any of the following terms are capitalized in this Evidence of Coverage, they shall have the meaning below. This section should be read carefully. Defined terms have the same meaning throughout this Evidence of Coverage.

Accidental Injury is physical harm or Disability which is the result of a specific unexpected incident caused by an outside force. The physical harm or Disability must have occurred at an identifiable time and place. Accidental Injury does not include illness or infection, except infection of a cut or wound.

Act means the Public Employees' Medical and Hospital Care Act (Part 5, Division 5, Title 2 of the Government Code of the State of California).

Acute Care is care rendered in the course of treating an illness, injury or condition marked by a sudden onset or abrupt change of status requiring prompt attention, which may include hospitalization, but which is of limited duration and which is not expected to last indefinitely.

The **Agreement** is the Memorandum of Agreement entered into by the CAHP Health Benefits Trust and the California Public Employees' Retirement System.

An **Alternative Birth Center** is a birth facility designed to provide a homelike atmosphere without sacrificing the necessary safeguards to the mother and/or infant if an unexpected complication occurs. The facility must be approved by Anthem Blue Cross and licensed according to state and local laws. A list of approved Alternative Birth Centers is available on request.

An **Ambulatory Surgical Center** is an outpatient surgical facility which may either be freestanding or located on the same grounds as a Hospital. It must be licensed separately as an outpatient clinic according to state and local laws and must meet all requirements of an outpatient clinic providing surgical services. It must also meet accreditation standards of the Joint Commission on Accreditation of Health Care Organizations or the Accreditation Association of Ambulatory Health Care.

Anniversary Date is the first day of each Contract Year.

Annuitant, as defined in accordance with the definition currently in effect in the Act and Regulations, refers to retired Employees of the State of California, and vested retired Employees of the California Association of Highway Patrolmen.

Anthem Blue Cross is an affiliate of Anthem Blue Cross Life and Health Insurance Company (Anthem Blue Cross Life and Health) which is licensed by the California Department of Insurance as a life and disability insurer. On behalf of Anthem Blue Cross Life and Health, Anthem Blue Cross shall furnish certain provider contracting services and perform all administrative services in connection with the processing of medical claims under the Plan and benefits provided under **HEALTH PROMOTION PROGRAM.**

An **Authorized Referral** occurs when a Member, because of his or her medical needs, is referred to a Non-Prudent Buyer Plan Provider, but only when:

1. There is no Prudent Buyer Plan Provider who practices in the appropriate specialty or provides the required services or has the necessary facilities within 30-mile radius of, or 30 minutes normal travel time from, the Member's residence or place of work; and
2. The Member is referred in writing to the Non-Prudent Buyer Plan Provider by a Physician who is a Prudent Buyer Plan Provider; and
3. The referral has been authorized by Anthem Blue Cross **before** services are rendered.

4. Authorized Referrals are granted in 90-day increments in the event a new Prudent Buyer Plan Provider has been added to the network. The Member or Member's Physician must call Anthem Blue Cross customer service toll-free at 1-800-759-5758 prior to scheduling an admission to, or receiving the services of, a Non-Prudent Buyer Plan Provider.

NOTE: Authorized Referrals are not available for providers located outside of California or for Members who reside outside California, unless the out-of-state provider is located within a 30-mile radius of, or 30 minutes normal travel time from, the residence or place of work of an active Employee who lives in a state bordering California. Authorized referrals are not available for bariatric surgical services or Urgent Care. Authorized Referrals are not required for the services of Non-Prudent Buyer Plan Providers whose specialty is not represented in the Prudent Buyer Plan network.

Average Wholesale Price is an accepted term in the pharmaceutical industry as a benchmark for pricing by pharmaceutical manufacturers.

Board means the Board of Administration of the California Public Employees' Retirement System (CalPERS).

A **Brand Name Prescription Drug (Brand Name Drug)** is a Prescription Drug that has been patented and is only produced by one manufacturer.

CAHP is the California Association of Highway Patrolmen.

Centers of Medical Excellence (CME) are health care providers designated by Anthem Blue Cross as a selected facility for specified medical services. A provider participating in a CME network has an Agreement in effect with Anthem Blue Cross at the time services are rendered or is available through their affiliated companies or their relationship with the Blue Cross and Blue Shield Association. CME agree to accept the Covered Expense as payment in full for covered services. A provider participating in the Prudent Buyer Plan Network is not necessarily a CME.

