Combined Evidence of Coverage and Disclosure Form

Effective January 1, 2020

Supplement to Original Medicare Plan with Major Medical Benefits

CAHP Health Benefits Trust
Preferred Provider Organization (PPO)

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

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

CalPERS

COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM

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

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

The benefits of the Plan shall be provided only to the extent that services are determined to be Medically Necessary, as defined herein. The determination of medical necessity shall be made by Anthem 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 2020

IF YOU HAVE QUESTIONS

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

MEDICAL CLAIMS AND MEMBER SERVICES

For medical claims submission or inquiries, benefit information, identification cards, or to obtain claim forms 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

EXPRESS SCRIPTS MEDICARE (PDP)

For information regarding your prescription drug coverage, refer to your CAHP Medicare Part D Prescription Drug Plan EOC, call or visit on-line. Representatives are available 24 hours a day, 7 days a week Express Scripts Medicare

1-855-315-3588
www.express-scripts.com

ELIGIBILITY OR ENROLLMENT

For information regarding eligibility or enrollment, consult your health benefits officer in your agency (active Employees) or contact the Health Account Services (Annuitants) as follows: CalPERS Health Account Management Division
P.O. Box 942715, Sacramento, CA 94229-2715
888 CalPERS (or **888**-225-7377) • (800) 959-6545 **(fax)** •TTY (877) 249-7442
www.calpers.ca.gov

NOTE: Important information pertaining to eligibility, enrollment, cancellation or termination of insurance, etc., is found in the CalPERS Health Program Guide. You may request a copy of this booklet by writing, 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.

INTRODUCTION

Welcome to the CAHP Supplement to Original Medicare Plan!

This CAHP Supplement to Original Medicare Plan (CAHP Supplemental Plan) is designed for Members enrolled in the California Public Employees' Retirement System's (CalPERS) health benefits program who are also enrolled in both Parts A (hospital insurance) and B (medical insurance) of Medicare. This Plan is in addition to a Medicare Part D Plan administered by Express Scripts and described in a separate EOC. Medicare Part A is hospital insurance that helps cover Inpatient care in hospitals, skilled nursing facilities, and hospices, in addition to home health care. Medicare Part B helps cover preventive care services and Medically Necessary services like doctors' visits, outpatient care, home health services, and other medical services. Check your Medicare card to find out if you have Part B. Medicare Part D covers prescription drugs and is administered by Express Scripts. **You are not allowed to enroll in a secondary Part D prescription drug plan that is not part of CalPERS. If you choose to opt out of the** CAHP Medicare Part D Prescription Drug Plan, administered by Express Scripts, **you will lose your Medicare Part D prescription drug coverage, and you will be responsible for all of your prescription drug costs.**

After you or your eligible Family Members are enrolled in this Plan, you may not change enrollment to a Basic Plan unless (1) there is an involuntary termination of your Medicare benefits, or (2) you move, other than temporarily, outside the United States as defined in the Federal Social Security Act. If you voluntarily cancel Part B of Medicare, you will not be eligible for a Basic Plan, nor will you be allowed to remain in this Plan.

A family group member, including a person enrolled in this CAHP Supplemental Plan, who is not eligible for Medicare and continues in the CAHP Basic Plan must enroll in this Plan when he or she is eligible to enroll in Medicare.

A Notice of Creditable Coverage documents your coverage under the CAHP Supplemental Plan. However, you should be aware that, if you have a subsequent break in this coverage of 63 days or more before enrolling a Part D, you could be subject to payment of higher Part D premiums. You may request a copy of a Notice of Creditable Coverage by calling the Anthem Blue Cross Member Services Department at 1-800-759-5758.

Please note that this Plan does not cover Custodial Care in any facility or situation, including a skilled nursing facility.

As a CAHP Supplemental Plan Member, you are responsible for meeting the requirements of the CAHP Supplemental Plan. Please take the time to familiarize yourself with this booklet and *Medicare & You.*

On behalf of the CAHP Board of Trustees and CAHP staff thank you for participating in the CAHP Supplemental Plan.

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.

ADVANCED HEALTH CARE DIRECTIVE

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

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

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

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

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

PREVENTIVE MEDICAL MISTAKES

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

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

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

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

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

I**mmediately report any medication problems** to your doctor.

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

Be assertive if something seems wrong or different than usual.

