Anthem Blue Cross
California Association of Highway Patrolmen (CAHP) Basic Plan

Coverage Period 01/01/2017 – 12/31/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Individual/Family | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.anthem.com/ca or by calling 1-800-759-5758.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For PPO Providers: **$0** Member/**$0** Family For Non-PPO Providers: **$0** Member/**$0** Family	Not applicable. See the chart starting on page 2 for your costs for services this plan covers.
Are there other Deductible's for specific services?	No	Not applicable. See the chart starting on page 2 for your costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **For Medical Services/Expenses**: For Participating PPO Providers: **$2,000** Member/ **$4,000** Family For Non-PPO Providers no out-of-pocket limit when using a Non-PPO provider. **For Pharmacy/Prescription Drug Services:** **$5,150 Member/$10,300 Family**	The **out-of-pocket limit** is the most you could pay during a Calendar Year for your share of the cost of covered services with participating providers. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Non-participating providers, premiums, balance-billed charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit.**
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for specific coverage limits, such as limits on the number of visits.

Questions: Call 1-800-759-5758 or visit us at www.anthem.com/ca/calpers
If you aren't clear about any of the underlined terms used in this form, you can view the glossary at www.dol.gov/ebsa/pdf/sbcuniformglossary.pdf or call 1-800-759-5758 to request a copy.

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Does this plan use a network of providers?	Yes. See www.anthem.com/ca/calpers for a list of participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, our in-network doctor or hospital may use an out-of-network **provider** for some services. Plan uses the term in-network, **preferred**, or participating for **providers** in their **network.** See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 10. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use PPO **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	**$15** Copay/Visit	**40%** Coinsurance	--------none--------
	Specialist visit	**$15** Copay/Visit	**40%** Coinsurance	--------none--------

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Other practitioner office visit	Chiropractor **10%** Coinsurance Acupuncturist **10%** Coinsurance	Chiropractor **40%** Coinsurance Acupuncturist **40%** Coinsurance	Benefits are limited to 20 visits per calendar year for any combined chiropractic or acupuncture service. An authorization is required for all physical and occupational therapy benefits in excess of 24 visits in a Year.
	Preventive care/ screening/ immunization	No Charge	**40%** Coinsurance	--------none--------
If you have a test	Diagnostic test (x-ray, blood work)	Lab – Office **10%** Coinsurance X-Ray – Office **10%** Coinsurance	Lab – Office **40%** Coinsurance X-Ray – Office **40%** Coinsurance	--------none--------
	Imaging (CT/PET scans, MRIs)	**10%** Coinsurance	**40%** Coinsurance	Prior authorization is required for PET scans. Contact Anthem Blue Cross at 1-800-274-7767 to initiate authorization. Services not preauthorized may not be covered.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition	Generic drugs	**$5** copay/30 day prescription supply at retail; **$10** copay/90 day prescription supply at mail order.	**100%** up-front cost; paper claim may be submitted to request partial reimbursement	After the second prescription drug fill at a retail pharmacy, the Member is responsible for a **$10** co-payment.
	Preferred Brand drugs	**$20** copay/30 day prescription supply at retail; **$40** copay/90 day prescription supply at mail order.	**100%** up-front cost; paper claim may be submitted to request partial reimbursement	After the second prescription drug fill at a retail pharmacy, the Member is responsible for a **$40** co-payment.
	Non-Preferred Brand drugs	**$25** copay/30 day prescription supply at retail; **$50** copay/90 day prescription supply at mail order. In addition to the copay amount, you will pay the difference in cost between the Brand Name Drug and its Generic equivalent.	**100%** up-front cost; paper claim may be submitted to request partial reimbursement	After the second prescription drug fill for Multi-Source Brand Drugs at a retail pharmacy, the Member is responsible for a **$50** co-payment, plus the difference in cost between the Brand Name Drug and its Generic equivalent.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Specialty drugs	**$5** copay/30 day prescription supply at retail. After the second prescription drug fill, the Member is responsible for a **$10** copay; **$10** copay/90 day prescription at mail order. **$20** copay/30 day prescription supply at retail single source brand drug. After the second prescription drug fill, the Member is responsible for a **$40** copay; **$40** copay/90 day prescription at mail order. **$25** copay/30 day prescription supply at retail for multi-source brand drug. After the second prescription drug fill **$50** copay; **$50** copay/90 day prescription at mail order. In addition to the copay amount, you will pay the difference in cost between the Brand Name Drug and its Generic equivalent.	**100%** up-front cost; paper claim may be submitted to request partial reimbursement	Some specialty medications may require Pre-authorization. Additional information regarding the Specialty Pharmacy Service can be obtained by calling 1-800-803-2523 or accessing Express Scripts online at www.express-scripts.com.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	**10%** Coinsurance	**40%** Coinsurance	Coverage is limited to **$350**/at a Non-Network Ambulatory Surgery Center.
	Physician/surgeon fees	**10%** Coinsurance	**40%** Coinsurance	--------none--------
If you need immediate medical attention	Emergency room services	**$50** Copay/**10%** Coinsurance	**$50** copay/**10%** Coinsurance	Non-emergency by non-PPO; **$50** copay/**40%** Coinsurance member responsibility. This is for the hospital/facility charge only. The ER physician charge may be separate.
	Emergency medical transportation	**20%** Coinsurance	**20%** coinsurance	If Medically Necessary for the Member to be moved via ambulance from one facility to another, services are covered at **100%.**
	Urgent care	**$15** Copay	**40%** Coinsurance	--------none--------
If you have a hospital stay	Facility fee (e.g., hospital room)	**10%** Coinsurance	Non-emergency and non- PPO; **$540.00** Inpatient Daily Maximum scheduled amount. The plans' payment shall not exceed **90%** of the scheduled amount listed above.	Utilization review is required for inpatient hospital admissions with the exception of maternity care of 48 hours or less for normal delivery or 96 hours or less following a cesarean section and limply node dissection. To initiate pre-service review contact Anthem Blue Cross at 1-800-274-7767 at least three working days prior to when the Member is scheduled to receive services. Services not preauthorized may not be covered.
	Physician/surgeon fee	**10%** Coinsurance	**40%** Coinsurance	--------none--------

