Preferred Provider Organization (PPO) Supplement to Original Medicare Plan with Major Medical Benefits

CAHP Health Benefits Trust

Combined Evidence of Coverage and Disclosure Form

Effective January 1, 2010

Sponsored by California Association of Highway Patrolmen
Medical Claims Administered by Anthem Blue Cross Life & Health Insurance Company.

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

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 Medco Health Solutions, Inc.

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.

THIS PLAN DOES NOT COVER CUSTODIAL CARE IN A SKILLED NURSING FACILITY OR IN ANY OTHER FACILITY OR SITUATION.

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.**

Please see inside back cover for important addresses and telephone numbers for this Plan.

CAHP Health Benefits Trust

SUPPLEMENT TO ORIGINAL MEDICARE PLAN

Plan Year 2010

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1: SUMMARY OF BENEFIT/ADMINISTRATIVE CHANGES

The following is a brief summary of the benefit/administrative changes effective January 1, 2010. Be sure to refer to the appropriate benefit description sections of this Evidence of Coverage for additional information.

There are no benefit/administrative changes effective January 1, 2010.

2: MEDICAL NECESSITY

Except for the benefits provided under **HEALTH PROMOTION PROGRAM,** benefits are provided only for services 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.

NOTE: The Plan will accept Medicare's determination of medical necessity.

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 environment change;
- Pain management centers to treat or cure chronic pain;
- Pre-operative workups 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 as specified in this Evidence of Coverage.

2: MEDICAL NECESSITY

MEDICAL POLICY

Anthem Blue Cross reviews and evaluates new technology according to its technology evaluation criteria developed by its medical directors. Technology assessment criteria is 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** and click on "Medical Policies and Clinical UM Guidelnes"**.**

3: HOW TO USE YOUR PLAN

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 (CalPERS) Board of Administration.

The Trust provides comprehensive health care coverage exclusively to Members and Employees of the CAHP.

The Trust contracts directly with Anthem Blue Cross Life and Health Insurance Company (Anthemb Blue Cross Life and Health), an affiliate of Anthem Blue Cross, as Claims Administrator of the medical, mental disorders and chemical dependency 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 Medco Health Solutions, Inc. to administer and provide prescription drug benefits to eligible Plan Members.

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 cost shall help keep your future monthly out-of-pocket premium cost at a minimum.

- **You should always make sure that the individuals or organizations providing services are approved to provide Medicare services.** If you are not sure, ask. This is very important, since this Plan does not provide benefits when Medicare approval is denied except for those benefits specifically listed under the section **MAJOR MEDICAL BENEFITS** and **BENEFITS FOR SERVICES NOT COVERED BY MEDICARE** under **SUMMARY OF BENEFITS.**
- **You will receive maximum Plan benefits when you receive services from a provider that accepts Medicare assignment.** If a provider accepts Medicare assignment, the Trust's payment is limited to the difference between the amount paid by Medicare and the approved charge under Medicare. This limits the Trust's claims liability, and will directly help to keep the future cost of providing health care at a minimum.
- If a provider does not accept Medicare assignment, the Plan will pay the difference between the Medicare payment and the Customary and Reasonable Charge, the Reasonable Charge or the Negotiated Rate for Covered Expense incurred. If the provider bills in excess of the Customary and Reasonable Charge (as determined annually by Anthem Blue Cross), **you will be responsible for paying the difference.**

NO-PENALTY PRUDENT BUYER PLAN

NOTE: This section applies only to Members who reside in California or have access to the Prudent Buyer Plan Network of Prudent Buyer Plan Providers (in certain areas of Arizona, Nevada and Oregon).

If you reside in California or have access to the Prudent Buyer Plan Network (located throughout California and in certain areas of Arizona, Nevada and Oregon) and **choose** to receive health care from Prudent Buyer Plan Providers, **you may further minimize your out-of-pocket costs and maximize savings to your Trust fund.** There is "no penalty" when you receive health care from Non-Prudent Buyer Plan Providers; however any amount charged in excess of the Customary and Reasonable Charge or the Reasonable Charge (Please refer to the definitions of **Customary and Reasonable Charge, Reasonable Charge, Negotiated Rate** and **Prudent Buyer Plan Provider** under **GENERAL DEFINITIONS**) will be your responsibility.

3: HOW TO USE YOUR PLAN

REMEMBER: As stated on the previous page, you will receive maximum Plan benefits when you receive services from a provider that accepts Medicare assignment.

The Prudent Buyer Plan Network

The Prudent Buyer Plan Network includes the following specialty providers:

- Hospitals
- Physicians
- Ambulatory Surgical Centers
- Skilled Nursing Facilities
- Home Health Agencies
- Physical Therapists
- Chiropractors
- Clinical Laboratories
- Diagnostic Imaging Facilities
- Durable Medical Equipment Supply Outlets
- Home Infusion Therapy Providers
- Acupuncturists
- Speech Pathologists

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 participating in the Prudent Buyer Plan Urgent Care Network by calling Anthem Blue Cross at **1-800-759-5758** to request a directory of Prudent Buyer Plan Providers or accessing Provider Finder online at **www.anthem.com/ca**. Office hours and days of operation vary, and you should call the provider before going to their office. When you call, confirm with the health care provider that he or she is a Prudent Buyer Plan Provider so that you can maximize your benefits.

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.

MEDICARE HANDBOOK

A copy of the directory of providers that accept assignment (Medicare Provider Directory) and a booklet that outlines the benefits Medicare provides ("Medicare & You") is available. You may contact your nearest Social Security office, visit the Web site at **www.medicare.gov** or write to:

Department of Health and Human Services
Centers for Medicare & Medicaid Services
7500 Security Blvd.
Baltimore, Maryland 21244-1850

3: HOW TO USE YOUR PLAN

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 30) are administered by Medco Health Solutions, Inc. (Medco).

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 Retail Pharmacy. Medco contracts with over 55,000 retail pharmacies within the United States. Information regarding Participating Pharmacies may be obtained by calling Medco at 1-800-711-0917, or by logging on to **www.medco.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 Medco.

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.

3: HOW TO USE YOUR PLAN

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** (page 37) section for additional information.

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.

4: HOW TO FILE A CLAIM

When you require healthcare, present your CAHP Health Benefits Trust identification card to your provider.

Always consult your Physician first. If your Physician decides hospitalization is necessary, he or she will make the arrangements. Your identification card should be presented along with your Social Security Medicare identification card at the Hospital admission desk. The Hospital will commence action on your claim by billing Medicare first. Following receipt of the Medicare payment, the Hospital will then bill Anthem Blue Cross for benefits under your Supplement to Original Medicare Plan.

If you do not have your identification card when you enter the Hospital or if the status of your contract is questioned, please request that the Hospital contact Anthem Blue Cross at **1-800-759-5758.**

Itemized charges and dates of service must be filed with Anthem Blue Cross by you or the provider of health care within 90 days after you have incurred expenses, or within 90 days of the date the "Explanation of Medicare Benefits" (EOMB) is issued by Medicare. If it is not reasonably possible to submit the claim within that timeframe, an extension of up to 12 months will be granted.

CLAIM-FREE SERVICE

You need not file a claim for Supplement to Original Medicare benefits if you are a California resident who has enrolled in Anthem Blue Cross' ***Claim-Free*** program, **and** if your provider billed Medicare and the Medicare claim is processed by Anthem Blue Cross, Blue Shield of California or the California offices of Trans-America Insurance or Occidental Insurance. Your Supplement to Original Medicare benefits will automatically be paid through Anthem Blue Cross' ***Claim-Free*** process, which makes it possible for Anthem Blue Cross to electronically obtain Medicare claims data directly from those Medicare claims processors. In some cases, you may receive your Supplement to Original Medicare benefit claim payment faster than your Medicare payment. If your Medicare claim is not processed by one of the above claims processors or if you are not enrolled in the ***Claim-Free*** program, then you will need to submit a claim as listed below.

To expedite your enrollment in the convenient *Claim-Free* program, call Anthem Blue Cross at **1-800-759-5758.** Make sure you have your Medicare card available when you place the call.

WHEN YOU NEED TO SUBMIT A CLAIM

First, you or your provider must submit all medical claims to the Social Security Medicare fiscal intermediary for Medicare benefits.

When Medicare has processed your claim, you will receive an "Explanation of Medicare Benefits" (EOMB) notice when services are received in the United States. Then, write your Member number and group number (from your identification card) on this Medicare notice (EOMB) and mail it, along with a CAHP medical claim form and a copy of the itemized bill for the services received, to the following address:

ANTHEM BLUE CROSS
Attn: CAHP, Unit
P.O. Box 60007
Los Angeles, CA 90060-0007

To obtain CAHP medical claim forms, please call Anthem Blue Cross at 1-800-759-5758 or access online at **www.anthem.com/ca.**

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

4: HOW TO FILE A CLAIM

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

- Claims for covered medical services or supplies that supplement Medicare benefits must be submitted to **Anthem Blue Cross within 90 days** of the date the EOMB is issued by Medicare. If it is not reasonably possible to submit the claim within that timeframe, an extension of up to 12 months will be available.

- All other claims for covered medical services or supplies must be submitted to Anthem Blue Cross **within 90 days** of the date services were incurred. If it is not reasonably possible to submit the claim within that timeframe, an extension of up to 12 months will be available.

- Claims for outpatient Prescription Drugs purchased at a Non-Participating Pharmacy must be submitted to Medco at the address listed under **OUTPATIENT PRESCRIPTION DRUG BENEFITS within 90 days** of the purchase date. If it is not reasonably possible to submit a claim within that timeframe, an extension of up to nine months will be allowed. Claim forms and itemized bills 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 PROGRAM** section of this Evidence of Coverage.

5: IF YOU HAVE QUESTIONS

Remember, it is your responsibility to stay informed about your health benefits coverage.

CLAIMS

For medical claims submission or inquiries, 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

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

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:

Medco Health Solutions Inc,
1-800-711-0917
or visit the Web site at **www.medco.com**

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

Medco Health Solutions
PO Box 650022
Dallas, TX 75265-0022
1-800-711-0917
or visit the Web site at **www.medco.com**

ELIGIBILITY OR ENROLLMENT

For information regarding eligibility or enrollment, consult your health benefits officer in your agency (Employees) or write to the Office of Employer and Member Health Services (Annuitants) as follows:

Office of Employer and Member Health Services
California Public Employees Retirement System
(CalPERS)
P.O. Box 942714, Sacramento, CA 94229-2714
(888) CalPERS (225-7377) • (916) 795-1277 (fax)
TTY (800) 735-2929 • (916) 795-3240
or visit the Web site at **www.calpers.ca.gov.**

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

MEDICARE PROGRAM

For information and assistance regarding your Medicare benefits, contact

Your local Social Security Administration office
1-800-772-1213 (TTY 1-800-325-0778)
or
Medicare Program
1-800-MEDICARE (1-800-633-4227)
TDD 1-877-486-2048
www.medicare.gov

Health Insurance Counseling and Advocacy Program (HICAP). For additional information concerning Medicare benefits, contact the Health Insurance Counseling and Advocacy Program (HICAP) or CalPERS. HICAP provides health insurance counseling for California senior citizens. Call the HICAP toll-free telephone number, **1-800-434-0222,** for a referral to your local HICAP counseling location. HICAP is a service provided free of charge by the State of California.

