Retiree Benefits

Open Enrollment

October 18, 2019 through November 1, 2019

2020 Benefit Elections

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General Information

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If you have questions, please contact:

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Principal Benefits for
Kaiser Permanente Traditional HMO Plan (1/1/20—12/31/20)

Accumulation Period

The Accumulation Period for this plan is January 1 through December 31.

Out-of-Pocket Maximum(s) and Deductible(s)

For Services that apply to the Plan Out-of-Pocket Maximum, you will not pay any more Cost Share for the rest of the Accumulation Period once you have reached the amounts listed below.

Amounts Per Accumulation Period	Self-Only Coverage (a Family of one Member)	Family Coverage Each Member in a Family of two or more Members	Family Coverage Entire Family of two or more Members
Plan Out-of-Pocket Maximum	$1,500	$1,500	$3,000
Plan Deductible	None	None	None
Drug Deductible	None	None	None

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

Outpatient Services	You Pay
Outpatient surgery and certain other outpatient procedures	$15 per procedure
Allergy injections (including allergy serum)	No charge
Most immunizations (including the vaccine)	No charge
Most X-rays and laboratory tests	No charge

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

Emergency Health Coverage	You Pay
Emergency Department visits	$100 per visit

Note: This Cost Share does not apply if you are admitted directly to the hospital as an inpatient for covered Services (see "Hospitalization Services" for inpatient Cost Share).

Ambulance Services	You Pay
Ambulance Services	No charge

Prescription Drug Coverage	You Pay
Covered outpatient items in accord with our drug formulary guidelines:	
Most generic items at a Plan Pharmacy	$10 for up to a 30-day supply
Most generic refills through our mail-order service	$20 for up to a 100-day supply
Most brand-name items at a Plan Pharmacy	$20 for up to a 30-day supply
Most brand-name refills through our mail-order service	$40 for up to a 100-day supply
Most specialty items at a Plan Pharmacy	20% Coinsurance (not to exceed $150) for up to a 30-day supply

Durable Medical Equipment (DME)	You Pay
DME items as described in the *EOC*	No charge

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

Substance Use Disorder Treatment	You Pay
Inpatient detoxification	No charge
Individual outpatient substance use disorder evaluation and treatment	$15 per visit
Group outpatient substance use disorder treatment	$5 per visit

(continues)

Home Health Services	**You Pay**
Home health care (up to 100 visits per Accumulation Period)	No charge
Other	**You Pay**
Skilled nursing facility care (up to 100 days per benefit period)	No charge
Prosthetic and orthotic devices as described in the *EOC*	No charge
Diagnosis and treatment of infertility and artificial insemination (such as outpatient procedures or laboratory tests) as described in the *EOC*	50% Coinsurance
Assisted reproductive technology ("ART") Services	Not covered
Hospice care	No charge

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Share, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Share amounts. For a complete explanation, please refer to the *EOC*. Please note that we provide all benefits required by law (for example, diabetes testing supplies).

Your Summary of Benefits
EPO
PACE

Anthem Blue Cross

Custom EPO 25 (0/25/0)

This Summary of Benefits is a brief overview of your plan's benefits only. For more detailed information about the benefits in your plan, please refer to your Certificate of Insurance or Evidence of Coverage (EOC), which explains the full range of covered services, as well as any exclusions and limitations for your plan.

Anthem Blue Cross EPO members must receive health care services from Anthem Blue Cross PPO (Prudent Buyer) network providers, unless they receive authorized referrals or need emergency and/or out-of-area urgent care. Emergency services received from a Non-PPO hospital and without an authorized referral are covered only for the first 48 hours. Coverage will continue beyond 48 hours if the member can't be moved safely.

In addition to dollar and percentage copays, members are responsible for deductibles, as described below. Please review the deductible information to know if a deductible applies to a specific covered service. Certain Covered Services have maximum visit and/or day limits per year. The number of visits and/or days allowed for these services will begin accumulating on the first visit and/or day, regardless of whether your Deductible has been met.

Members are also responsible for all costs over the plan maximums. Plan maximums and other important information appear in italics. Benefits are subject to all terms, conditions, limitations, and exclusions of the Policy.

Subject to Utilization Review
Certain services are subject to the utilization review program. Before scheduling services, the member must make sure utilization review is obtained. If utilization review is not obtained, benefits may be reduced or not paid, according to the plan.