Chemical Dependency is the addictive relationship between a Member and any alcohol, Drug or other chemical substance meeting the criteria of the current edition of the *Diagnostic and Statistical Manual of Mental Disorders for Psychoactive Substance Use Disorders*, but not including addition to or dependency on tobacco or food substances (or dependency on items not ingested).

Claims Administrator refers to Anthem Blue Cross Life and Health Insurance Company (Anthem Blue Cross Life and Health). On behalf of Anthem Blue Cross Life and Health, Anthem Blue Cross shall perform all administrative services in connection with the processing of medical claims under the Plan and benefits provided under **HEALTH PROMOTION PROGRAM.** As used in this Evidence of Coverage, the term "Anthem Blue Cross" shall be used for convenience to refer to both Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company.

A **Clinical Laboratory** is a laboratory that collects, tests, and evaluates specimens (i.e., hematology, immunology, cytology, histology and microbiology).

COBRA (Consolidated Omnibus Budget Reconciliation Act) is a federal law that allows an enrolled Employee or Annuitant or his or her enrolled Family Members to continue coverage as defined in **CONTINUATION OF COVERAGE (COBRA)** under **TERMINATION AND RELATED PROVISIONS.**

A **Contract Year** is a period of time during which benefits and benefit levels remain un-changed.

A **Contracting Hospital** is a Hospital which has a contract with Anthem Blue Cross to provide care to Members. A Contracting Hospital is not necessarily a Prudent Buyer Plan Hospital. A list of Contracting Hospitals will be sent upon request.

Cosmetic Surgery is performed for beautification or to alter or reshape normal (including aged) structures or tissues of the body to improve the appearance of the patient.

Covered Expense is the expense incurred by the Member for covered services but not more than the amounts stated in **DETERMINATION OF COVERED EXPENSE** under **PRUDENT BUYER PLAN BENEFITS,** and **DETERMINATION OF COVERED EXPENSE** under **OUTPATIENT PRESCRIPTION DRUG BENEFITS** and under **HEALTH PROMOTION PROGRAM.**

Custodial Care means care that is provided primarily for the maintenance of the patient or which is designed essentially to assist the patient in meeting his or her activities of daily living and which is not primarily provided for its therapeutic value in the treatment of sickness or accidental bodily injury. Custodial care includes, but is not limited to, help in walking, bathing, dressing, feeding, preparation of special diets, and supervision over self-administration of medication not requiring constant attention of trained medical personnel.

A **Customary and Reasonable (C&R) Charge,** as determined annually by Anthem Blue Cross, is a charge which falls within the common range of fees billed by a majority of Physicians for a procedure in a given geographic region. If it exceeds that range, the expense must be justified based on the complexity of treatment or severity of the condition in a specific case. Some providers charge much more than the C&R Charge and the Member is responsible for paying all of that excess expense, in addition to any deductible and co-insurance amounts, amounts over stated benefit maximums, and any other non-covered expense.

A **Diagnostic Imaging Facility** is a facility that performs radiological procedures such as x-rays, computerized axial tomography (CAT) scans, and magnetic resonance imaging (MRI).

A **Disability** is an injury, an illness (including a Mental Disorder), or a condition (including pregnancy); however,

1. All injuries sustained in any one accident will be considered one Disability;
2. All illnesses existing simultaneously which are due to the same or related causes will be considered one Disability;
3. If any illness is due to causes which are the same as or related to the causes of any prior illness, the succeeding illness will be considered a continuation of the previous Disability and not a separate Disability.

Drug means a prescribed Drug approved by the State of California Department of Health Services or the Federal Food and Drug Administration for general use by the public. For the purposes of this Evidence of Coverage, insulin and niacin for lowering cholesterol will be considered a Prescription Drug.

Effective Date means the date on which the Member's coverage commences.

Emergency means a sudden, serious and unexpected acute illness, injury or condition (including without limitation sudden and unexpected severe pain), or Psychiatric Emergency Medical Condition, which the member reasonably perceives could permanently endanger health if medical treatment is not received immediately. Determination as to whether services were rendered in connection with an Emergency shall rest solely with Anthem Blue Cross.