6: SUMMARY OF BENEFITS

This Plan is designed for Members who are enrolled in both Parts A (hospital insurance) and B (medical insurance) of Original Medicare. The benefits described in this Evidence of Coverage are payable only for Covered Expense to supplement Original Medicare Plan benefits, except as specifically stated under **MAJOR MEDICAL BENEFITS, SPECIAL DUTY NURSING BENEFITS, SERVICES AND BENEFITS OUTSIDE THE UNITED STATES, HEARING AID SERVICES, OUTPATIENT PRESCRIPTION DRUG BENEFITS** and **HEALTH PROMOTION PROGRAM.**

For complete information about Medicare, you should contact your local Social Security Office, or write to the Centers for Medicare & Medicaid Services at the address listed on pages 5 & 6, or refer to its publications.

The following benefits are provided for care received inside the United States and its territories, and are subject to the **PLAN EXCLUSIONS AND LIMITATIONS** set forth herein. **NOTE:** See page 28 for care received while you are temporarily outside the United States.

Benefits are subject to all provisions of this Evidence of Coverage, which may limit benefits or result in benefits not being payable.

SUPPLEMENT TO ORIGINAL MEDICARE PLAN MEMBER CO-PAYMENTS

HOSPITAL (Part A)	
Inpatient Hospital (page 17)	
Skilled Nursing Facility (page 17)	No Charge If Medicare Approved
Hospice (page 17)	
First three pints of unreplaced blood (page 18)	
MEDICAL (Part B) (pages 18-20)	
Office Visits	$10
Outpatient Hospital	No Charge If Medicare Approved
Ambulatory Surgical Center Services	
Diagnostic X-Ray/Lab	
Durable Medical Equipment	
Ambulance	
Chiropractic	
Speech/Physical/Occupational Therapy	
Routine Physical Exam+	
Mental Health Care	

+ Must be incurred during the first twelve months of being enrolled in Medicare.

6: SUMMARY OF BENEFITS

MAJOR MEDICAL BENEFITS are payable, as stated in this Evidence of Coverage, for certain services and supplies in excess of Original Medicare Plan benefits or when Medicare benefits are not approved. Please refer to **MAJOR MEDICAL BENEFITS** (pages 21-27).

MAJOR MEDICAL BENEFITS FIRST LEVEL PAYMENT

After Original Medicare Plan Benefits Have Been Exhausted *	
Other Services (pages 22 – 23)	80% of Covered Expenses
Extented Skilled Nursing Facility Benefits (page 23)	
Dental Services (page 24)	
Speech Therapy (page 25)	
Extend Hospice Care (pages 25-27)	
Mental Disorders, except outpatient psychotherapy and psychological testing (page 24-25)	
Outpatient psychotherapy and psychological testing (page 25)	50% of Covered Expenses
Services Not Covered By Original Medicare Plan	
Special Duty Nursing Services** (page 28)	80% of Covered Expenses
Shingles Vaccine (Page 29)	90%
Hearing Aid Services (page 28)	

* Services subject to $100 Calendar Year deductible.

** Services subject to $50 Calendar Year deductible.

MAJOR MEDICAL BENEFITS SECOND LEVEL OF PAYMENT

After a Member incurs $15,000 in Covered Expense under Major Medical Benefits during a Calendar Year, payment will be provided at **100%** of Covered Expense incurred by that Member for the remainder of that Year, except for outpatient psychotherapy and psychological testing which will continue to be paid at 50%.

6: SUMMARY OF BENEFITS

MAJOR MEDICAL MAXIMUM BENEFITS

Mental Disorders (pages 24-25) Inpatient Hospital Inpatient Physician Visit Outpatient Psychotherapy and Psychological Testing	 30 Days Calendar Year Up to $40 for each visit Up to $20 for each visit
Speech Therapy (page 25)	$5,000 during a Members lifetime
Hearing Aid Services (page 28) For covered hearing aids For covered audiological exams	 $1,000 each 36 months $200 each 36 months
Special Duty Nursing Benefits (page 28)	$800 during a Calendar Year
Hospice Care (page 25)	$7,500 during a Member's lifetime - including 2 bereavement counseling visits for your family members during the 12-month period following your death
Lifetime Maximum	$1,000,000 during each Member's lifetime (up to $1,000 automatically restored each January 1)

OUTPATIENT PRESCRIPTION DRUG CO-PAYMENTS

Retail Pharmacy (pages 30-31)	
Generic	$5
Single-Source Brand	$20
Multi-Source Brand	$25
Mail Order Program (page 32) and retail pharmacy if after first refill (pages 30-31)	
Generic	$10
Single-Source Brand	$40
Multi-Source Brand	$50

6: SUMMARY OF BENEFITS

HEALTH PROMOTION PROGRAM

Smoking Cessation Program	100% up to $100 per program per Year, 2 programs during a Member's lifetime
Smoking Cessation Products	50% up to $175 for 90-day supply per Year, 2 times during a Member's lifetime
Weight Management Program	80% up to $125 during a Member's lifetime

7: CONDITIONS UNDER WHICH SERVICES AND BENEFITS SHALL BE PAID

1. Benefits shall be provided only while Medically Necessary in connection with the direct care and treatment of a covered illness, disease or injury. When an illness, disease or injury necessitates an inpatient confinement in a Hospital or Skilled Nursing Facility, services shall be limited to those customarily furnished by the Hospital or Skilled Nursing Facility and only those services which could not have been performed prior to admission to the Hospital or Skilled Nursing Facility. Such inpatient services shall be provided only for the number of days required for the care and treatment of the illness, disease or injury for which the Member was confined. The providing of services and benefits hereunder must be ordered by the attending Physician, must be in accordance with standard medical practice in the community in which service was rendered and must be recognized as a legal course of treatment in the United States.

2. Anthem Blue Cross, on behalf of the Trust, shall pay Hospitals, Prudent Buyer Plan Providers, and medical transportation providers directly for that portion of the expense for which the Trust is required to pay. In addition, payment will be made directly to other providers of service upon written assignment of benefits by the Member. Such payment shall fully discharge, to the extent of payment, the liability of the Trust to the Member for such services and benefits.

3. Skilled Nursing Facility and Home Health Care services and benefits set forth herein shall be limited by the extent of available Skilled Nursing Facilities and Home Health Care Providers and only those covered services and benefits which are consistent with the degree of Disability and the medical needs of the Member on referral by the attending Physician, who is a licensed medical doctor (M.D.). Such services and benefits shall continue only while the Member is under the direct care and active medical supervision of a Physician for the illness, disease or injury necessitating continuous Skilled Nursing Facility or Home Health Care services. Anthem Blue Cross may require written declarations by the attending Physician as to the need for such care at such times and intervals as Anthem Blue Cross may determine.

4. The Trust shall not be responsible for expense incurred for services and benefits, unless written proof of expense incurred on properly completed claim forms from the Hospital, Skilled Nursing Facility and attending Physician or other providers of service itemizing the services and benefits rendered and the charges are filed with the Trust or Anthem Blue Cross within 90 days of the date such services and benefits were rendered. If it is not reasonably possible to submit the claim for services within that timeframe, an extension of up to 12 months shall be allowed. Cancelled checks or receipts shall not be accepted as proof of expense incurred in lieu of properly completed claim forms.

8: PERSONAL CASE MANAGEMENT PROGRAM

The **personal 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. Anthem Blue Cross, on behalf of the Trust, provides these services at the sole and absolute discretion of the Plan.
Personal case management is available only after Medicare benefits have been exhausted, or as an alternative to services which are covered under this Plan but are not covered by Medicare.

A. How the Personal Case Management Program Works

1. Members may be identified for possible personal case management by the attending Physician, Hospital staff, Anthem Blue Cross' claims reports, or the Trust, or the Member or the Member's family may call Anthem Blue Cross.
2. Benefits for personal case management will be considered only when **all** of the following criteria are met:
   a. The Member requires extensive long-term treatment not covered by Medicare, **and**
   b. Anthem Blue Cross anticipates that such treatment utilizing services or supplies covered under this Plan will result in considerable cost, **and**
   c. A cost-benefit analysis by Anthem Blue Cross determines that the benefits payable under this Plan for the alternative plan of treatment can be provided at a lower overall cost than the benefits the Member would otherwise receive under this Plan while maintaining the same standards of care, **and**
   d. The Member or the Member's legal guardian and the Member's Physician agree, in a letter of agreement, with Anthem Blue Cross' recommended substitution of benefits and with the specific terms and conditions under which the alternative benefits are to be provided.
3. 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.
4. **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 compromise the Member's freedom to make such decisions.**

B. How Benefits Are Affected by the Personal 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.

9: SERVICES AND BENEFITS TO SUPPLEMENT ORIGINAL MEDICARE

The following benefits are provided to supplement Original Medicare Plan benefits for care received in the United States and its territories:

HOSPITAL BENEFITS

1. **Member Co-Payment**

   No charge, if Medicare approved

2. **Covered Services**

   The Plan shall provide the following benefits if the Member is admitted to a Hospital for Medicare-approved services:

   1. Payment to the Hospital of the Medicare Deductible for the first 60 days of each Benefit Period.
   2. Payment to the Hospital for any applicable Medicare Co-insurance for specialized treatment rooms, supplies and other Medically Necessary ancillary services for the 61st through the 90th day of each Benefit Period.
   3. Payment to the Hospital of the Medicare Co-insurance for each day used when the Member exercises his or her option to use the 60-day Medicare lifetime reserve.
   4. Payment up to the Reasonable Charge for the first three pints of unreplaced whole blood, packaged red blood cells or any other blood derivative received during a covered Stay.
   5. Inpatient Hospital benefits for Mental Disorders are limited to a combined total of 190 days in each Member's lifetime.
   6. If Medicare benefits have been exhausted or are not applicable, the Plan shall pay benefits, as stated in the **MAJOR MEDICAL BENEFITS** section of this Evidence of Coverage for services that are Medically Necessary, as defined in the **MEDICAL NECESSITY** section.

SKILLED NURSING FACILITY BENEFITS

1. **Member Co-Payment**

   No charge, if Medicare approved

2. **Covered Services**

   The Plan shall provide the following benefits if the Member is admitted to a Skilled Nursing Facility:

   1. If approved by Medicare, payment to the Skilled Nursing Facility of the Medicare Co-insurance for the 21st through 100th day during each Benefit Period.
   2. If Medicare benefits have been exhausted or are not applicable, the Plan shall pay, as stated in the **MAJOR MEDICAL BENEFITS** section of this Evidence of Coverage, for services that are Medically Necessary, as defined in the **MEDICAL NECESSITY** section.
   3. **This Plan does not provide benefits for Custodial Care.**

HOSPICE BENEFITS

1. **Member Co-Payment**

No charge, if Medicare approved

2. **Covered Services**

The maximum lifetime Plan benefit for any Member shall in no event exceed an aggregate payment of $7,500.