Explanation of Maximum Allowed Amount
Maximum Allowed Amount is the total reimbursement payable under the plan for covered services received from Participating and Non-Participating Providers. It is the payment towards the services billed by a provider combined with any applicable deductible, copayment or coinsurance.

PPO Providers—The rate the provider has agreed to accept as reimbursement for covered services. Members are not responsible for the difference between the provider's usual charges & the maximum allowed amount.

Non-PPO Providers—*(services covered only with an authorized referral includes those not represented in the PPO provider network; and medical emergencies).* For non-emergency care, reimbursement amount is based on: an Anthem Blue Cross rate or fee schedule, a rate negotiated with the provider, information from a third party vendor, or billed charges. Members are responsible for the difference between the provider's usual charges & the maximum allowed amount.

For Medical Emergency care rendered by a Non-Participating Provider or Non-Contracting Hospital, reimbursement is based on the reasonable and customary value. Members may be responsible for any amount in excess of the reasonable and customary value.

When using Non-PPO and Other Health Care Providers, members are responsible for any difference between the covered expense & actual charges, as well as any deductible & percentage copay.	
Calendar year deductible	None
Deductible for emergency room services	$100/visit (*waived if admitted directly from ER*)
Annual Out-of-Pocket Maximums	
∘ PPO Providers	$1,500/member; $3,000/family

The following do not apply to out-of-pocket maximums: non-covered expenses. After an annual out-of-pocket maximum is met for medical and prescription drugs during a calendar year, the individual member or family will no longer be required to pay a copay or coinsurance for medical and prescription drug covered expenses for the remainder of that year. The member remains responsible for non-covered expenses.

Lifetime Maximum	Unlimited

Covered Services	PPO: Per Member Copay[§]
Preventive Care Services Preventive Care Services including*, physical exams, preventive screenings *(including screenings for cancer, HPV, diabetes, cholesterol, blood pressure, hearing and vision, immunizations, health education, intervention services, HIV testing),* and additional preventive care for women provided for in the guidelines supported by the Health Resources and Services Administration. *This list is not exhaustive. This benefit includes all Preventive Care Services required by federal and state law.	No copay
Physician Medical Services • Office & home visits *(includes retail health clinic)* • Preferred Online Visits *(includes Mental/Behavioral Health and Substance Abuse)* • Hospital & skilled nursing facility visits • Surgeon & surgical assistant; anesthesiologist or anesthetist • Drugs administered by a medical provider *(certain drugs are subject to utilization review)*	 $25/visit [†] $25/visit No copay No copay 20% *(up to $150 maximum)*
Diabetes Education Programs *(requires physician supervision)* [†] • Teach members & their families about the disease process, the daily management of diabetic therapy & self-management training	$25/visit
Physical Therapy, Physical Medicine & Occupational Therapy	$25/visit
Chiropractic Services *(limited to 30 visits /calendar year)* [ƒ]	$25/visit
Speech Therapy	$25/visit
Acupuncture • Services for the treatment of disease, illness or injury *(limited 20 visits/calendar year)*	 $25 /visit
Diagnostic X-ray & Lab *(facility & non-facility based)* • Other diagnostic x-ray & lab	 No copay
Advanced Imaging *(subject to utilization review)*	$100/test
Urgent Care *(physician services)* [†]	$25/visit *(copay waived if admitted inpatient and outpatient ER)*
Emergency Care • Emergency room services & supplies (*waived if admitted inpatient*) • Physician services	 $100/visit No copay
Hospital Medical Services *(subject to utilization review for inpatient and certain outpatient services; waived for emergency admissions)* • Semi-private or private room, medically necessary services & supplies • Outpatient surgery *(including services & supplies)*	 $250/admit $125/admit
Skilled Nursing Facility (*subject to utilization review*) • Semi-private room, services & supplies (*limited to 100 days/calendar year; limit does not apply to mental health and substance abuse*)	 No copay
Related Outpatient Medical Services & Supplies • Outpatient Medical Services • Ground or air ambulance transportation, services & disposable supplies *(air ambulance in a non-medical emergency is subject to utilization review)* • Blood transfusions, blood processing & the cost of unreplaced blood & blood products • Autologous blood (*self-donated blood collection, testing, processing & storage for planned surgery*)	 $100/trip[‡] No copay[‡] No copay[‡]
Ambulatory Surgical Centers *(certain surgeries are subject to utilization review)* • Outpatient surgery, services & supplies	 $125/admit
Pregnancy & Maternity Care • Physician office visits • Abortions *(including prescription drug for abortion, mifepristone)* Normal delivery, cesarean section, complications of pregnancy & abortion. Refer to the Physician & Hospital Medical Services benefits for both inpatient and outpatient hospital coverage.	 $25/visit [†] $150
Mental or Nervous Disorders and Substance Abuse • Inpatient facility care (*subject to utilization review; waived for emergency admissions*) • Inpatient physician visits • Outpatient facility care	 $250/admit No copay No copay