Emergency Care means services received during the initial treatment of an Emergency.

Employee is defined in accordance with the definition currently in effect in the Act and Regulations, or any eligible Employee of the California Association of Highway Patrolmen.

Employer is defined in accordance with the definition currently in effect in the Act and Regulations, and includes the California Association of Highway Patrolmen.

An **Experimental** procedure is any treatment, therapy, procedure, drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supply which is mainly limited to laboratory and/or animal research.

Family Member means the Spouse and children of an Employee or Annuitant who qualify under Articles 1 and 5 of the Act and Sections 599.500, 599.501 and 599.502 of the Regulations and the Spouse and children of an eligible Employee or vested retired Employee of the California Association of Highway Patrolmen. In addition, a Family Member shall include a Domestic Partner as defined in Section 22770 of the PEMHCA Act.

1. A Member's or Annuitant's lawful spouse,
2. A member or annuitant's child under age 26, including a natural, adopted, or step child, and a child with whom the member or annuitant has a parent child Relationship as defined under regulations.
3. An unmarried child age 26 or over who is incapable of self-support because of a physical or mental disability which existed continuously from a date prior to attainment of age 26.
4. Domestic Partner.

A **Generic Prescription Drug (Generic Drug)** is a Prescription Drug which does not bear the trademark of a specific manufacturer. It is chemically the same and costs less than a Brand Name Prescription Drug.

Home Health Agencies are Home Health Care providers which are licensed according to state and local laws to provide skilled nursing and other services on a visiting basis in the Member's home. They must be recognized as Home Health Care providers under Medicare and/or accredited by a recognized accrediting agency such as the Joint Commission on the Accreditation of Healthcare Organizations.

Home Health Care is Physician-directed professional, technical and related medical and personal care service provided in the Member's home, on a visiting or part-time basis, by a Home Health Agency.

A **Home Infusion Therapy Provider** is a provider licensed according to state and local laws as a pharmacy, and must be either certified as a Home Health Care provider by Medicare, or accredited as a home pharmacy by the Joint Commission on Accreditation of Health Care Organizations.

Hospice means a public agency or private organization that is primarily engaged in providing pain relief, symptom management and supportive services to terminally ill people and their families. Care may be provided on a home-based or inpatient basis, or both. A Hospice must be: (1) certified by Medicare as a Hospice; (2) recognized by Medicare as a Hospice demonstration site; or (3) accredited as a Hospice by the Joint Commission on Accreditation of Hospitals.

A **Hospice Care Program** is a program administered by a Hospice for symptom management and supportive services to terminally ill people and their families.

A **Hospital** is a facility which provides diagnosis, treatment and care of persons who need acute inpatient Hospital care under the supervision of Physicians. It must be licensed as a general acute care Hospital according to state and local laws. It must also be registered as a general Hospital by the American Hospital Association and meet accreditation standards of the Joint Commission on Accreditation of Health Care Organizations. For the limited purpose of inpatient care for the acute phase

of a Mental Disorder or Chemical Dependency, the term Hospital will also include Psychiatric Health Facilities**.**

Infertility is (1) the presence of a condition recognized by a Physician as the cause of Infertility, or (2) the inability to conceive a pregnancy or carry a pregnancy to a live birth after a year or more of regular sexual relations without contraception.

An **Investigational** procedure is a treatment, therapy, procedure, drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage or supply which may have progressed to limited use on humans, but which is not widely accepted as a proven and effective procedure within the organized medical community within the United States and US territories.

Express Scripts is the prescription drug benefits claims administrator for the CAHP Health Benefits Trust, but only for benefits administered through Express Scripts.

Medical Management Programs are programs for utilization review and case management, which are described under **PRUDENT BUYER PLAN BENEFITS MEDICAL MANAGEMENT PROGRAMS**.

Medically Necessary shall mean health care services that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

1. In accordance with generally accepted standards of medical practice.
2. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or diseases; and
3. Not primarily for the convenience of the patient, Physician or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations and the views of physicians practicing in relevant clinical areas and any other relevant factors.

Medicare refers to the programs of medical care coverage set forth in Title XVIII of the Social Security Act as amended by Public Law 89-97 or as thereafter amended.

Member means any Employee, Annuitant or Family Member enrolled under this Plan.