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	**10%** Coinsurance	**40%** Coinsurance	For additional information please refer to the CAHP Health Benefits Trust Evidence of Coverage Booklet under section; Covered Medical Services and Supplies.
	Mental/Behavioral health inpatient services	**10%** Coinsurance	Non-emergency and non-PPO; **$540.00** Inpatient Daily Maximum scheduled amount. The plans' payment shall not exceed **90%** of the scheduled amount listed above.	Utilization review is required for inpatient hospital admissions with the exception of maternity care of 48 hours or less for normal delivery or 96 hours or less following a cesarean section and lymph node dissection. To initiate pre-service review contact Anthem Blue Cross at 1-800-274-7767 at least three working days prior to when the Member is scheduled to receive services. Services not preauthorized may not be covered.
	Substance use disorder outpatient services	**10%** Coinsurance	**40%** Coinsurance	For additional information please refer to the CAHP Health Benefits Trust Evidence of Coverage Booklet under section; Cover Medical Services and Supplies.
	Substance use disorder inpatient services	**10%** Coinsurance	Non-emergency and non- PPO; **$540.00** Inpatient Daily Maximum scheduled amount. The plans' payment shall not exceed **90%** of the scheduled amount listed above.	Utilization review is required for inpatient hospital admissions with the exception of maternity care of 48 hours or less for normal delivery or 96 hours or less following a cesarean section and lymph node dissection. To initiate pre-service review contact Anthem Blue Cross at 1-800-274-7767 at least three working days prior to when the Member is scheduled to receive services. Services not preauthorized may not be covered.
If you are pregnant	Prenatal and postnatal care	**10%** Coinsurance	**40%** Coinsurance	----------none----------