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

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 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 HEALTHCARE FRAUD

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

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

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

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

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

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

1. Call the Physician and ask for an explanation. There may be an error.
2. If the provider does not resolve the matter, call Anthem Blue Cross member services 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 26 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 39)

LANGUAGE ASSISTANCE PROGRAM

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

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

Written materials available for translation include grievance and appeal letters, consent forms, claim denial letters, and explanations of benefits. These materials are available in the top 15 languages as determined by law:

Oral interpretation services are available in additional languages.

In addition, appropriate auxiliary aids and services, including qualified interpreters for individuals with disabilities and information in alternate formats are also available, free of charge and in a timely manner, when those aids and services are necessary to ensure an equal opportunity to participate for individuals with disabilities.

Anthem does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.

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

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

IDENTITY PROTECTION SERVICES

The Claims Administrator has made identity protection services available to Members. To learn more about these services, please visit www.anthem.com/resources**.**

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SUMMARY OF BENEFITS AND ADMINISTRATIVE CHANGES

The following is a brief summary of the benefit and administrative changes that will take effect January 1, 2020. Be sure to refer to the appropriate benefit description sections of this Evidence of Coverage booklet for additional information.

Benefit Changes

No benefit changes.

SUMMARY OF BENEFITS

The benefits described in this Evidence of Coverage booklet are payable only for services and supplies that Medicare determines to be allowable and Medically Necessary, or specifically stated under **MAJOR MEDICAL BENEFITS, SPECIAL DUTY NURSING BENEFITS, SERVICES AND BENEFITS OUTSIDE THE UNITED STATES, HEARING AID SERVICES 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 page 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 31 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 13)	No Charge
Skilled Nursing Facility (page 13)	If Medicare Approved
Hospice (page 13)	
First three pints of unreplaced blood (page 14)	
MEDICAL (Part B) (page 13)	
Office Visits	$10
Outpatient Hospital	No Charge
Ambulatory Surgical Center Services	If Medicare Approved
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 enrollment	

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 16).

MAJOR MEDICAL BENEFITS FIRST LEVEL PAYMENT

After Original Medicare Plan Benefits Have Been Exhausted *	80% of Covered Expenses
Covered Services (pages 17 – 18)	
Extended Skilled Nursing Facility Benefits (page 19)	
Dental Services (page 19-20)	
Speech Therapy (page 20-21)	
Extend Hospice Care (page 21)	
Mental Disorders, except outpatient psychotherapy and psychological testing (page 20)	50% of Covered Expenses
Outpatient psychotherapy and psychological testing (page 16)	
Services Not Covered By Original Medicare Plan	
Special Duty Nursing Services** (page 23)	80% of Covered Expenses
Hearing Aid Services (pages 23-24)	90%, subject to a maximum Plan payment of $1,000

* 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%.

MAJOR MEDICAL MAXIMUM BENEFITS

Mental Disorders (page 20) 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 (pages 20-21)	$5,000 during a Members lifetime
Hearing Aid Services (pages 23-24) For covered hearing aids For covered audiological exams	 $1,000 each 36 months $200 each 36 months
Special Duty Nursing Benefits (page 23)	$800 during a Calendar Year
Hospice Care (page 21-22)	$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 (page 17)	$1,000,000 during each Member's lifetime (up to $1,000 automatically restored each January 1)

HEALTH PROMOTION PROGRAM

Smoking Cessation Program (page 25)	100% up to $100 per program per Year, 2 programs during a Member's lifetime
Smoking Cessation Products (page 25)	50% up to $175 for 90-day supply per Year, 2 times during a Member's lifetime
Weight Management Program (page 26)	80% up to $125 during a Member's lifetime

HOW TO USE YOUR PLAN

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

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

The Trust contracts directly with Anthem Blue Cross Life and Health Insurance Company (Anthem Blue Cross Life and Health), an affiliate of Anthem Blue Cross, as Claims Administrator of the medical, 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.

YOUR EMPLOYER HAS AGREED TO BE SUBJECT TO THE TERMS AND CONDITIONS OF ANTHEM'S PROVIDER AGREEMENTS WHICH MAY INCLUDE PRE-SERVICE REVIEW AND UTILIZATION MANAGEMENT REQUIREMENTS, COORDINATION OF BENEFITS, TIMELY FILING LIMITS, AND OTHER REQUIREMENTS TO ADMINISTER THE BENEFITS UNDER THIS PLAN.