Mental Disorders for the purpose of this Plan, are conditions that are listed in the most current edition of the Diagnostic and Statistical Manual (DSM) of Mental Disorders. One or more of these conditions may be specifically excluded in this Evidence of Coverage.

A **Multi-Source Brand Prescription Drug (Multi-Source Brand Drug)** is a Prescription Drug that has generic equivalents available.

The **Negotiated Rate** is the fee Prudent Buyer Plan Providers agree to accept as payment in full for covered services. It is always lower than the Customary and Reasonable Charge for that service in the same geographical area. Negotiated Rates are determined by the Prudent Buyer Plan Participating Provider Agreement. Because Prudent Buyer Plan Providers agree to accept this special rate, the Member is guaranteed protection against having to pay any covered charges in excess of that amount (other than deductible and co-insurance amounts, if applicable, or amounts in excess of stated

maximum benefits). If Medicare is the primary payer, the negotiated rate may be determined by Medicare's approved amount. The Negotiated Rate is one of the main advantages of choosing a Prudent Buyer Plan Provider.

A **Non-Participating Retail Pharmacy** is a Pharmacy which does not have a Participating Pharmacy Agreement in effect with Express Scripts at the time services are rendered. In most instances, the Member will be responsible for a larger portion of the pharmaceutical bill when using a Non-Participating Pharmacy.

A **Non-Prudent Buyer Plan Provider** is one of the following providers which is eligible to enter into a Prudent Buyer Plan Participating Provider Agreement with Anthem Blue Cross but does not have a Prudent Buyer Plan Participating Provider Agreement in effect with Anthem Blue Cross at the time services are rendered:

a. A **Hospital.** A Hospital that is a Non-Prudent Buyer Plan Provider may also be referred to in this Evidence of Coverage as a Non-Prudent Buyer Plan Hospital.
b. A Physician.
c. A Home Health Agency.
d. An Ambulatory Surgical Center.
e. A Home Infusion Therapy Provider.
f. A Clinical Laboratory.
g. A Diagnostic Imaging Facility.
h. A Skilled Nursing Facility.
i. A Durable Medical Equipment Supply Outlet.

Any of the providers listed above whose principal place of business is outside of California are also Non-Prudent Buyer Plan Providers. Exceptions: Providers in certain areas of Arizona, Nevada and Oregon may contract with the Prudent Buyer Plan Network.

Open Enrollment Period means a period of time established by the Board during which eligible Employees and Annuitants may enroll in a health benefit plan, add Family Members, or change their enrollment from one health benefit plan to another.

Out-of-Pocket Expense is the difference between the Covered Expense and the Trust's payment. The maximum Out-of-Pocket Expense **does not** include (1) Outpatient Prescription Drug co-payments, (2) co-payments for benefits provided under **HEALTH PROMOTION PROGRAM,** (3) Non-Prudent Buyer Plan Provider co-payments other than for an approved Authorized Referral or Emergency Care, (4) non-covered expense, and charges in excess of the Plan maximums for which the Member is responsible, such as amounts over the Scheduled Amount for Non-Prudent Buyer Plan Hospitals, (5) amounts over Customary and/or Reasonable Charges for Non-Prudent Buyer Plan Providers and providers not represented in the Prudent Buyer Plan Network..

An **Outpatient Day Treatment Center** is an outpatient psychiatric facility, a Chemical Dependency Treatment Facility or other outpatient facility providing an organized, multidisciplinary program consisting of acute and/or rehabilitative care. The facility must have a medical director who is a Physician (M.D.). It must be licensed according to state and local laws.

A **Participating Retail Pharmacy** is a Pharmacy which has a Participating Pharmacy Agreement in effect with Express Scripts at the time services are rendered. Members may call local Pharmacies to determine whether they are Participating Pharmacies or they may contact Express Scripts Member Services at 1-800-711-0917.

A **Period of Disability** is the period of time beginning on the date the Member is confined to the home as a result of a debilitating illness or injury and ending on the date the Member no longer receives Home Health Care services for the treatment of such condition.