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Delivery and all inpatient services	**10%** Coinsurance	Non-emergency & non- PPO; **$540** Inpatient Daily Maximum scheduled amount. The plans' payment shall not exceed **90%** of the scheduled amount listed above.	Utilization review is required for inpatient hospital admissions with the exception of maternity care of 48 hours or less for normal delivery or 96 hours or less following a cesarean section and limply node dissection. To initiate pre-service review contact Anthem Blue Cross at 1-800-274-7767 at least three working days prior to when the Member is scheduled to receive services. Services not preauthorized may not be covered.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	**10%** Coinsurance	**40%** Coinsurance	90 visits maximum for each period of disability. Prior authorization is required. Services not preauthorized may not be covered.
	Rehabilitation services	**10%** Coinsurance	**40%** Coinsurance	Prior authorization is required for all physical and occupational therapy benefits in excess of 24 visits in a Year. Services not preauthorized may not be covered.
	Habilitation services	**10%** Coinsurance	**40%** Coinsurance	Prior authorization is required.
	Skilled nursing care	**10%** Coinsurance	**40%** Coinsurance	100 days maximum per confinement period. Prior authorization is required. Services not preauthorized may not be covered.
	Durable medical equipment	**10%** Coinsurance	**40%** Coinsurance	Prior authorization can be obtained if the durable medical equipment purchase price is **$5,000** or more.
	Hospice service	No Charge	No Charge	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 physician.
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	--------none--------
	Glasses	Not Covered	Not Covered	--------none--------
	Dental check-up	Not Covered	Not Covered	--------none--------

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic services
- Dental Implants
- Infertility treatment
- Long-term care
- Personal development programs
- Private-duty nursing
- Routine foot care (unless you have been diagnosed with diabetes. Consult your formal contract of coverage
- Vision Services or Supplies

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery (For morbid obesity. Consult your formal contract of coverage)
- Hearing Aids (Up to **$1,000** every 36 months)
- Most coverage provided outside the United States. See www.BCBS.com/bluecardworldwide

Your Rights to Continue Coverage:

"If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights, maybe limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact the plan at 1-877-737-7776. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov .

Your Grievance and Appeals Rights: If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Anthem Blue Cross (in writing within 60 days of notice of denial) P.O. Box 60007 Los Angeles, CA 90060-0007 Attn: CAHP Unit
If Anthem Blue Cross affirms the denial the following steps apply:
STEP 2: Special Review Procedures for Denial of Experimental of Investigational Treatment STEP 3: Independent External Review
STEP 4: Administrative Appeal Process STEP 5: Binding Arbitration (or Small Claims Court)

Questions: Call 1-800-759-5758 or visit us at **www.anthem.com/ca/calpers**
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Does this Coverage Provide Minimum Essential Coverage? The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard? The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Si no es miembro todavía y necesita ayuda en idioma español, le suplicamos que se ponga en contacto con su agente de ventas o con el administrador de su grupo. Si ya está inscrito, le rogamos que llame al número de servicio de atención al cliente que aparece en su tarjeta de identificación.

如果您是非會員並需要中文協助，請聯絡您的銷售代表或小組管理員。如果您已參保，則請使用您 ID 卡上的號碼聯絡客戶服務人員。

Kung hindi ka pa miyembro at kailangan ng tulong sa wikang Tagalog, mangyaring makipag-ugnayan sa iyong sales representative o administrator ng iyong pangkat. Kung naka-enroll ka na, mangyaring makipag-ugnayan sa serbisyo para sa customer gamit ang numero sa iyong ID card.

Doo bee a'tah ni'liigoo eí dooda'í, shikáa adoołwoł íínízinigo t'áá diné k'éjíígo, t'áá shoodí ba na'ałníhí ya sidáhí bich'į naabídíílkiid. Eí doo biigha daago ni ba'nija'go ho'aałagíí bich'į hodiilní. Hai'dąą iini'taago eíya, t'áá shoodí diné ya atáh halne'ígíí ní béésh bee hane'í wólta' bi'ki si'niilígíí bi'kéhgo bich'į hodiilní.

아직 가입하지 않았거나 한국어로 된 도움말이 필요한 경우 영업 관리자나 그룹 관리자에게 문의하시기 바랍니다. 이미 가입한 경우 ID 카드에 있는 번호를 사용하여 고객 서비스에 문의하시기 바랍니다.

Nếu quý vị chưa phải là một hội viên và cần được giúp đỡ bằng Tiếng Việt, xin liên lạc với đại diện thương mãi của quý vị hoặc quản trị viên nhóm. Nếu quý vị đã ghi danh, xin liên lạc với dịch vụ khách hàng qua việc dùng số điện thoại ghi trên thẻ ID của quý vị.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,650
- **Patient pays** $895

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$15
Coinsurance	$730
Limits or exclusions	$150
Total	**$895**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,830
- **Patient pays** $570

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$350
Coinsurance	$140
Limits or exclusions	$80
Total	**$570**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

Costs don't include **premiums**. Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.

- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.