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, Plan Members are responsible for any difference between the combined amount paid by the CAHP Supplemental Plan and Medicare and the charges billed by providers who are not Anthem Blue Cross Physician members and who do not accept Medicare assignment, within the limits of applicable law. Such providers may bill Members for the balance of any unpaid charges and for services and supplies that are not covered by Medicare or the CAHP Supplemental Plan.

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

OUTPATIENT PRESCRIPTION DRUG BENEFITS

If you are enrolled in the Express Scripts Medicare (PDP) refer to your Medicare Part D Prescription Drug Evidence of Coverage Booklet or contact Express Scripts Medicare at 1-855-315-3588.

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 25) 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, 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 Member Access Web site. Once registered, simply click the "Login" button and enter your User ID and Password to access the Member Access Web site.

HOW TO FILE A CLAIM

When you require healthcare, present your CAHP Supplement to Medicare 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.**

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.
- **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.

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.

MEDICAL POLICY

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

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

HEALTH PLAN INDIVIDUAL CASE MANAGEMENT PROGRAM

The **health plan individual case management program** enables the Plan to authorize Members to obtain medically appropriate care in a more economical, cost effective and coordinated manner during prolonged periods of intensive medical care. Through a case manager an alternative plan of treatment, which may include services not otherwise covered under the Plan, may be recommended. 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. The personal case management program (Case Management) helps coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions. The programs coordinate benefits and educate Members who agree to take part in the Case Management program to help meet their health-related needs.
2. The Case Management programs are confidential and voluntary, and are made available at no extra cost to the Member. These programs are provided by, or on behalf of and at the request of, the Member's health plan case management staff. These Case Management programs are separate from any covered services you are receiving.
3. If you meet program criteria and agree to take part, then Anthem Blue Cross will help you meet your identified health care needs. This is reached through contact and team work with you and /or your chosen authorized representative, treating *physicians*, and other providers.

    a. In addition, Anthem Blue Cross may assist in coordinating care with existing community-based programs and services to meet your needs. This may include giving you information about external agencies and community-based programs and services.
4. 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.
5. **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 Health Plan Individual Case Management Program

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

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

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.

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 up to a $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.

1. **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.

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.

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** and **HEALTH PROMOTION PROGRAM.** 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 additional Covered Expense that a 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.

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.).

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a. Outpatient diagnostic x-ray and laboratory services.
b. The following ambulance services:

- 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.
- 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.

(1) 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.

c. Radiation therapy and chemotherapy.
d. Surgical implants. This includes Medically Necessary surgically implanted hearing devices (i.e. cochlear implants, audient bone conduction devices).
e. Rental of dialysis equipment and all necessary services and supplies required for hemodialysis treatment, but not including the purchase of dialysis equipment.
f. 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.
g. 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.
h. Administration of blood and blood plasma, including blood processing and the cost of unreplaced blood.
i. Biofeedback procedures when provided for other than Mental Disorders.
j. 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.
k. Allergy testing and serum, immunizations and inoculations for the direct care or treatment of an actual illness, disease or injury.
l. 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. 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

(1) 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 term "acute phase" means the recent, severely intensified phase of an illness.

(2) 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.

(3) 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.

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**.

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
   11030 White Rock Road
   Rancho Cordova, CA 95670

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

EXCLUSIONS AND LIMITATIONS

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

1. Reimbursement of Covered Expense in excess of the maximum amounts stated in this Evidence of Coverage.
   NOTE: Member co-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. There is no vested right to receive any particular benefit set forth in the plan. Plan benefits may be modified. Any modified benefit (such as the elimination of a particular benefit or an increase in the members copayment) applies to services or supplies furnished on or after the effective date of the modification.
5. Food, dietary supplements, health or beauty aids.

SELF-CARE TOOLS

WebMD

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

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

WebMD allows you to:

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

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, or by a public school system or school district, except when payment under this Plan is expressly required by federal or state law. The Plan will not cover payment for these services if the Member is not required to pay for them or they are given to the Member for free.