A **Physician** means:

a. A doctor of medicine (M.D.) or a doctor of osteopathy (D.O.) who is licensed to practice medicine or osteopathy where the care is provided, or

b. One of the following providers, but only when the provider is licensed to practice where the care is provided, is rendering a service within the scope of that license and such license is required to render that service, is providing a service for which benefits are specified in this Plan, and when benefits would be payable if the services were provided by a Physician as defined in 1. above:

(1) A dentist (D.D.S. or D.M.D.)

(2) An optometrist (O.D.)

(3) A dispensing optician

(4) A podiatrist or chiropodist (D.P.M., D.S.P. or D.S.C.)

(5) A licensed clinical psychologist (Ph.D.)

(6) A chiropractor (D.C.)

(7) An acupuncturist (A.C.), (but only for acupuncture and for no other services)

(8) A certified registered nurse anesthetist (C.R.N.A.)

(9) A licensed clinical social worker (C.S.W. or L.C.S.W.)

(10) A marriage and family therapist (M.F.T.)

(11) A physical therapist (P.T. or R.P.T.)*

(12) A speech pathologist*

(13) An audiologist*

(14) An occupational therapist (O.T.R.)*

(15) A respiratory practitioner (R.C.P.)*

(16) A qualified psychiatric mental health nurse (a registered nurse having a masters degree in psychiatric mental health nursing who meets the qualifications for registration and is in fact registered as a psychiatric mental health nurse with the California Department of Registered Nurses.)*

(17) A registered dietitian (R.D.)* or another nutritional professional* with a master's or higher degree in a field covering clinical nutrition sciences, from a college or university accredited by a regional accreditation agency, who is deemed qualified to provide these services by the referring M.D. or D.O. A registered dietitian or other nutritional professional as described here are covered for the provision of diabetic medical nutrition therapy and nutritional counseling for the treatment of eating disorders such as anorexia nervosa and bulimia nervosa only

(18) A nurse midwife

(19) A nurse practitioner

(20) A physician assistant

(21) Any agency licensed by the state to provide services for the treatment of Mental Disorders or Chemical Dependency, when required by law to cover those services.

*** NOTE:** The providers indicated by asterisks are covered only by referral of a Physician defined in 1. above. Providers listed in 2. above may not be represented in the Prudent Buyer Plan Network.

A **Pharmacy** is a licensed retail pharmacy.

The **Plan** is the CAHP Health Benefits Trust Prudent Buyer Plan, as set forth in the Agreement, the Administrative Services Agreement with Anthem Blue Cross Life and Health Insurance Company and the Administrative Services Agreement with Express Scripts.

A **Prescription** is a written order issued by a licensed prescriber for the purpose of dispensing a Drug.

The **Prescription Drug Negotiated Rate** is the rate that Express Scripts has negotiated with Participating Retail Pharmacies under a Participating Retail Pharmacy Agreement for Prescription Drug Covered Expense. Participating Retail Pharmacies have agreed to charge Members no more than the Prescription Drug Negotiated Rate. It is also the rate which Express Scripts Mail Service has agreed to accept as payment in full for mail order Prescription Drugs. In addition, it is the maximum allowable expense for a Non-Participating Retail Pharmacy.

Preventive Care Services include routine examinations, screenings, tests, education, and immunizations administered with the intent of preventing future disease, illness, or injury. Services are considered preventive if you have no current symptoms or prior history of a medical condition associated with that screening or services. These services shall meet requirements as determined by federal and state law. Sources for determining which services are recommended include the following:

a. Services with an “A” or “B” rating from the United States Preventive Services Task Force (USPSTF)

b. Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

c. Preventive care and screenings for infants, children, and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and

d. Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration.

Please call the customer service number listed on your ID card for additional information about services that are covered by this Plan as preventive care services. You may also refer to the following websites that are maintained by the U.S. Department of Health & Human Services:

https://www.healthcare.gov/what-are-my-preventive-care-benefits

http://www.ahrq.gov

http://www.cdc.gov/vaccines/acip/index.html

Providers Not Represented in the Prudent Buyer Plan Network are types of providers not fully represented in the Prudent Buyer Network.

The **Prudent Buyer Plan Network** is a network of Prudent Buyer Plan Providers which have a Prudent Buyer Plan Participating Provider Agreement in effect with Anthem Blue Cross at the time services are rendered. Prudent Buyer Plan Network Providers agree to accept the Negotiated Rate as payment for covered services.