When approved by Medicare, the Plan pays the difference between what Medicare pays and the Reasonable Charge.

If not approved by Medicare, covered services are payable under **MAJOR MEDICAL BENEFITS.**

FIRST THREE PINTS OF UNREPLACED BLOOD

1. **Member Co-Payment**

No charge, if Medicare approved

2. **Covered Services**

The first three pints of unreplaced whole blood, packaged red blood cells or any other blood derivative received during a covered Stay.

PROFESSIONAL/MEDICAL SERVICES

1. **Member Co-Payment**

$10 co-payment for each Office Visit
No charge for other services, if Medicare approved

The Plan pays the Medicare Part B Deductible incurred for the services listed below (Members are still required to pay the $10 co-payment for each office visit.) In order to receive this payment, the Member must provide Anthem Blue Cross with written proof by submitting a copy of an Explanation of Medicare Benefits (EOMB) that shows that Medicare has applied these amounts to the Member's Medicare Part B Deductible.

Office Visit Co-Payment: Your Co-Payment for each office visit to a Physician will be the **lesser of either Medicare's Co-insurance amount or $10.** This Co-Payment applies only to the charge for the visit itself. It does not apply to any other charges made during that visit, such as testing procedures, surgery, etc.

After the Medicare Deductible is met or, if applicable, the **lesser of either Medicare's Co-insurance amount or $10** office visit Co-Payment is subtracted, the Plan shall pay the following allowances, subject to any stated maximums:

1. When services are provided by a provider who accepts Medicare assignment, pays the remaining charges allowable by Medicare.
2. When services are provided by a Prudent Buyer Plan Provider who does not accept Medicare assignment, pays the difference between what Medicare pays and the Negotiated Rate.
3. When services are provided by a Non-Prudent Buyer Plan Provider (or a provider not represented in the Prudent Buyer Plan network) who does not accept Medicare assignment, pays the difference between what Medicare pays and the Customary and Reasonable Charge for Covered Expense.

   NOTE: If you go to a Non-Prudent Buyer Plan Physician, you should make sure that your Physician accepts assignment of Medicare benefits, or you will be responsible for charges that exceed the Customary and Reasonable Charge as determined by Anthem Blue Cross. These excess amounts are

not reimbursable and do not apply to the **MAJOR MEDICAL MAXIMUM BENEFITS** Second Level of Payment amount.

2. Covered Services

1. Services of a Physician in the home of the Member or the office of the Physician. Physician's care includes services for allergy, acupuncture, chiropractic treatment and urgent care, if Medicare approved.
2. Services of a Physician rendered to a Member during a covered inpatient confinement in a Hospital or Skilled Nursing Facility.
3. Services of a Physician rendered to a Member during a covered Hospice confinement.
4. The following ambulance services:
   a. Base charge, mileage and non-reusable supplies of a licensed ambulance company for ground service to transport a Member to and from a Hospital.
   b. 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.
   c. 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. Outpatient diagnostic x-rays and laboratory services, including allergy testing.
5. Services of a Home Health Care provider, Home Infusion Therapy Provider, and Hospice Care provider as listed under Part B of Medicare.
6. Services of a Physician in connection with surgery and surgical assistance.
7. Services of an anesthesiologist or anesthetist.
8. Radiation therapy, chemotherapy and hemodialysis.
9. Medical supplies, rental or purchase of appliances and durable medical equipment required for the treatment of an illness or injury.
10. Hospital or Ambulatory Surgical Center services for outpatient surgical treatment.
11. Services of a Physician (as defined under **GENERAL DEFINITIONS**) for physical, speech and occupational therapy, chiropractic care and acupuncture. The maximum lifetime Plan benefit for speech therapy services for any Member shall in no event exceed $5,000.
12. Services for Routine Physical Exam are only payable if Medicare allows. No benefits are allowed under **MAJOR MEDICAL BENEFITS**.
13. Outpatient mental health care services if Medicare approved.

9: SERVICES AND BENEFITS TO SUPPLEMENT ORIGINAL MEDICARE

NOTE: You should make sure that your provider accepts assignment of Medicare benefits, or you will be responsible for charges that exceed the Customary and Reasonable Charge or the Reasonable Charge, as determined by Anthem Blue Cross. This amount is not reimbursable and does not apply to the MAJOR MEDICAL MAXIMUM BENEFITS Second Level of Payment amount.

10: MAJOR MEDICAL BENEFITS

MAJOR MEDICAL BENEFITS are payable, as stated in this section, for certain services and supplies in excess of Original Medicare Plan benefits or when Medicare benefits have not been provided.

The benefits described below are provided for Covered Expense incurred for the treatment of a covered illness, injury or condition. Covered Expense under **MAJOR MEDICAL BENEFITS** does not include any amount paid under **SERVICES AND BENEFITS TO SUPPLEMENT MEDICARE, HEALTH PROMOTION PROGRAM** and **OUTPATIENT PRESCRIPTION DRUG BENEFITS.** Expense is incurred on the date the Member receives the service or supply for which the charge is made. These benefits are subject to all provisions of the Agreement, which may limit benefits or result in benefits not being payable.

MAJOR MEDICAL BENEFITS under this section are provided for care received in the United States and its territories.

MAJOR MEDICAL DEDUCTIBLE

1. Each Member shall be responsible for the first $100 of Covered Expense incurred for **MAJOR MEDICAL BENEFITS** during any one Calendar Year; however, when an aggregate of $200 in deductible amounts has been met by enrolled Members of the same family during any one Calendar Year, the Trust shall waive any further deductible amount for all Members of that family during the remainder of that Calendar Year. For purposes of the family deductible, Covered Expense over an individual Member's Major Medical deductible will not be counted toward the family deductible.
2. Covered Expense incurred for Major Medical Benefits during the last calendar quarter of the preceding Year and which has been applied against the deductible amount for that Year shall be carried forward to apply against the deductible amount for the ensuing Year.

PAYMENT

Payment is provided as follows for Covered Expense incurred in excess of the Major Medical deductible. All payments are subject to any maximum amount stated under the **MAJOR MEDICAL MAXIMUM BENEFITS** section.

A. First Level Payment

Until a Member incurs an aggregate amount of $15,000 of Covered Expense in a Year, payment is provided as follows:

- 50 percent of the Covered Expense the Member incurs for outpatient psychotherapy and psychological testing, including outpatient biofeedback procedures for treatment of a Mental Disorder.
- 80 percent of Covered Expense the Member incurs for all services other than outpatient psychotherapy and psychological testing.

B. Second Level of Payment

After a Member incurs an aggregate amount of $15,000 in Covered Expense in a Year, payment for any additional Covered Expense that Member incurs during the remainder of that Year is provided as follows:

- Payment continues to be provided for 50 percent of any additional Covered Expense that Member incurs for outpatient psychotherapy and psychological testing, including outpatient biofeedback procedures for treatment of a Mental Disorder.
- 100 percent of any additional Covered Expense that Member incurs for the rest of that Year for all services other than outpatient psychotherapy and psychological testing.

10: MAJOR MEDICAL BENEFITS

MAJOR MEDICAL MAXIMUM BENEFITS

All **MAJOR MEDICAL BENEFITS** paid under this Plan are limited to a combined maximum amount of $1,000,000 during each Member's lifetime, including the following maximum benefits:

1. Benefits paid under **Mental Disorders** for inpatient Hospital care and inpatient or outpatient Physician's visits are limited as follows:
   - All inpatient Hospital services are limited to a maximum of 30 days during each Calendar Year.
   - Benefits paid for outpatient psychotherapy and psychological testing are limited to a $20 maximum payment for each visit.
   - Benefits paid for inpatient Physician visits are limited to a $40 maximum payment each visit.
2. Benefits paid for services under **Speech Therapy** are limited to a $5,000 combined maximum payment during each Member's lifetime for all Speech Therapy benefits paid under this Plan.
3. Benefits paid for services under **Hospice Care** are limited to:
   - a $7,500 maximum aggregate payment during each Member's lifetime for all Hospice Care benefits paid under this Plan, including
   - a maximum of two visits for bereavement counseling provided by a Hospice Care Program for Family Members within one year of the Member's death.

Up to $1,000 in **MAJOR MEDICAL BENEFITS** received are automatically restored to the Lifetime Maximum each January 1.

Any additional limits on the number of visits or days covered are stated under the specific benefit.

COVERED SERVICES AND BENEFITS

1. Payment

80%; subject to the Calendar Year deductible and applies towards the Second Level of Payment amount

2. Covered Services

The following **MAJOR MEDICAL BENEFITS** shall be provided only to the extent that the covered services and benefits set forth in this part have **not** been provided to the Member under the provisions of Medicare or this Plan:

a. Services and supplies rendered by a Hospital, or Ambulatory Surgical Center. Covered services herein shall not include private room charges in excess of the average semiprivate (two-bed) room accommodations at such Hospital, except if the attending Physician certifies that private room accommodations are Medically Necessary due to the severity of the Member's illness, disease or injury.

b. Professional services of a Physician.

c. Anesthetic supplies and administration of anesthesia by an anesthetist.

d. Professional nursing services of a licensed nurse (R.N., L.P.N., or L.V.N.).

e. Outpatient diagnostic x-ray and laboratory services.

f. The following ambulance services:

   i. Base charge, mileage and non-reusable supplies of a licensed ambulance company for ground service to transport a Member to and/or from a Hospital or Skilled Nursing Facility.

ii. Base charge, mileage and non-reusable supplies of a licensed air ambulance to transport a Member from the area where the Member is first disabled to the nearest Hospital where appropriate treatment is provided.

iii. Monitoring, electrocardiograms (EKG or ECG), 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.

g. Radiation therapy and chemotherapy.

h. Surgical implants. This includes Medically Necessary surgically implanted hearing devices (i.e. cochlear implants, audient bone conduction devices).

i. Rental of dialysis equipment and all necessary services and supplies required for hemodialysis treatment, but not including the purchase of dialysis equipment.

j. 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.

k. Medical appliances and rental of Hospital beds, wheelchairs and other durable medical equipment, but only when certified by the Physician that such appliances or equipment are Medically Necessary and required for the direct care and treatment of an illness, disease or injury and are to be used solely by the patient-Member. In no event shall Covered Expense for rental charges exceed the purchase price of such equipment.

l. Administration of blood and blood plasma, including blood processing and the cost of unreplaced blood.

m. Biofeedback procedures when provided for other than Mental Disorders.

n. Home Infusion Therapy services and Home Health Care services of a licensed nurse, physical therapist, occupational therapist and speech therapist when Medicare benefits are exhausted or Medicare conditions are not met, provided the Member is not receiving Hospice Care benefits.

o. Allergy testing and serum, immunizations and inoculations for the direct care or treatment of an actual illness, disease or injury.

p. Chiropractic treatment and acupuncture.