Covered Services	PPO: Per Member Copay[§]
∘ Physician office visits *(Behavioral Health treatment for Autism or Pervasive Development disorders require pre-service review)*	$25/visit (*deductible waived*) [†]
Durable Medical Equipment *(may be subject to utilization review)* ∘ Rental or purchase of DME *(breast pump and supplies are covered under preventive care at no charge for in-network)*	20%
Home Health Care (*subject to utilization review*) ∘ Services & supplies from a home health agency (*limited to 100 visits/calendar year, one visit by a home health aide equals four hours or less*)	$25/visit
Home Infusion Therapy (*subject to utilization review*) ∘ Includes medication, ancillary services & supplies; caregiver training & visits by provider to monitor therapy; durable medical equipment; lab services	$25/visit
Hemodialysis, Radiation and Chemotherapy *(facility & non facility based)*	$25/visit
Hospice Care ∘ Inpatient or outpatient services; family bereavement services	No copay
Bariatric Surgery *(subject to utilization review; covered only when performed at a Centers of Medical Excellence [CME])* ∘ Inpatient services provided in connection with medically necessary surgery for weight loss, only for morbid obesity ∘ Travel expenses for an authorized, specified surgery *(recipient & companion transportation limited to $3,000 per surgery)*	$250/admit No copay
Organ & Tissue Transplants (*subject to utilization review; specified organ transplants covered only when performed at Centers of Medical Excellence [CME]*) ∘ Inpatient services provided in connection with non-investigative organ or tissue transplants ∘ Transplant travel expense for an authorized, specified transplant (*recipient & companion transportation limited to $10,000 per transplant*) ∘ Unrelated donor search, limited to $30,000 per transplant	$250/admit No copay
Prosthetic Devices ∘ Coverage for breast prostheses; prosthetic devices to restore a method of speaking; surgical implants; artificial limbs or eyes; the first pair of contact lenses or eyeglasses when required as a result of eye surgery; & therapeutic shoes & inserts for members with diabetes	No copay

Certain types of physicians may not be represented in the PPO network in the state where the member receives services. If such physician is not available in the service area, the member's copay is the same as for PPO (with and without pre-notification, if applicable). Member is responsible for applicable copays, deductibles and charges which exceed covered expense.

This Summary of Benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits. This proposed benefit summary is subject to the approval of the California Department of Insurance and the California Department of Managed Health Care.

† The dollar copay applies only to the visit itself. An additional copay applies for any services performed in office (i.e., X-ray, lab, surgery), after any applicable deductible.

‡ These providers are not represented in the PPO network.

§ Non-emergency services from non-PPO providers are covered only with an authorized referral.

f Additional visits as authorized if medically necessary; pre-service review must be obtained prior to receiving the services.