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. **Non-Licensed Providers.** Treatment or services rendered by non-licensed health care providers and treatment or services for which the provider of services is not required to be licensed. This includes treatment or services from a non-licensed provider under the supervision of a licensed Physician, except as specifically provided or arranged by Anthem Blue Cross.
22. **Not Medically Necessary.** Any expense incurred for services or supplies that are not Medically Necessary as defined in this Evidence of Coverage.
23. **Not Specifically Listed.** Services not specifically listed in this Plan as covered services.
24. **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.
25. **Outpatient Prescription Drugs and Medications.** Outpatient Prescription Drugs or medications**.** Any non-prescription, over-the-counter patent or proprietary drug or medicine. Cosmetic, dietary supplements, health or beauty aids.
26. **Outpatient Speech Therapy.** Outpatient speech therapy, except as specifically stated under **MAJOR MEDICAL BENEFITS**.
27. **Pathological Gambling or Co-dependency.** Services for pathological gambling or co-dependency.
28. **Personal Comfort Items.** Personal comfort items, including cosmetics, dietary supplements, health or beauty aids.
29. **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.
30. **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.
31. **Rehabilitative Care.** Hospitalization primarily for environmental change, physical therapy or treatment of chronic pain.
32. **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.

33. **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).
34. **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**.
35. **Services Not Covered by Medicare.** Services not covered by Medicare unless specifically listed as benefits in this Evidence of Coverage.
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. **Waived Cost-Shares Non-Participating Provider.** For any service for which you are responsible under the terms of this *plan* to pay a co-payment or deductible, and the co-payment or deductible is waived by a Non-Participating Provider.
45. **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, within sixty (60) days, of his or her filing a claim against the third party and to take such action, furnish such information and assistance, and execute such papers as Anthem Blue Cross may require to facilitate enforcement of the Trust's rights. The Member also agrees to 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 personally responsible 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** is any necessary, reasonable and customary item of expense which is at least partially covered by any plan covering the person for whom a claim is made. When a plan provides benefits in the form of services rather than cash reimbursement for services, the reasonable cash value of each service rendered shall be deemed to be both an Allowable Expense and a benefit paid. An expense that is not covered by any plan covering the person for whom a claim is made is not Allowable Expense.

The following are not Allowable Expense:

- Use of a private hospital room is not an Allowable Expense unless the patient's stay in a private hospital room is Medically Necessary in terms of generally accepted medical practice, or one of the plans routinely provides coverage for hospital private rooms.
- If you are covered by two plans that calculate benefits or services on the basis of a reasonable and customary amount or relative value schedule reimbursement method or some other similar reimbursement method, any amount in excess of the higher of the reasonable and customary amounts.
- If a person is covered by two plans that provide benefits or services on the basis of negotiated rates or fees, an amount in excess of the lower of the negotiated rates.
- If a person is covered by one plan that calculates its benefits or services on the basis of a reasonable and customary amount or relative value schedule reimbursement method or some other similar reimbursement method and another plan provides its benefits or services on the basis of negotiated rates or fees, any amount in excess of the negotiated rate.
- The amount of any benefit reduction by the Principal Plan because you did not comply with the plan's provisions is not an Allowable Expense. Examples of these types of provisions

include second surgical opinions, utilization review requirements, and network provider arrangements.

- If you advise us that all plans covering you are high deductible health plans as defined by Section 223 of the Internal Revenue Code, and you intend to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code, any amount that is subject to the primary high deductible health plan's deductible.

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.
3. **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.
4. 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.
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 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.

6. 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.
7. 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.
8. 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.
9. 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.
10. 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.
11. 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.

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.

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 another CalPERS-sponsored health 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 Health Account 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.

TERMINATIONS 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. Loss of coverage under an employer’s health plan due to 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 as well as the disabled Member. The Member is required to furnish proof of the Social Security Administration's determination of disability to his or her Employer during the first 18 months of the COBRA continuation period **but no later than 60 days** after the later of the following events: (1) the date of the Social Security Administration's determination of the disability; (2) the date on which the original qualifying event occurs; (3) the date on which the qualified beneficiary loses coverage; or (4) the date on which the qualified beneficiary is informed of the obligation to provide the disability notice. The period of continuation shall in no event continue beyond (1) the period of disability, or (2) a maximum of 29 months after the date the Subscriber's coverage terminated due to the loss of employment, whichever occurs first.

   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 remainder of his or her life; that person's covered Family Members may continue coverage for 36 months after their coverage terminates due to the Subscriber's death. However, coverage could terminate prior to such time for either the Subscriber or Family Member in accordance with items c., d., or e. above.