NOTE: This Plan does **not** provide benefits for routine exams or test not connected with the care and treatment of an actual illness, disease or injury.

LIMITED BENEFITS

A. Extended Skilled Nursing Facility Benefits

1. Payment

80%; subject to the Calendar Year deductible and applies towards the Second Level of Payment amount

2. Services

Benefits for Covered Expense incurred are provided according to the following:

a. A room of two or more beds, including meals, services of a dietitian and general nursing care. If higher priced accommodations are used, an allowance of the average semiprivate (two-bed) room rate of the facility shall be provided toward the room charge for the accommodations occupied.

b. Specialized treatment rooms.

c. Laboratory examinations.

d. Physical, occupational and speech therapy treatment.

e. Oxygen and other gas therapy.

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

g. Blood transfusion, but not the cost of blood, blood products or blood processing except as provided under **COVERED SERVICES AND BENEFITS** of this section.

3. Conditions of Coverage

The Member must be admitted within 14 days following three or more days of a covered Hospital Stay. If the Member is readmitted to a Skilled Nursing Facility within 14 days of the previous discharge and care is required for the same illness or injury for which previously confined, benefits will continue. Benefits renew with each Benefit Period.

4. Days Covered

The foregoing services shall be furnished to the Member for the first 100 days of confinement. Benefits renew with each new Benefit Period.

After all Medicare Skilled Nursing Facility benefits have been used as set forth under **SERVICES AND BENEFITS TO SUPPLEMENT MEDICARE,** and the Member requires further care and treatment of the same illness, disease or injury for which the Member has continuously been confined, the Trust shall continue to pay (under **MAJOR MEDICAL BENEFITS)** the Skilled Nursing Facility for the foregoing services and benefits while the Member is in need of and receiving continuous skilled nursing services for such illness, disease or injury.

B. Dental Benefits

1. Payment

80%; subject to the Calendar Year deductible and applies towards the Second Level of Payment amount

2. Covered Services

Benefits for Covered Expense incurred are provided for professional services of a dentist (D.D.S. or D.M.D.) solely for the following:

1. Treatment of tumors.
2. Repair or alleviation of damage to natural teeth caused solely by Accidental Injury which occurs while the Member is covered under this Plan. Services must commence within 6 months following the date of Accidental Injury. 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. Natural teeth damaged as a result of chewing or biting shall not be deemed an Accidental Injury.

C. Mental Disorders Benefits

1. Payment

80% inpatient care; subject to the Calendar Year deductible and applies towards the Second Level of Payment amount

50% outpatient care; subject to the Calendar Year deductible and applies towards the Second Level of Payment amount, however, payment continues at 50% even after Second Level of Payment is reached

2. Covered Services

Benefits are payable at the levels of payment shown under **PAYMENT** and are subject to the amounts stated under **MAJOR MEDICAL MAXIMUM BENEFITS** of this section for Covered Expense incurred as follows:

a. Hospital Inpatient Services and Benefits

i. Hospital services, including biofeedback procedures, shall be provided for a Member who is under the direct care and treatment of a Physician for the acute phase of a Mental Disorder, which according to generally accepted medical professional standards is amenable to favorable modification while the Member is hospitalized as a registered bed patient. The words "acute phase" mean the recent, severely intensified phase of an illness.

ii. Payment for one visit per day to the Member in the Hospital by the attending Physician, including biofeedback procedures, shall be provided, but not to exceed $40 for each day that the Member is entitled to receive Hospital services and benefits hereunder as a registered bed patient.

iii. The maximum length of stay shall not exceed 30 days during a Calendar Year. A Member who is in the Hospital on December 31 of any Year has a right to any unused benefit days of the Year for the rest of the Hospital Stay. However, benefit days of the next Year cannot be used for that same Hospital Stay.

b. Outpatient Psychotherapy or Psychological Testing Benefit

Physician's services for outpatient psychotherapy or psychological testing, including outpatient biofeedback procedures for treatment of a Mental Disorder, shall be paid at 50 percent of Covered Expense incurred, but in no event shall such payment exceed $20 for each visit.

D. Speech Therapy Benefits

1. Payment

80%; subject to the Calendar Year deductible and applies towards the Second Level of Payment amount

2. Services Covered

1. Professional services of a qualified speech therapist (one who holds a certificate of competence in clinical speech pathology from the American Speech and Hearing Association) for correction of a speech impediment if caused by illness or injury or due to surgery on account of illness. Speech impediments due to congenital anomalies are included only after corrective surgery. Speech impediments due to cerebral palsy, considered a congenital condition, will also be covered without corrective surgery. Charges for speech therapy due to functional Mental Disorders are excluded.
2. The combined maximum amount payable for all Covered Expense incurred under the Speech Therapy benefits of this Plan shall in no event exceed an aggregate payment amount of $5,000 during each Member's lifetime.

E. Hospice Care

1. Payment

80%; subject to the Calendar Year deductible and applies towards the Second Level of Payment amount

2. Services Covered

Benefits for expense incurred are provided according to the following:

a. The combined maximum amount payable for all Covered Expense incurred under the Hospice Care benefits of this Plan shall in no event exceed an aggregate payment amount of $7,500 during each Member's lifetime.

b. Inpatient Hospice Care, including services and supplies.

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

d. Services of a licensed nurse (R.N., L.P.N., or L.V.N.).

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

f. Medical social services.

g. Services of a home health aide.

h. Respiratory therapy.

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

j. Nutritional support such as intravenous feeding or hyperalimentation.

k. Dietary and nutritional guidance.

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

m. Inpatient or outpatient Respite Care of the Member, to provide relief to Members or Family Members or others caring for the Member. Respite Care is limited to a combined maximum of five days.

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

o. Medically Necessary supplies, and drugs and medicines approved for general use by the Food and Drug Administration and provided by a Hospice Care Program.

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

3. Conditions of Service for Hospice Care

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 **PLAN 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 services 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 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.

i. Services that exceed an aggregate payment amount of $7,500 of Covered Expense incurred during each Member's lifetime.

11: SERVICES NOT COVERED BY ORIGINAL MEDICARE

SPECIAL DUTY NURSING BENEFITS

This is not a Medicare-approved service or benefit. However, upon receipt of due written notice and written proof of expense incurred for services of a registered nurse or a licensed vocational nurse ordered by the attending Physician while the Member is hospitalized as a registered bed patient, the Plan shall pay for services in accordance with the following:

1. Each Member shall be responsible for the first $50 of Covered Expense incurred for such services during any one Calendar Year.

2. Payment shall be made for 80 percent of Covered Expense incurred in excess of the deductible in 1. above, not to exceed 80 percent of the Customary and Reasonable Charge for such services.

3. Benefits are limited to an $800 maximum payment for Covered Expense incurred by the Member during a Calendar Year.

SERVICES AND BENEFITS OUTSIDE THE UNITED STATES

The Trust shall provide the Member with the services and benefits set forth under the CAHP Health Benefits Trust Basic Plan Preferred Provider Organization during a temporary absence from the United States. "Temporary absence from the United States" means a period not to exceed six consecutive months. If you are in a foreign country, you may have to pay the bill and then be reimbursed. If you require medical care, ask for an itemized bill along with a report from the attending Physician, written in English.

In the event a Member is confined in a Hospital on the date the temporary absence outside the United States exceeds six (6) months, inpatient benefits will be provided until that Member is discharged from the Hospital or until the maximum benefits under the Plan have been provided.

HEARING AID SERVICES

The Plan pays 90% of the following hearing aid services, subject to a maximum Plan payment of $1,000 per Member for hearing aids once every 36 months, and a maximum Plan payment of $200 per Member for audiological evaluations once every 36 months 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:

1. Audiological evaluations to measure the extent of hearing loss and hearing aid evaluation to determine the most appropriate make and model of hearing aid.
2. 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.

   NOTE: No benefits will be provided for the following:

   1. Purchase of batteries or other ancillary equipment, except those covered under the terms of the initial hearing aid purchase.
   2. Charges for hearing aids which exceed specifications prescribed for the correction of hearing loss.
   3. Replacement parts for hearing aids; repair of hearing aids after the covered one year warranty period.
   4. Replacement of a hearing aid more than once in any period of 36 months.
   5. Surgically implanted hearing devices. Medically Necessary surgically implanted hearing devices may be covered under Medicare or **MAJOR MEDICAL BENEFITS**.

11: SERVICES NOT COVERED BY ORIGINAL MEDICARE

SHINGLES VACCINE

The Plan pays 80% of Reasonable Charges for the following service that is 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.

3. The Immunizing agents.

4. Limited to a one-time administration age 60 and over.

12: 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 pharmacy care.

RETAIL PHARMACY BENEFITS (page 30)

- **A. Co-Payments**
- **B. Reimbursement**
- **C. When You Use a Participating Pharmacy**
- **D. When You Use a Non-Participating Retail Pharmacy**

MAIL ORDER PROGRAM (page 32)

- **A. Co-Payments**
- **B. When You Use the Mail Order Program**

DETERMINATION OF COVERED EXPENSE (page 32)

PRESCRIPTION DRUG CONDITIONS OF SERVICE (page 32)

PRESCRIPTION DRUG SERVICES AND SUPPLIES THAT ARE COVERED (page 33)

PRESCRIPTION DRUG SERVICES AND SUPPLIES THAT ARE NOT COVERED (page 33)

PRESCRIPTION DRUG PROGRAM UTILIZATION REVIEW AND PRIOR AUTHORIZATION PROGRAM (page 34)

SPECIALTY PHARMACY SERVICES (page 34)

SERVICES COVERED BY OTHER BENEFITS (page 35)

DEFINITIONS (page 35)

PRESCRIPTION DRUG REVIEW PROCESS (page 35)

RETAIL PHARMACY BENEFITS

Co-Payments

A. The Member is responsible for a **$5** co-payment for the initial Generic Drug and first refill. After second prescription drug fill, the Member is responsible for a **$10** co-payment.

B. 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.

C. 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.

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.

D. 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

A. 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.**

B. 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**.

C. When the Member has a Compound Prescription filled at a Non-Participating Retail Pharmacy, 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 Medco Member Services at 1–800-711-0917 or access online at **www.medco.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:

Medco Health Solutions Inc
PO Box 2187
Lee’s Summit, MO 64063-2187
1-800-711-0917

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 accessing online at **www.medco.com**. The Member must mail the claim form to **Medco 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**.

12: OUTPATIENT PRESCRIPTION DRUG BENEFITS

MAIL ORDER PROGRAM

Co-Payments

A. The Member is responsible for a **$10** co-payment for each Generic Drug or refill-ordered through the mail order program.

B. The Member is responsible for a **$40** co-payment for each Single Source Brand Drug or refill ordered through the mail order program.

C. 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 Prescription Drug or refill ordered through the mail order program.