A **Prudent Buyer Plan Physician** is a licensed doctor of medicine (M.D.), doctor of osteopathy (D.O.) or doctor of podiatry (D.P.M.) who has a Prudent Buyer Plan Participating Provider Agreement in effect with Anthem Blue Cross at the time services are rendered.

A **Prudent Buyer Plan Provider** is one of the following providers in California and in certain areas of Arizona, Nevada and Oregon which has a Prudent Buyer Plan Participating Provider Agreement in effect with Anthem Blue Cross at the time services are rendered. Prudent Buyer Plan Providers have agreed to participate in procedures established to review the utilization of services. **All Prudent Buyer Plan Providers are independent contractors and are not employees or agents of Anthem Blue Cross. Those providers alone have undertaken and are responsible for providing medical care.** A list of Prudent Buyer Plan Providers is available upon request.

a. A **Hospital.** A Hospital which is a Prudent Buyer Plan Provider may also be referred to in this Evidence of Coverage as a Prudent Buyer Plan Hospital. Hospital services determined to be not Medically Necessary, according to the procedures listed under **MEDICAL MANAGEMENT PROGRAMS,** are not covered by this Plan. A Contracting Hospital is not necessarily a Prudent Buyer Plan Hospital.

b. A **Physician.** A Physician who is a Prudent Buyer Plan Provider may also be referred to in this Evidence of Coverage as a Prudent Buyer Plan Physician.

c. A **Home Health Agency.** A Home Health Agency that is a Prudent Buyer Plan Provider may also be referred to in this Evidence of Coverage as a Prudent Buyer Plan Home Health Agency. Home Health services determined to be not Medically Necessary, according to the procedures listed under **MEDICAL MANAGEMENT PROGRAMS,** are not covered by this Plan.

d. An **Ambulatory Surgical Center.** An Ambulatory Surgical Center that is a Prudent Buyer Plan Provider may also be referred to as a Prudent Buyer Plan Ambulatory Surgical Center.

e. A **Home Infusion Therapy Provider.** A Home Infusion Therapy Provider that is a Prudent Buyer Plan Provider may also be referred to in this Evidence of Coverage as a Prudent Buyer Plan Home Infusion Therapy Provider. Home Infusion Therapy services determined to be not Medically Necessary be, according to the procedures listed under **MEDICAL MANAGEMENT PROGRAMS,** are not covered by this Plan.

f. A **Clinical Laboratory.** A Clinical Laboratory that is a Prudent Buyer Plan Provider may also be referred to in this Evidence of Coverage as a Prudent Buyer Plan Clinical Laboratory.

g. A **Diagnostic Imaging Facility.** A Diagnostic Imaging Facility that is a Prudent Buyer Plan Provider may also be referred to in this Evidence of Coverage as a Prudent Buyer Plan Diagnostic Imaging Facility.

h. A **Skilled Nursing Facility.** A Skilled Nursing Facility that is a Prudent Buyer Plan Provider may also be referred to in this Evidence of Coverage as a Prudent Buyer Plan Skilled Nursing Facility. Skilled Nursing Facility services determined to be not Medically Necessary, according to the procedures listed under **MEDICAL MANAGEMENT PROGRAMS,** are not covered by this Plan.

i. A **Durable Medical Equipment Supply Outlet.** A Durable Medical Equipment Supply Outlet that is a Prudent Buyer Plan Provider may also be referred to in this Evidence of Coverage as a Prudent Buyer Plan Durable Medical Equipment Supply Outlet.

j. A **Psychiatric Health Facility** is an acute 24-hour facility as defined in Health and Safety Code 1250.2. It must be licensed by the California Department of Health Services, qualified to provide short-term inpatient treatment according to the California Insurance Code, accredited by the Joint Commission on Accreditation of Health Care Organizations and staffed by an organized medical or professional staff which includes a Physician as medical director.

Psychiatric Emergency Medical Condition is a mental disorder that manifests itself by acute symptoms of sufficient severity that the patient is either (1) an immediate danger to himself or herself or to others, or (2) immediately unable to provide for or utilize fold, shelter, or clothing due to the Mental Disorder.