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

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

GENERAL PROVISIONS

EVIDENCE OF COVERAGE

The Trust shall issue to the Subscriber an Evidence of Coverage. This Evidence of Coverage is not the Agreement. It does not change the coverage under the Agreement in 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 those 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.

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.

RIGHT OF RECOVERY

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

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

PROTECTION OF COVERAGE

Neither 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.

NOTICE OF PRIVACY PRACTICES

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

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

HOW YOUR MEDICAL INFORMATION WILL BE USED AND DISCLOSED

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

As Required By Law

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

Business Associates

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

Health Oversight Activities

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

Health Plan Operations

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

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

Health-Related Benefits and Services

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

Lawsuits and Disputes

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

Law Enforcement

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

Policy Holder

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

Relations

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

Serious Threat to Health or Safety

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

Workers' Compensation

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

AUTHORIZATIONS

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

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

The CAHP Health Benefits Trust
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 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 **1-800-734-2247**.

Protecting your privacy

Where to find our Notice of Privacy Practices

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law governing the privacy of individually identifiable health information. We are required by HIPAA to notify you of the availability of our Notice of Privacy Practices. The notice describes our privacy practices, legal duties and your rights concerning your Protected Health Information. We must follow the privacy practices described in the notice while it is in effect (it will remain in effect unless and until we publish and issue a new notice).

We may collect, use and share your Protected Health Information (PHI) for the following reasons and others as allowed or required by law, including the HIPAA Privacy Rule:
For payment: We use and share PHI to manage your account or benefits; or to pay claims for health care you get through your plan.

For health care operations: We use and share PHI for health care operations.

For treatment activities: We do not provide treatment. This is the role of a health care provider, such as your doctor or a hospital. Examples of ways we use your information for payment, treatment and health care operations:

- We keep information about your premium and deductible payments.
- We may give information to a doctor's office to confirm your benefits.
- We may share explanation of benefits (EOB) with the subscriber of your plan for payment purposes.
- We may share PHI with your health care provider so that the provider may treat you.
- We may use PHI to review the quality of care and services you get.
- We may use PHI to provide you with case management or care coordination services for conditions like asthma, diabetes or traumatic injury.
- We may also use and share PHI directly or indirectly with or through health information exchanges for payment, health care operations and treatment. If you do not want your PHI to be shared for payment, health care operations, or treatment purposes in health information exchanges, please visit anthem.com/health-insurance/about-us/privacy for more information.

We, including our affiliates or vendors, may call or text any telephone numbers provided by you using an automated telephone dialing system and/or a prerecorded message. Without limitation, these calls may concern treatment options, other health-related benefits and services, enrollment, payment, or billing.

You may obtain a copy of our Notice of Privacy Practices on our website at https://www.anthem.com/ca/health-insurance/about-us/privacy or you may contact Member Services using the contact information on your identification card.

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 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 or 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 Health Account Management Division at P.O. Box 942715, Sacramento, CA 94229-2715.

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;** or **STEP4: 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.

2. **Malpractice grievances:** Claims of malpractice must be taken up directly with the provider(s) of medical care.

3. **Bad faith grievances:** You must proceed to **STEP 4: 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 4: BINDING ARBITRATION (OR SMALL CLAIMS COURT)

If you do not use **STEP 2** or **STEP3,** 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.

REQUIRED MONTHLY CONTRIBUTION

Type of Enrollment	Enrollment Code	Cost*
Subscriber Only	2311	$418.37
Subscriber and One Family Member	2312	$772.54
Subscriber and Two or More Family Members	2313	$982.26

STATE EMPLOYEES AND ANNUITANTS

*The required monthly contributions shown above are effective January 1, 2020, 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 change as of January 1, 2021, following at least sixty (60) days written notice to the Board prior to such change.

GENERAL DEFINITIONS

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

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

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

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

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

An **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.

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.

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 26, 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 26 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 26 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 26,
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.

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.