D. The Member will receive **up to** a 90-day supply of medication per applicable co-payment as specified in A., B. and C. above.

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 co-payment amount and a properly completed order form. Order forms can be obtained by contacting Medco Member Services at 1-800-711-0917 or by accessing online at **www.medco.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.

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.

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

B. For Prescription Drugs dispensed by a Non-Participating Retail Pharmacy, the amount Medco 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:

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

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

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

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

E. 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.

F. For a retail Pharmacy, the Prescription must not exceed a 30-day supply.

G. For the mail order program, the Prescription must not exceed a 90-day supply.

H. 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.

I. The pharmacy data system will track for 180 days usage: refills can be obtained when 75% of the drug has been used.

PRESCRIPTION DRUG SERVICES AND SUPPLIES THAT ARE COVERED

A. Outpatient Drugs and medications which the law restricts to sale by Prescription.

B. Niacin for lowering cholesterol.

C. 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).

D. Prescription oral, transdermal (i.e. patch), intravaginal (i.e. Nuvaring), diaphragms, and Injectable (i.e. Depo-Provera 150mg) contraceptives.

E. All compound Prescription Drugs which contain at least one covered Prescription ingredient.

F. 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 **PLAN GENERAL EXCLUSIONS AND LIMITATIONS,** Prescription Drug benefits are **not** provided for or in connection with the following:

A. Immunizing agents, allergy desensitization products or allergy serum, biological sera, blood, blood products or blood plasma.*

B. Insulin, hypodermic syringes and/or needles.*

C. Contraceptive medications, materials or devices, (i.e. condoms, jellies, ointments, foams, devices, IUDs and time released subdermal drugs – Norplant).

D. Drugs and medications dispensed or administered in an outpatient facility, including, but not limited to, outpatient Hospital facilities and Physicians' offices.*

E. 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.*

F. Professional charges in connection with administering, injecting or dispensing of Drugs.*

G. A Non-Prescription patent or proprietary medicine, or medication not requiring a Prescription, except niacin for lowering cholesterol.

H. Durable medical equipment, devices, appliances and supplies, even if prescribed by a Physician.*

I. Services or supplies for which the Member is not charged.

J. Oxygen.*

K. Cosmetics, dietary supplements and health or beauty aids.

L. 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.

M. Any expense for a Drug or medication incurred in excess of: (a) the Prescription Drug Negotiated Rate for Drugs dispensed by Non-Participating Retail Pharmacies, Participating Retail Pharmacies or through the mail order program.

N. Non-medicinal substances or items (for example, dextroamphetamine for weight loss).

O. Drugs used primarily for cosmetic purposes (for example, Retin-A for wrinkles).

P. 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.

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

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

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

T. Smoking cessation Drugs, except as provided under **HEALTH PROMOTION PROGRAM.**

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

V. 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.

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

X. 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.

Y. Any quantity of dispensed medications that are deemed inappropriate as determined through Medco's utilization review.

*** NOTE:** Items marked by an asterisk (*) are covered as stated under **MAJOR MEDICAL BENEFITS** if not provided by Medicare.

PRESCRIPTION DRUG PROGRAM UTILIZATION REVIEW AND PRIOR AUTHORIZATION PROGRAM

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. Growth Hormones, Gleevec®, Tracleer®, Iressa, Xolir, Erythroid, Myeloid and Platelet Proliferation Stimulants, etc.). A Participating Retail Pharmacy will advise you if the prescribed Drug requires prior authorization and then will initiate the review on your behalf. 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 Medco 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 admister 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 by accessing online at **www.medco.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.

DEFINITIONS

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

A **Brand Name Prescription Drug (Brand Name Drug)** is a Prescription Drug that has been patented and is only produced by one manufacturer.

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, niacin for lowering cholesterol will be considered a Prescription Drug.

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.

A **Multi-Source Brand Prescription Drug (Multi-Source Brand Drug)** is a Prescription Drug that has generic equivalents available.

A **Non-Participating Retail Pharmacy** is a Pharmacy which does not have a Participating Pharmacy Agreement in effect with Medco 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 **Participating Retail Pharmacy** is a Pharmacy which has a Participating Pharmacy Agreement in effect with Medco at the time services are rendered. Members may call local Pharmacies to determine whether they are Participating Pharmacies or they may contact Medco Member Services at 1-800-711-0917.

A **Pharmacy** is a licensed retail pharmacy.

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 Medco 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 Medco Mail Service has agreed to accept as payment in full for mail order Prescription Drugs. In addition, it is the allowable expense for a Non-Participating Retail Pharmacy.

A **Single Source Brand Prescription Drug (Single Source Brand Drug)** is a Prescription Drug that does not have generic equivalents available.

PRESCRIPTION DRUG REVIEW PROCESS

If you have questions or concerns about your outpatient Prescription Drug coverage, you may contact Medco by calling 1-800-711-0917. If you are dissatisfied with the resolution of your inquiry and want to file a grievance, you may proceed directly to the **GRIEVANCE/CLAIMS REVIEW PROCEDURES, STEP 4 TRUST'S CLAIMS REVIEW** on page63.

13: 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

Members 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 **(800) 734-2247** or visiting the website at **www.thecahp.org.**

14: HEALTH PROMOTION PROGRAM

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.

The 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.

A. Benefit Reimbursement

The Plan will provide 100% reimbursement up to a $100 maximum payment for one approved behavior modification smoking cessation program per Member during the Contract Year. Benefits are limited to twice per lifetime for each Member.

B. Approved Programs

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

1. 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.
2. 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% reimbursement up to a $175 maximum payment for either 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 during the Contract Year. Benefits are limited to twice per lifetime for each Member.

WEIGHT MANAGEMENT PROGRAM

A. Benefit Reimbursement

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

B. Approved Programs

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

1. Weight Watchers - Call 1-800-651-6000 or your local Weight Watchers Center or visit the Web site at **www.weightwatchers.com** for information.
2. 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
11050 Olson Drive, Suite 110
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-payment and charges in excess of maximum Plan benefits are not included in the **MAJOR MEDICAL BENEFITS** Second Level of Payment amount.

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 **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.

MedcoHealth

Health topics, including information on specific diseases and conditions, as well as prescription drug information, can be located on the Medco Web site **www.medcohealth.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

Subimo Healthcare Advisor

To assist Members in obtaining information regarding health conditions, treatments and resources, the Anthem Blue Cross Web site, **www.anthem.com/ca**, offers a link to Healthcare Advisor ™ by Subimo, an interactive Web site where you can:

14: HEALTH PROMOTION PROGRAM

1. Find additional information about your health condition, treatment options and what to expect. You can research common complications and risks for a particular procedure and how quickly most people recover.

2. Screen hospitals in a select area based on clinical quality and experience, reputation, performance data or other hospital characteristics. Quality and medical data for hospitals throughout the United States is available.

   Note: the list of hospitals displayed will include those in the Prudent Buyer Plan Network and Non-Prudent Buyer Plan Providers. To receive the highest level of benefits available under this Plan, it is your responsibility to verify the provider you choose is a Prudent Buyer Plan Provider.

3. Get estimated costs for specific health care services or treatment.

The information on the Subimo Web site is intended for general information and may not apply to your particular condition. It is not intended to replace or substitute for the opinion or advice of your treating Physician regarding your medical condition or treatment. You should always seek prompt medical care from a qualified Physician about the specifics of your individual medical condition or treatment.

The Subimo Web site is owned and operated by Submio, LLC, headquartered in River Forest, IL. Subimo is solely responsible for its Web site and is not affiliated with Anthem Blue Cross or any affiliate of Anthem Blue Cross.

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15: PLAN EXCLUSIONS AND LIMITATIONS

GENERAL EXCLUSIONS AND LIMITATIONS

Benefits under this Supplement to Original Medicare Plan are provided only for services Medicare deems allowable and Medically Necessary, except as specifically listed in this Evidence of Coverage. Benefits provided by this Plan beyond those covered by Medicare 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. The following exclusions apply only to those services not covered by Medicare. 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. Remember, a particular condition may be affected by more than one exclusion. Additional exclusions and limitations which clarify a specific benefit are listed under that benefit. Benefits of this Plan are not provided for, or in connection with, the following:

1. **After Coverage Ends.** Any expense incurred for services and benefits rendered after the Member's coverage ends, except as otherwise provided 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. **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.
4. **Caffeine Addiction**. Any expense incurred in connection with treatment for caffeine addiction.
5. **Chemical Dependency.** Alcoholism or alcoholism rehabilitation programs, or drug addiction or drug addiction rehabilitation programs, including any complications resulting there from.
6. **Cosmetic Services.** Cosmetic surgery and other services and supplies determined by Anthem Blue Cross to be furnished primarily to improve appearance rather than physical function or control of organic disease. This exclusion does not apply to reconstructive surgery performed to correct deformities caused by congenital or developmental abnormalities, illness, or injury for the purpose of improving bodily function or symptomatology or to create a normal appearance. 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; sagging eyelids; prominent ears; skin scars; baldness; and correction of breast size, asymmetry or shape, except surgery performed to restore symmetry following mastectomy.
7. **Custodial Care or Rest Cures.** Custodial 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, except as specifically provided under **Extended Skilled Nursing Facility Benefits**.
8. **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.

9. **Excess Amounts.** Any amounts in excess of:
   a. Allowable charges as determined by Medicare, for benefits provided under **TO SUPPLEMENT MEDICARE HOSPITAL PROGRAM (PART A)** and for services of any Provider who accepts Medicare assignment, and
   b. The Negotiated Rate for services of a Prudent Buyer Plan Provider who does not accept Medicare assignment under **TO SUPPLEMENT MEDICARE HOSPITAL PROGRAM (PART A)**, and **TO SUPPLEMENT MEDICARE MEDICAL PROGRAM (PART B)**, and
   c. Covered Expense under **MAJOR MEDICAL BENEFITS**, and
   d. The Customary and Reasonable Charge or Reasonable Charge for services of a Non-Prudent Buyer Plan Provider who does not accept Medicare assignment under **TO SUPPLEMENT MEDICARE HOSPITAL PROGRAM (PART A)** and **TO SUPPLEMENT MEDICARE MEDICAL PROGRAM (PART B)**, and
   e. The lifetime maximums for covered services as provided under **MAJOR MEDICAL BENEFITS**.
10. **Experimental or Investigational.** Experimental or Investigational procedures.
11. **Facial Asymmetry.** Diagnosis or treatment (including surgery) to correct facial asymmetry including, but not limited to mandibular and maxillary procedures, unless Medically Necessary.
12. **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.
13. **Free Services.** Any services or benefits for which no charge is made to the Member or for which the Member has no legal obligation to pay. Any services or benefits for which no charge is made to the Member in the absence of insurance coverage, except when rendered by a non-government, charitable, research Hospital which:
    a. Is internationally recognized as devoting itself primarily to medical research, and
    b. Spends at least 10 percent of its budget each Year on research not directly related to patient care, and
    c. Receives at least one-third of its gross revenue from donations or grants other than gifts or payments as compensation for medical services to patients, and
    d. Accepts patients without regard to ability to pay, and
    e. Two-thirds of its patients have conditions directly related to the specific areas in which the Hospital conducts research.
14. **Government Services.** Any services actually given to a Member by local, state or federal government agency, 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.
15. **Hearing Aids and Tests.** Furnishing or replacement of hearing aids and routine hearing tests, except as specifically stated under **Hearing Aid Services**.
16. **Hospital Admissions.** Hospitalization primarily for x-ray, laboratory, or other diagnostic studies if such studies can be rendered safely and adequately on an outpatient basis.
17. **Human Organ Transplant.** Charges incident to human organ transplant.
18. **Inpatient Treatment of Eating Disorders.** Inpatient services primarily for eating disorders, such as the treatment of anorexia and/or anorexia nervosa, bulimia and/or bulimia-nervosa (binge-purge syndrome) unless provided under **MAJOR MEDICAL BENEFITS**.