A **Reasonable Charge** is one which Anthem Blue Cross considers not to be excessive, based on the circumstances of the care provided. Such circumstances include: level of skill, experience involved, the prevailing or common cost of similar services or supplies and any other factors which determine value. The Member is responsible for paying amounts over the Reasonable Charge, in addition to any applicable deductible and co-insurance amounts, amounts over stated benefit maximums, and any non-covered expense.

Regulations means the California Public Employees' Medical and Hospital Care Act Regulations as adopted by the Board and set forth in Subchapter 3, Chapter 2, Division 1, and Title 2 of the California Code of Regulations.

A **Related Health Provider** is one of the following, licensed according to state and local laws to provide covered medical services:

a. A licensed ambulance company.
b. A blood bank.
c. A registered nurse.
d. A Hospice.

A **Residential Treatment Center** is an Inpatient Treatment Facility where the Member resides in a modified community environment and follows a comprehensive medical treatment regimen for treatment and rehabilitation as the result of a Mental Disorder or Chemical Dependency. The facility must be licensed to provide psychiatric treatment of Mental Disorders or rehabilitative treatment of Chemical Dependency according to state and local laws.

The **Scheduled Amount** is the amount of Covered Expense for Non-Prudent Buyer Plan Hospitals, determined according to the Table of Allowances stated under **PRUDENT BUYER PLAN BENEFITS - DETERMINATION OF COVERED EXPENSE.** Any amount by which a Non-Prudent Buyer Plan Hospital's inpatient charges exceed the Scheduled Amount will not be considered Covered Expense, except for Emergency Care or an Authorized Referral. Hospitals charge much more than this amount and the Member is responsible for paying all of this excess expense, in addition to co-payment amounts, amounts overstated benefit maximums, and any other non-covered expense.

Service Area is the area in which the Non-Prudent Buyer Plan Hospital's principal place of business is located. The counties encompassed by each Service Area are as follows:

Service Area 1: Counties of Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Inyo, Kings, Lake, Lassen, Madera, Mariposa, Mendocino, Merced, Modoc, Mono, Nevada,

Placer, Plumas, Sacramento, San Benito, Shasta, Sierra, Siskiyou, Solano, Sutter, Tehama, Trinity, Tulare, Tuolumne, Yolo and Yuba.

Service Area 2: Counties of Alameda, Contra Costa, Monterey, Napa and Santa Cruz.

Service Area 3: Counties of Marin, San Francisco, San Mateo and Santa Clara.

Service Area 4: Counties of Los Angeles and Riverside (city of Palm Springs only) and any area outside the State of California.

Service Area 5: Orange County.

Service Area 6: Counties of Kern, Riverside (except city of Palm Springs), San Bernardino, San Luis Obispo, Santa Barbara and Ventura.

Service Area 7: San Diego County.

Service Area 8: Counties of Fresno, San Joaquin, Sonoma and Stanislaus.

Service Area 9: Imperial County.

A **Single Source Brand Prescription Drug (Single Source Brand Drug)** is a Prescription Drug that does not have generic equivalents available.

A **Skilled Nursing Facility** is a facility which is licensed to operate in accordance with state and local laws pertaining to institutions identified as such and which is listed as such by the American Hospital Association and accredited by the Joint Commission on Accreditation of Health Care Organizations and related facilities, or which is recognized as a Skilled Nursing Facility by the Secretary of Health and Human Services of the United States government pursuant to the Medicare Act.

Special Care Units are special areas of a Hospital which have highly skilled personnel and special equipment for acute conditions that require constant treatment and observation.

A **Spouse** is the Subscriber's spouse under a legally valid marriage.

A **Stay** is an inpatient confinement of a Member which begins when the Member is admitted to the facility and ends when the Member is discharged from the facility.

Subscriber means the person enrolled hereunder who is responsible for payment to the Trust, and whose employment or other status, except family dependency, is the basis for eligibility for enrollment under this Plan. Subscribers must be members or eligible Employees or vested retirees of the California Association of Highway Patrolmen.

A Member who is an Employee is **Totally Disabled** when, because of illness or injury, he or she is unable to work for income in any job for which he or she is qualified or for which he or she becomes qualified by training or experience, and who is in fact unemployed. A Member who is an Annuitant or a Family Member is **Totally Disabled** when unable to perform all activities usual for a person of that age.