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 for the purpose of this Plan, are conditions that are listed in the most current edition of the Diagnostic and Statistical Manual (DSM) of Mental Disorders. **ONE OR MORE OF THESE CONDITIONS MAY BE SPECIFICALLY EXCLUDED IN THIS EVIDENCE OF COVERAGE.**

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 and such license is required to render that service, is providing a service for which benefits are specified in this Plan, and when benefits would be payable if the services were provided by a Physician as defined in 1. above:
   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 licensed 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 nurse midwife

q. A nurse practitioner

r. A physician assistant

s. 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).*

t. Any agency licensed by the state to provide services for the treatment of Mental Disorders or Chemical Dependency, when required by law to cover those services

u. A registered dietitian (R.D.)* or another nutritional professional* with a master's or higher degree in a field covering clinical nutrition sciences, from a college or university accredited by a regional accreditation agency, who is deemed qualified to provide these services by the referring M.D. or D.O. A registered dietitian or other nutritional professional as described here are covered for the provision of diabetic medical nutrition therapy and nutritional counseling for the treatment of eating disorders such as anorexia nervosa and bulimia nervosa only

*__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 Express Scripts

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 being 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, and 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.

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.

IT'S IMPORTANT WE TREAT YOU FAIRLY

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Richmond, VA 23279 or by email to compliance.coordinator@anthem.com. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1-800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf . Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

GET HELP IN YOUR LANGUAGE

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

You have the right to get this information and help in your language for free. Call the Member Services number on your ID card for help. (TTY/TDD: 711)

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

Spanish

Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda**. (TTY/TDD: 711)**

Arabic

يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجانًا. اتصل برقم خدمات الأعضاء الموجود على بطاقة التعريف الخاصة بك للمساعدة(TTY/TDD: 711).

Armenian

Դուք իրավունք ունեք Ձեր լեզվով անվճար ստանալ այս տեղեկատվությունը և ցանկացած օգնություն: Օգնություն ստանալու համար զանգահարեք Անդամների սպասարկման կենտրոն՝ Ձեր ID քարտի վրա նշված համարով: (TTY/TDD: 711)

Chinese

您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。(TTY/TDD: 711)

Farsi

شما این حق را دارید که این اطلاعات و کمکها را به صورت رایگان به زبان خودتان دریافت کنید. برای دریافت کمک به شماره مرکز خدمات اعضاء که بر روی کارت شناسایی‌تان درج شده است، تماس بگیرید. (TTY/TDD: 711)

Hindi

आपके पास यह जानकारी और मदद अपनी भाषा में मुफ़्त में प्राप्त करने का अधिकार है। मदद के लिए अपने ID *कार्ड पर सदस्य सेवाएँ नंबर पर कॉल करें।*(TTY/TDD: 711)

Hmong

Koj muaj cai tau txais qhov lus qhia no thiab kev pab hais ua koj hom lus yam tsis xam tus nqi. Hu rau tus nab npawb xov tooj lis Cov Kev Pab Cuam Rau Tswv Cuab nyob rau ntawm koj daim ID txhawm rau thov kev pab. (TTY/TDD: 711)

Japanese

この情報と支援を希望する言語で無料で受けることができます。支援を受けるには、ID カードに記載されているメンバーサービス番号に電話してください。(TTY/TDD: 711)

Khmer

អ្នកមានសិទ្ធិក្នុងការទទួលព័ត៌មាននេះ និងទទួលជំនួយជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។ សូមហៅទូរស័ព្ទទៅលេខសេវាសមាជិកដែលមានលើប័ណ្ណ ID *របស់អ្នកដើម្បីទទួលជំនួយ។*(TTY/TDD: 711)

Korean

귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으려면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오. (TTY/TDD: 711)

Punjabi

ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਇਹ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਮੁਫ਼ਤ ਵਿੱਚ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਮਦਦ ਲਈ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਉੱਤੇ ਮੈਂਬਰ ਸਰਵਿਸਿਜ਼ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ।(TTY/TDD: 711)

Russian

Вы имеете право получить данную информацию и помощь на вашем языке бесплатно. Для получения помощи звоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. (TTY/TDD: 711)

Tagalog

May karapatan kayong makuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng Member Services na nasa inyong ID card para sa tulong. (TTY/TDD: 711)

Thai

ท่านมีสิทธิขอรับบริการสอบถามข้อมูลและความช่วยเหลือในภาษาของท่านฟรี โทรไปที่หมายเลขฝ่ายบริการสมาชิกบนบัตรประจำตัวของท่านเพื่อขอความช่วยเหลือ(TTY/TDD: 711)

Vietnamese

Quý vị có quyền nhận miễn phí thông tin này và sự trợ giúp bằng ngôn ngữ của quý vị. Hãy gọi cho số Dịch Vụ Thành Viên trên thẻ ID của quý vị để được giúp đỡ. (TTY/TDD: 711)

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