19. **Mental Disorders.** Mental Disorders, except as specifically provided under **MAJOR MEDICAL BENEFITS**.
20. **Nicotine Addiction.** Services for smoking cessation or reduction, nicotine use or addiction, except as provided under **HEALTH PROMOTION PROGRAM**.
21. **Not Medically Necessary.** Any expense incurred for services or supplies that are not Medically Necessary as defined in this Evidence of Coverage.
22. **Not Specifically Listed.** Services not specifically listed in this Plan as covered services.
23. **Orthodontic or Dental Care.** Braces, bridges, dental plates or other dental prostheses or replacement thereof. Dental services or treatment on or to the teeth or gums, cysts, extraction of teeth, treatment of dental abscess or granuloma, except as specifically provided in **Dental Benefits** under **MAJOR MEDICAL BENEFITS.** Cosmetic dental surgery or other services for beautification.
24. **Outpatient Prescription Drugs and Medications.** Outpatient Prescription Drugs or medications, except as specifically stated in the section entitled **OUTPATIENT PRESCRIPTION DRUG BENEFITS.** Any non-prescription, over-the-counter patent or proprietary drug or medicine. Cosmetic, dietary supplements, health or beauty aids.
25. **Outpatient Speech Therapy.** Outpatient speech therapy, except as specifically stated under **MAJOR MEDICAL BENEFITS**.
26. **Pathological Gambling or Co-dependency.** Services for pathological gambling or co-dependency.
27. **Personal Comfort Items.** Personal comfort items, including cosmetics, dietary supplements, health or beauty aids.
28. **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.
29. **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.
30. **Rehabilitative Care.** Hospitalization primarily for environmental change, physical therapy or treatment of chronic pain.
31. **Relatives.** Professional services rendered to a Member by a person who ordinarily resides in the Member's home or who is related to the Member by blood or marriage.
32. **Routine Exams or Tests.** Medical examinations or tests not connected with the care and treatment of an actual illness, disease or injury; routine physical examinations (including examinations made as a requirement of employment or governmental authority).
33. **Services and Benefits Outside the United States.** Services and benefits rendered outside the United States, except as specifically stated under **SERVICES NOT COVERED BY MEDICARE**.
34. **Services Not Covered by Medicare.** Services not covered by Medicare unless specifically listed as benefits in this Evidence of Coverage.
35. **Sex Change.** Any procedure or treatment designed to alter physical characteristics of the Member to those of the opposite sex.
36. **Sexual Dysfunctions.** Services or devices for or incident to sexual dysfunctions or sexual inadequacies unrelated solely to a physical cause.
37. **Speech Disorders.** Services primarily for correction of speech disorders, including but not limited to stuttering or stammering.

38. **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 treatment of an Accidental Injury sustained while covered under this Plan.

39. **Telephone/Online Consultations.** Consultations for any purpose, provided by telephone, facsimile machine or online via computer.

40. **Trainee Services.** Services performed in a Hospital by house officers, residents, interns and others in training.

41. **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, routine eye examinations for the fitting of glasses and eye refractions.

42. **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.

43. **Weight Alteration Programs (Inpatient and Outpatient).** Services primarily for weight reduction or treatment of obesity, except as provided under **HEALTH PROMOTION PROGRAM.** Weight loss or weight gain programs including, but not limited to, dietary evaluations and counseling, exercise program, behavioral modification programs, laboratory test, food supplements, vitamins and other nutritional supplements, and surgery, associated with loss, except surgical treatment of morbid obesity covered by Medicare.

44. **Work-Related.** Work-related conditions if benefits are recovered or can be recovered, either by adjudication, settlement or, otherwise under any workers' compensation, employers' liability law, or occupational disease law, even if the Member does not claim those benefits.

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, <u>within sixty (60) days</u>, 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 take 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 or not 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 employer's 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 **only** 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 lien holder. For purposes of this subsection, reasonable value shall be determined to be the Customary and 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 and/or settlement of the claim under circumstances 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.

MEDICARE NON-DUPLICATION OF BENEFITS

The Trust shall provide the benefits of this Plan only to the extent they do not duplicate benefits available from Medicare.

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:

A. Definitions

1. **Allowable Expense** means a Customary and Reasonable Charge for services or supplies which is considered payable in whole or in part under at least one of the plans covering the Member. 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.
2. This **Plan** means the CAHP Health Benefits Trust Supplement to Original Medicare Plan.
3. 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.

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

5. **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.

B. 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, then 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 Calendar 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 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 dependents, 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.

C. Effect on Benefits

1. 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.

2. Secondary Carrier

If this Plan is the 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:

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

b. 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.

D. Provision of Benefits by Secondary Plan

With respect to the provisions of Section C. 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 this contract, 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.

E. 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.

F. 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 provisions.

16: ENROLLMENT PROVISIONS

ELIGIBILITY FOR ENROLLMENT

1. All Members who are eligible in accordance with the Act and who are enrolled under Medicare Parts A and B may enroll hereunder. Enrollment is restricted to members and 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, 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.

A new Medicare prescription drug program, know as Medicare Part D, became effective on January 1, 2006. Members eligible for Medicare Benefits do not need to enroll in Medicare Part D because your current **OUTPATIENT PRESCRIPTION DRUG BENEFITS** are superior in both benefits and cost. Please refer to the **CREDITABLE COVERAGE** (page 36) section for additional information.

CONDITIONS OF ENROLLMENT

1. Each Employee or Annuitant eligible to become a Subscriber according to the requirements stated under this **ENROLLMENT PROVISIONS** section, and who files an application with the Employer for membership for himself or herself and his or her eligible Family Members on forms provided by 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. The following provision applies only to Members who are enrolled in a Combination Basic/Supplement to Original Medicare contract (for example: the Subscriber is enrolled in the Supplement to Original Medicare Plan and the Spouse is enrolled in the Basic Plan or vice versa).

   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 and Supplement to Original Medicare 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 the CalPERS Office of Employer and Member Health Services 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.

17: TERMINATION AND RELATED PROVISIONS

VOLUNTARY CANCELLATION

A Member may cancel voluntarily 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)

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.

A. Eligibility for Continuation - Qualifying Events

Subscribers or Family Members, other than a domestic partner and a child of a domestic partner, 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...

1. The Subscriber's termination, for any reason other than gross misconduct;
2. A reduction in the Subscriber's work hours;
3. 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...

4. The death of the Subscriber;
5. The Spouse's divorce or legal separation from the Subscriber, or if the Spouse vacates the residence shared with the Subscriber;
6. The end of a child's status as a Family Member, in accordance with the Act or Regulations.

B. Requirements for Continuation

1. Notice

For qualifying events 1., 2. and 3., the Subscriber's Employer will notify the Subscriber of the right to continue coverage. In the event of the Subscriber's death, a Family Member will be notified of the

continuation right. Anyone choosing to continue coverage must so notify the 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 the CalPERS/Employer **within 60 days** of the date of such qualifying event.

The Member must inform the CalPERS/Employer of qualifying events 5. or 6. on the previous page 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 the 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, the 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.

2. 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.

3. 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:**

a. 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.

b. 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 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.)

4. 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.

5. 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.

6. When the Continuation Ends

This continuation will end on the earliest of:

a. 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 a 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.

b. The end of 36 months from the date the Member's coverage terminates, if the qualifying event was the death of the Subscriber; divorce or 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.

c. The date the Plan terminates.

d. The end of the last period for which the final required monthly contribution was paid.

e. 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 pre-existing conditions no longer apply to the Member.

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 reminder 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 c., d., or e. above.

BENEFITS AFTER TERMINATION

There is no coverage for treatment of any condition 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 under this paragraph 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 the attending 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 the 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.

18: 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 any way. 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 for coverage by workers' compensation insurance. It also does not replace that insurance.

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.

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.

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.

LIABILITY OF MEMBER FOR CERTAIN CHARGES

1. In the event the Plan fails to pay a provider who has provided 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.
2. The Member is liable for all expenses in excess of the benefits of this Plan.

18: GENERAL PROVISIONS

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.

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 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.

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

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 subsequest benefits payments to offset overpayments.

RIGHT TO RECEIVE AND RELEASE INFORMATION

1. For the purpose of enforcing or interpreting this Plan, or participating in resolving any matter in dispute in regard to this Plan, the Trust, the Board, Anthem Blue Cross, 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 the section, shall not be deemed a breach of any person's right or privacy.
2. 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.

BENEFITS NON-TRANSFERABLE

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.

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.

18: GENERAL PROVISIONS

PROTECTION OF COVERAGE

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

1. The Administrative Services Agreement between Anthem Blue Cross and the Trust is still in effect, and
2. The Member is still eligible, and
3. The Member's required monthly contributions are paid according to the terms of the Administrative Services Agreement between Anthem Blue Cross and the Trust.

TERMS OF COVERAGE

1. 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.
2. The benefits to which a Member may be entitled will depend on the terms of coverage in effect on the date the expense is incurred. An expense is incurred on the date the Member receives the service or supply for which the charge is made.
3. 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. Hospitals and other health care facilities may be paid either a fixed fee or on a discounted fee-for-service basis.

19: 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. But 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
2030 V Street
Sacramento, CA 95818
Attn: Privacy Officer

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

19: NOTICE OF PRIVACY PRACTICES

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 us at (800) 734-2247.

20: GRIEVANCE/CLAIMS REVIEW PROCEDURE

STEP 1: MEDICARE CLAIMS REVIEW PROCEDURE

If you have questions regarding a determination on a claim which was submitted to Medicare, contact the Medicare office indicated on your Explanation of Medicare Benefit (EOMB) form.

STEP 2: 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 booklet 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 a 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 3, STEP 4, STEP 5** or **STEP 6.**

If you have questions or concerns about your outpatient Prescription Drug coverage, you may contact Medco by calling 1-800-711-0917. If you are dissatisfied with the resolution of your inquiry and want to file a grievance, you may proceed to STEP 4.

NOTE: You should follow the STEP 1 and STEP 2 grievance procedures 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 Office of Employer and Member Health Services at P.O. Box 942714, Sacramento, CA 94229-2714.