The **Trust** is the CAHP Health Benefits Trust, which is sponsored by the California Association of Highway Patrolmen. The Trust is a self-insured health and welfare trust fund that is regulated by the Public Employees' Medical and Hospital Care Act (PEMHCA). PEMHCA is administered by the California Public Employees' Retirement System.

Urgent Care is the services received for a sudden, serious, or unexpected illness, injury or conditions, other than one which is life threatening, which requires immediate care for the relief of severe pain or diagnosis and treatment of such condition.

A **Year** or a **Calendar Year** is a twelve-month period starting each January 1 at 12:01 a.m. Pacific Standard Time and ending on January 1 of the following year.

You (your) refer to the Subscribers and Family Members who are enrolled for benefits under this Plan.

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, Richmond, VA 23279 or by email to compliance.coordinator@anthem.com. 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.

GET HELP IN YOUR LANGUAGE

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

You have the right to get this information and help in your language for free. Call the Member Services number on your ID card for help. (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

Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda**. (TTY/TDD: 711)**

Arabic

يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجانًا. اتصل برقم خدمات الأعضاء الموجود على بطاقة التعريف الخاصة بك للمساعدة(TDD/TTY: 711).

Armenian

Դուք իրավունք ունեք Ձեր լեզվով անվճար ստանալ այս տեղեկատվությունը և ցանկացած օգնություն: Օգնություն ստանալու համար զանգահարեք Անդամների սպասարկման կենտրոն՝ Ձեր ID քարտի վրա նշված համարով: (TTY/TDD: 711)

Chinese

您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。(TTY/TDD: 711)

Farsi

شما این حق را دارید که این اطلاعات و کمکها را به صورت رایگان به زبان خودتان دریافت کنید. برای دریافت کمک به شماره مرکز خدمات اعضاء که بر روی کارت شناسایی‌تان درج شده است، تماس بگیرید. (TTY/TDD: 711)

Hindi

आपके पास यह जानकारी और मदद अपनी भाषा में मुफ़्त में प्राप्त करने का अधिकार है। मदद के लिए अपने ID *कार्ड पर सदस्य सेवाएँ नंबर पर कॉल करें।*(TTY/TDD: 711)

Hmong

Koj muaj cai tau txais qhov lus qhia no thiab kev pab hais ua koj hom lus yam tsis xam tus nqi. Hu rau tus nab npawb xov tooj lis Cov Kev Pab Cuam Rau Tswv Cuab nyob rau ntawm koj daim ID txhawm rau thov kev pab. (TTY/TDD: 711)

Japanese

この情報と支援を希望する言語で無料で受けることができます。支援を受けるには、ID カードに記載されているメンバーサービス番号に電話してください。(TTY/TDD: 711)

Khmer

អ្នកមានសិទ្ធិក្នុងការទទួលព័ត៌មាននេះ និងទទួលជំនួយជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។ សូមហៅទូរស័ព្ទទៅលេខសេវាសមាជិកដែលមានលើប័ណ្ណ ID *របស់អ្នកដើម្បីទទួលជំនួយ។*(TTY/TDD: 711)

Korean

귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으려면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오. (TTY/TDD: 711)

Punjabi

ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਇਹ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਮੁਫ਼ਤ ਵਿੱਚ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਮਦਦ ਲਈ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਉੱਤੇ ਮੈਂਬਰ ਸਰਵਿਸਿਜ਼ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ।(TTY/TDD: 711)

Russian

Вы имеете право получить данную информацию и помощь на вашем языке бесплатно. Для получения помощи звоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. (TTY/TDD: 711)

Tagalog

May karapatan kayong makuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng Member Services na nasa inyong ID card para sa tulong. (TTY/TDD: 711)

Thai

ท่านมีสิทธิขอรับบริการสอบถามข้อมูลและความช่วยเหลือในภาษาของท่านฟรี โทรไปที่หมายเลขฝ่ายบริการสมาชิกบนบัตรประจำตัวของท่านเพื่อขอความช่วยเหลือ(TTY/TDD: 711)

Vietnamese

Quý vị có quyền nhận miễn phí thông tin này và sự trợ giúp bằng ngôn ngữ của quý vị. Hãy gọi cho số Dịch Vụ Thành Viên trên thẻ ID của quý vị để được giúp đỡ. (TTY/TDD: 711)

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