For grievances not resolved after completing **STEP 1** AND **STEP 2** procedures:

1. **Covered grievances:** If you have followed the grievance procedure listed above and are still dissatisfied, you may proceed to **STEP 3: SPECIAL REVIEW PROCEDURES FOR DENIAL EXPERIMENTAL OR INVESTIGATIONAL TREATMENT; STEP 4: TRUST'S CLAIMS REVIEW; STEP 5: ADMINISTRATIVE APPEAL PROCESS** or **STEP 6: 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 the 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 6: BINDING ARBITRATION (OR SMALL CLAIMS COURT)** for claims for benefits involving charges of bad faith.

STEP 3: 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 2** on the previous page.

If the independent review affirms the denial and you still disagree, you may proceed to **STEP 4, STEP 5,** or **STEP 6**.

STEP 4: TRUST'S CLAIMS REVIEW

Except for determination of Customary and Reasonable Charges, and Reasonable Charges, a Member aggrieved by a decision of Anthem Blue Cross after reconsideration of a denied claim may request further review by the Trust. Such request must be in writing and must include the reason for the request for further review and all pertinent documents and data.

Mail the request for Trust's Claims Review to:

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

Such request must be submitted to the Trust no later than 30 days following Anthem Blue Cross' final determination of payment. If you do not wish to request further review from the Trust, you may proceed to STEP 5 or STEP 6.

The Plan's final determination under claims review shall be made by the Trust within 30 days as to whether any of the terms, conditions, reductions, limitations or exclusions of the Plan apply so as to preclude services or benefits which would otherwise be provided herein. The Trust shall make its decision after review and consideration of (1) all written information submitted by the Member and (2) information received from Anthem Blue Cross. The Trust shall exercise the option to request additional information, or to schedule the review as an agenda item at the quarterly Trustees' meeting. Under these circumstances, the 30-day limitation for determination will not apply.

If the Trust affirms Anthem Blue Cross' denial and you still disagree, you may proceed to STEP 5 or STEP 6.

STEP 5: ADMINISTRATIVE APPEAL PROCESS

CalPERS staff will conduct an administrative review upon your appeal of Anthem Blue Cross' or the Trust's denial of coverage for benefits beyond those covered by Medicare. Your written appeal must be submitted to CalPERS **within 30 days** of the postmarked date of Anthem Blue Cross' or the Trust's letter of denial following your grievance. Not every dispute may be appealed to CalPERS. For example, you must proceed directly to **STEP 6** for issues involving quality of care, access to care, or allegations of bad faith.

NOTE: If you are covered by Medicare and Medicare has made a decision regarding your appeal of a Medicare claim determination, you cannot appeal the Medicare decision through the CalPERS Board of Administration.

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 6.**

To file an administrative appeal, write to CalPERS Office of Employer and Member Health Services, P.O. Box 942714, Sacramento, CA 94229-2714, or call **(888) CalPERS** (225-7377).

STEP 6: BINDING ARBITRATION (OR SMALL CLAIMS COURT)

If you do not use **STEP 4** or **STEP 5,** 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. Copies of such arbitration rules are available from Anthem Blue Cross. The arbitration shall be held in the State of California.
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.

21: REQUIRED MONTHLY CONTRIBUTION

Type of Enrollment	Enrollment Code	Cost*
Subscriber Only	2311	$354.00
Subscriber and One Family Member	2312	$655.00
Subscriber and Two or More Family Members	2313	$832.00

STATE EMPLOYEES AND ANNUITANTS

*The required monthly contributions shown above are effective January 1, 2010, and will be reduced by the amount the State of California contributes toward the cost of your health benefit 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 affected retirement system without action on your part. For current contribution information, contact your Retirement System Health Benefits Officer.

REQUIRED MONTHLY CONTRIBUTION

The required monthly contributions may be changed as of January 1, 2011, following at least sixty (60) days written notice to the Board prior to such change.

22: 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 **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 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 all benefits provided under **HEALTH PROMOTION PROGRAM.**

The term **Benefit Period** means the total of all successive Hospital or Skilled Nursing Facility confinements, including those that occurred before the Effective Date of coverage of the Member, that are separated from each other by less than 60 days.

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

CAHP is the California Association of Highway Patrolmen.

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 all 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.

22: GENERAL DEFINITIONS

A **Clinical Laboratory** is a laboratory that collects, tests, and evaluates specimens (i.e., hematology, immunology, cytology, histology and microbiology).

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 maximum amounts stated under the specific benefit. Covered Expense does not exceed any amount in excess of the following:

1. The Negotiated Rate for services provided by a Prudent Buyer Plan Provider.
2. A Customary and Reasonable Charge for services provided by a Non-Prudent Buyer Plan Physician, or by a Physician whose specialty is not represented in the Prudent Buyer Plan Provider network.
3. A Reasonable Charge for services provided by a Non-Prudent Buyer Plan Provider other than a Physician.
4. The amount in excess of Medicare's allowable charge when the provider accepts Medicare assignment.

Custodial Care means care 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 providers 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 applicable deductible and co-payment amounts, amounts over stated maximum benefits, 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 a bodily injury or an illness (including a Mental Disorder). However, all bodily injuries sustained in any one accident are considered one Disability, and all illnesses existing simultaneously which are due to the same or related causes shall be considered one Disability. If any illness is due to causes which are the same as or related to the causes of any prior illness, the succeeding illness shall be considered a continuation of the previous Disability and not a separate Disability.

Effective Date means the date on which the Member's coverage commences.

Emergency means a sudden, serious and unexpected acute illness, injury or condition which the Member reasonably perceives could permanently endanger health if medical treatment is not received immediately. Final determination as to whether services were rendered in connection with an Emergency shall rest solely with Anthem Blue Cross.

22: GENERAL DEFINITIONS

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 Annuitant of the California Association of Highway Patrolmen. In addition, a Family Member shall include a Domestic Partner as defined in Section 22770 of the Act.

1. A Member's or Annuitant's lawful spouse,
2. Any unmarried child under age 23, including an adopted child, a stepchild, or recognized natural child who lives with the Member or Annuitant in a regular parent-child relationship,
3. An unmarried child under age 23 who is economically dependent upon the Member or Annuitant while there exists a parent-child relationship, or a court order,
4. An unmarried child age 23 or over who is incapable of self-support because of a physician or mental disability which existed continuously from a date prior to attainment of age 23,
5. Domestic Partner.

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 a private organization that is primarily engaged in providing pain relief, symptom management and supportive services to terminally ill persons and their families to help them cope with the terminal illness. This care may be provided in the home or on an 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 or Nervous Disorder, the term Hospital also shall include Psychiatric Health Facilities.

22: GENERAL DEFINITIONS

Intensive Care Service is care in a special Hospital unit concentrating highly skilled personnel and special equipment for the patient whose acute illness or injury requires continuous treatment and observation, or whose progress must be rigidly controlled.

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.

Medco Health Solutions, Inc. (Medco) is the prescription drug benefits claims administrator for the CAHP Health Benefits Trust, but only for benefits administered through Medco.

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.

NOTE: The Plan will accept Medicare's definition of medical necessity.

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.

Medicare Deductible and **Co-insurance** mean the portion of the charges for services payable by the Member as set forth in Section 1813 of the Medicare Act.

Member means any Employee, Annuitant or Family Member enrolled under this Plan.

Mental Disorders are conditions, other than chemical dependencies, that affect thinking, and the ability to figure things out, perception, mood and behavior. A Mental Disorder is recognized primarily by symptoms or signs that appear as distortions of normal thinking, distortions of the way things are perceived (for example, seeing or hearing things that are not there), moodiness, sudden and/or extreme changes in mood, depression, and/or unusual behavior such as depressed behavior or highly agitated or manic behavior. Some Mental Disorders are: schizophrenia, manic-depressive and other conditions usually classified in the medical community as psychoses; depressive, phobic, manic and anxiety conditions (including panic disorders); bipolar affective disorders including mania and depression; obsessive compulsive disorders; hypochondria; personality disorders (including paranoid, schizoid, dependent, anti-social and borderline); dementia and delirious states; posttraumatic stress disorder; hyperkinetic syndromes (including attention deficit disorders); adjustment reactions; reactions to stress; anorexia nervosa and bulimia. Any condition meeting this definition is a Mental Disorder no matter what the cause. **ONE OR MORE OF THESE CONDITIONS MAY BE SPECIFICALLY EXCLUDED IN THIS EVIDENCE OF COVERAGE.**

22: GENERAL DEFINITIONS

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, 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-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:

1. A Hospital.
2. A Physician.
3. A Home Health Agency.
4. An Ambulatory Surgical Center.
5. A Clinical Laboratory.
6. A Diagnostic Imaging Center.
7. A Home Infusion Therapy Provider.
8. A Skilled Nursing Facility.
9. A Durable Medical Equipment Supply Outlet.

Any of the above providers whose principal place of business is outside of California is also a Non-Prudent Buyer Plan Provider. 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 benefits plan, add Family Members, or change their enrollment from one health benefit plan to another.

A **Physician** means:

1. 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
2. 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, 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:
    a. A dentist (D.D.S. or D.M.D.)
    b. An optometrist (O.D.)
    c. A dispensing optician
    d. A podiatrist or chiropodist (D.P.M., D.S.P. or D.S.C.)
    e. A licensed clinical psychologist

f. A chiropractor (D.C.)

g. An acupuncturist (but only for acupuncture and for no other services)

h. A certified registered nurse anesthetist (C.R.N.A.)

i. A clinical social worker (C.S.W. or L.C.S.W.)

j. A marriage and family therapist (M.F.T.)

k. A physical therapist (P.T. or R.P.T.)*

l. A speech pathologist*

m. An audiologist*

n. An occupational therapist (O.T.R.)*

o. A respiratory care practitioner (R.C.P.)*

p. 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 or other state department of registered nurses).*

*** NOTE:** The providers indicated above 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.

The **Plan** is the CAHP Health Benefits Trust Supplement to Original Medicare 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 Medco Health Solutions, Inc.

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 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. **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.**

1. 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. A directory of Prudent Buyer Plan Hospitals is available upon request.
2. 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. A directory of Prudent Buyer Plan Physicians is available upon request.
3. 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. A list of Prudent Buyer Plan Home Health Agencies is available upon request.
4. An **Ambulatory Surgical Center.** An Ambulatory Surgical Center that is a Prudent Buyer Plan Provider may also be referred to as Prudent Buyer Plan Ambulatory Surgical Center. A list of Prudent Buyer Plan Ambulatory Surgical Centers is available upon request.

5. 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. A list of Prudent Buyer Plan Clinical Laboratories is available upon request.
6. 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. A list of Prudent Buyer Plan Diagnostic Imaging Facilities is available upon request.
7. 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. A list of Prudent Buyer Plan Home Infusion Therapy Providers is available upon request.
8. 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. A list of Prudent Buyer Plan Skilled Nursing Facilities is available upon request.
9. 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. A list of Prudent Buyer Plan Durable Medical Equipment Supply Outlets is available upon request.

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 of Accreditation of Health Care Organizations and staffed by an organized medical or profession staff which includes a Physician as medical director.

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 the deductible and co-insurance amounts, amounts over stated benefit maximums, and any non-covered expense.

Reconstructive Surgery is performed to correct deformities resulting from injury or disease, or which is Medically Necessary following injury or disease to restore an individual to normal.

Regulations means the Public Employees' Medical and Hospital Care Act Regulations as adopted by the Board and set forth in Subchapter 3, Chapter 2, Division 1, Title 2 of the California Code of Regulations.

Respite Care means a short-term inpatient Stay in a Hospice which may be necessary for the Member in order to give temporary relief to the person who regularly assists with the Member's care. Inpatient Respite Care is limited each time to Stays of no more than five days in a row.

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 between persons of the opposite sex.

22: GENERAL DEFINITIONS

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 of the required monthly contribution to the Trust, and whose employment or other status, except family dependency, is the basis for eligibility for enrollment under the Plan. Subscribers must be members, eligible Employees, or vested Annuitants 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.

United States means all of the States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam and American Samoa.

A **Year** or **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.

23: FOR YOUR 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.

PREVENTING MEDICAL MISTAKES

While death is the most tragic outcome, medical mistakes cause other problems such as permanent disbabilities, 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.

23: FOR YOUR INFORMATION

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 you 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.

Addition 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 a consumers about patient safety but 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.

23: FOR YOUR INFORMATION

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)

Another way is to not maintain ineligible family members on your policy. Spouse 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 children under the age of 23 that are not yours and you do not have a legal or financial obligation to cover them. These dependents may be entitled to **CONTINUATION OF COVERAGE** (page 51)

24: PREVENTIVE CARE GUIDELINES

These guidelines are for information only and may be subject to change. Additionally, your Physician may modify these guidelines based on your health and history or individual risk factors. Please talk to your Physician carefully about individual risk factors when making decisions about diagnostic tests.

These guidelines were adapted from the U.S. Preventive Services Task Force *Guide to Clinical Preventive Services* (2nd edition). 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 **http://www.anthem.com/ca**.

Children: Birth to 10 years

Health Screenings	**Frequency**
Height, Weight, and Newborn Hearing	Annually and/or as recommended by your Physician.
Blood Pressure	Annually and/or as recommended by your Physician.
Hemoglobin/Hematocrit	At 6-12 months and at 15 months, 5 years for high risk for iron deficiency.
Test for thyroid activity, galactose metabolism disorder, hemoglobin (blood) disorder, phenylketonuria level (PKU), vision impairment	After birth, prior to hospital discharge but no later than 6th day of life. Thyroid activity screening can be done after birth, optimally at 2–6 days.
Vision Screening	Screening for medical eye conditions which may need further evaluations by an eye specialist (eye refractions in preparation for glasses not included).
Lead Screening	At 9-12 months and at 24 months in accordance with state law. Discuss risk with your Physician.
Tuberculosis Screening	Discuss risk with your Physician.
Hepatitis C Screening	Discuss with your Physician.
Immunizations	**Frequency**
Diphtheria, Tetanus, and Pertussis (DTaP or DTP)	Five doses: age 2, 4, 6, 15–18 months, and 4–6 years.
IPV (inactivated polio virus)	Four doses: age 2, 4, 6–18 months, and 4–6 years.
Measles, Mumps, & Rubella (MMR)	Two doses: age 12-15 months, and either 4–6 years or 11–12 years.
Influenzae Type B (Hib)	Four doses: age 2, 4, 6, and 12–15 months.
Hepatitis B Vaccine. Those who have not previously received three doses of hepatitis B vaccine should initiate or complete the series at age 11–12 years.	Three doses: at birth–age 2 months (preferably prior to hospital discharge); 1–4 months; and 6–18 months.
Hepatitis A	24 months – 12 years (2 doses, the second administered 6-18 months after the first).
Influenza (flu) Vaccine	Annually, each fall season, for healthy children 6-59 months and for at risk individuals.
Pneumococcal Conjugate (Prevnar)	2,4,6 months, booster 12-15 months; 2-5 years for high risk or if not previously vaccinated.
Chickenpox (varicella virus)	Two doses: age 12–15 months, and age 4-6. Children who lack a reliable history of chickenpox should be vaccinated at 11–12 years of age.
Rotavirus	Three doses: age 2, 4, and 6 months

24: PREVENTIVE CARE GUIDELINES

Adolescents: Ages 11–24 years

Health Screenings	Frequency
Height, Weight, and Hearing	Annually and/or as recommended by your Physician.
Blood Pressure	At least every 2 years or as recommended by your Physician.
Papanicolaou (Pap test for women)	Every 1–3 years, age 18 or earlier if sexually active.
Human Papilloma Virus (HPV) Screening	Every 1-3 years, for sexually active female adolescents beginning by age 21
Chlamydia Test	Recommended for sexually active female adolescents under age 25 and in other women with risk factors for infection.
Hepatitis C Screening	Discuss with your Physician.
Influenza (flu) Vaccine	Annually, each fall season, for at risk individuals.
Skin Cancer Screening	Discuss with your Physician.
Total Cholesterol & High-Density Lipoprotein (HDL)	Discuss with your Physician.
Tuberculosis Screening	Discuss with your Physician.
Rubella susceptibility by history of vaccination or serologic tests for antibodies	Recommended for all women of childbearing age.
Immunizations	**Frequency**
Td Booster (tetanus, diphtheria)	At 11-16 years.
Hepatitis A	2-12 years (2 doses, the second administered 6-18 months after the first), 12-18 years, discuss with your Physician.
Hepatitis B Vaccine	Those who have not previously received three doses of hepatitis B vaccine should initiate or complete the series at age 11-12 years.
Meningococcal	Discuss with your physician about disease and benefits of vaccination for high risk.
Measles, Mumps, & Rubella (MMR)	At age 11–12 years if no previous second dose of MMR was received.
Chickenpox (varicella virus)	Unvaccinated persons who lack a reliable history of chickenpox should be vaccinated at age 11–12 years. Persons age 13 years and older should receive two doses at least one month apart.
Rubella Vaccine	Females over age 12 years who are rubella susceptible.
Lyme Disease Vaccine	For persons over age 15 with a high risk of contracting Lyme disease.
Human Papilloma Virus (HPV)	Adolescent females at age 11-12 years. Females 13-26 years old if did not previously receive vaccine or complete full vaccine series. Three doses with second and third doses 2 and 6 months after first dose.

24: PREVENTIVE CARE GUIDELINES

Adults: Ages 25–64 years

Health Screenings	Frequency
Height & Weight	Annually and/or as recommended by your Physician.
Blood Pressure	Annually and/or as recommended by your Physician.
Total Blood Cholesterol & High-Density Lipoprotein (HDL)	Periodic screenings are recommended for men ages 35 and older; women ages 45 and older.
Papanicolaou (Pap test for women)	At least every 1–3 years.
Human Papilloma Virus (HPV) Screening	All sexually active women ages 25 and older as part of routine cervical cancer screening. Discuss with your physician.
Prostate Cancer Screening (PSA test for men)	Discuss PSA screening with your Physician. Discuss testicular self-examination with your Physician.
Chlamydia Screening	All sexually active women ages 25 and younger. Discuss with your Physician.
Colorectal Cancer Screening: fecal occult blood test and/or sigmoidoscopy, colonoscopy or double contrast barium enema	Average risk patients beginning at age 50. A patient with increased risk factor(s) may receive screening at an earlier age if determined medically necessary. Every 5 years. Discuss test method and frequency with your Physician.
Mammogram & Breast Examination	Breast examination recommended annually by your Physician.
Hepatitis C Screening	Discuss with your Physician.
Skin Cancer Screening	Discuss with your Physician.
Tuberculosis Screening	Discuss with your Physician.
Screening for rubella susceptibility by history of vaccination or serologic tests for antibodies	Recommended for all women of childbearing age.
Sexually Transmitted Diseases	Recommended for all sexually active individuals.
Bone Densitometry	Discuss bone mass measurement and risk factors of osteoporosis with your Physician.
Immunizations and HRT	**Frequency**
Td Booster (tetanus, diphtheria)	Once every 10 years; 15–30 year intervals for adults who received a five-dose childhood series.
Rubella Vaccine	Once for all women of childbearing age without proof of immunization/immunity.
Measles, Mumps & Rubella (MMR)	For those without proof of immunity or if no previous 2nd dose.
Hepatitis B	Discuss with your Physician.
Chickenpox (varicella virus)	Discuss with your Physician for high risk, 2 doses 4-8 weeks apart.
Influenza (flu) Vaccine	Annually each fall season.
Hormone Replacement Therapy (HRT)	Pre- and postmenopausal women should discuss benefits and risks with their Physician.
Lyme Disease Vaccine	For persons with a high risk of contracting Lyme disease.

24: PREVENTIVE CARE GUIDELINES

Seniors: Age 65 and older

Health Screenings	**Frequency**
Height & Weight	Annually and/or as recommended by your Physician.
Blood Pressure	Annually and/or as recommended by your Physician.
Total Blood Cholesterol & High-Density Lipoprotein (HDL)	At least every 5 years. Discuss frequency and testing options with your Physician.
Papanicolaou (Pap test for women)	Discuss with your Physician.
Prostate Cancer Screening (PSA test for men)	Discuss PSA screening with your Physician.
Colorectal Cancer Screening: fecal occult blood test and/or sigmoidoscopy, colonoscopy or double contrast barium enema	Discuss frequency and method with your Physician.
Mammogram & Breast Examination	Breast examination recommended annually by your physician.
Hepatitis C Screening	Discuss with your Physician.
Skin Cancer Screening	Discuss with your Physician.
Visual Acuity	Screening for medical eye conditions which may need further evaluations by an eye specialist (eye refractions in preparation for glasses not included).
Hearing Impairment	Periodic screening. Discuss with your Physician.
Bone Densitometry	Routinely. Discuss bone mass measurement and risk factors for osteoporosis with your Physician.
Tuberculosis Screening	Discuss with your Physician.
Immunizations and HRT	**Frequency**
Td Booster (tetanus, diphtheria)	Once every 10 years; at 15–30-year intervals for adults who received a five-dose childhood series.
Chickenpox (varicella virus)	High risk, 2 doses 4-8 weeks apart.
Pneumococcal Vaccine	Once after age 65, booster may be required.
Influenza (flu) Vaccine	Annually each fall season.
Hepatitis B Vaccine	High risk. If not previously immunized, one dose at current visit, then at 1 and 6 months later.
Hormone Replacement Therapy (HRT)	Pre- and postmenopausal women should discuss benefits and risks with their Physician.
Lyme Disease Vaccine	For persons with a high risk of contracting Lyme disease.

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www.medco.com

MEDICARE
For nearest Social Security Office contact:
www.medicare.gov

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