Exclusions and Limitations

Not Medically Necessary. Services or supplies that are not medically necessary, as defined.
Experimental or Investigative. Any experimental or investigative procedure or medication. But, if member is denied benefits because it is determined that the requested treatment is experimental or investigative, the member may request an independent medical review, as described in the Certificate.
Services Received Outside of the United States. Services rendered by providers located outside the United States, unless the services are for an emergency, emergency ambulance or urgent care.
Crime or Nuclear Energy. Conditions that result from (1) the member's commission of or attempt to commit a felony, as long as any injuries are not a result of a medical condition or an act of domestic violence; or (2) any release of nuclear energy, whether or not the result of war, when government funds are available for the treatment of illness or injury arising from the release of nuclear energy.
Not Covered. Services received before the member's effective date. Services received after the member's coverage ends, except as specified as covered in the Certificate.
Excess Amounts. Any amounts in excess of covered expense or any medical benefit maximum.
Work-Related. Any injury, condition or disease arising out of employment for which benefits or payments are covered by any worker's compensation law or similar law. If we provide benefits for such injuries, conditions or diseases we shall be entitled to establish a lien or other recovery under section 4903 of the California Labor Code or any other applicable law, as specified in the EOC/Certificate.
Government Treatment. Any services the member actually received that were provided by a local, state or federal government agency, except when payment under this plan is expressly required by federal or state law. We 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.
Services of Relatives. Professional services received from a person living in the member's home or who is related to the member by blood or marriage, except as specified as covered in the Certificate.
Voluntary Payment. Services for which the member has no legal obligation to pay, or for which no charge would be made in the absence of insurance coverage or other health plan coverage, except services received at a non-governmental charitable research hospital. Such a hospital must meet the following guidelines:1. it must be internationally known as being devoted mainly to medical research;2. at least 10% of its yearly budget must be spent on research not directly related to patient care;3. at least one-third of its gross income must come from donations or grants other than gifts or payments for patient care;4. it must accept patients who are unable to pay; and5. Two-thirds of its patients must have conditions directly related to the hospital's research.
Private Contracts. Services or supplies provided pursuant to a private contract between the member and a provider, for which reimbursement under Medicare program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act.
Inpatient Diagnostic Tests. Inpatient room and board charges in connection with a hospital stay primarily for diagnostic tests which could have been performed safely on an outpatient basis.
Mental or Nervous Disorders. Academic or educational testing, counseling, and remediation. Mental or nervous disorders or substance abuse, including rehabilitative care in relation to these conditions, except as specified as covered in the Certificate.
Orthodontia. Braces, other orthodontic appliances or orthodontic services.
Dental Services or Supplies. For dental treatment, regardless of origin or cause, except as specified below. "Dental treatment" includes but is not limited to preventative care and fluoride treatments; dental x rays, supplies, appliances, dental implants and all associated expenses; diagnosis and treatment related to the teeth, jawbones or gums, including but not limited to:
1. Extraction, restoration, and replacement of teeth; 2. Services to improve dental clinical outcomes.
This exclusion does not apply to the following:
1. Services which we are required by law to cover; 2. Services specified as covered in this booklet;
3. Dental services to prepare the mouth for radiation therapy to treat head and/or neck cancer.
Hearing Aids or Tests. Hearing aids and routine hearing tests, except as specified as covered in the Certificate.
Optometric Services or Supplies. Optometric services, eye exercises including orthoptics. Routine eye exams and routine eye refractions, as specified as covered in the Certificate. Eyeglasses or contact
lenses, except as specified as covered in the Certificate.
Outpatient Occupational Therapy. Outpatient occupational therapy, except by a home health agency, hospice, or home infusion therapy provider, as specified as covered in the Certificate.
Outpatient Speech Therapy. Outpatient speech therapy, except as specified as covered in the Certificate.
Cosmetic Surgery. Cosmetic surgery or other services performed to alter or reshape normal (including aged) structures or tissues of the body to improve appearance
Commercial Weight Loss Programs. Weight loss programs, whether or not they are pursued under medical or physician supervision, unless specifically listed as covered in this plan. This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs. This exclusion does not apply to medically necessary treatments for morbid obesity or dietary evaluations and counseling, and behavioral modification programs for the treatment of anorexia nervosa or bulimia nervosa. Surgical treatment for morbid obesity is covered as described in the Certificate.
Sterilization Reversal.
Infertility Treatment. Any services or supplies furnished in connection with the diagnosis and treatment of infertility, including, but not limited to diagnostic tests, medication, surgery, artificial insemination, in vitro fertilization, sterilization reversal and gamete intrafallopian transfer, except as specified as covered in the Certificate.
Surrogate Mother Services. For any services or supplies provided to a person not covered under the plan in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).
Orthopedic shoes and shoe inserts. This exclusion does not apply to orthopedic footwear used as an integral part of a brace, shoe inserts that are custom molded to the patient, or therapeutic shoes and inserts designed to treat foot complications due to diabetes, as specifically stated in the EOC/Certificate.
Air Conditioners. Air purifiers, air conditioners or humidifiers.
Custodial Care or Rest Cures. Inpatient room and board charges in connection with a hospital stay primarily for environmental change or physical therapy. Services provided by a rest home, a home for the aged, a nursing home or any similar facility. Services provided by a skilled nursing facility or custodial care or rest cures, except as specified as covered in the Certificate.
Clinical Trials - Services and supplies in connection with clinical trials, except as specified as covered in the Certificate or EOC.
Health Club Memberships. Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment or facilities used for developing or maintaining physical fitness, even if ordered by a physician. This exclusion also applies to health spas, except as specified as covered in the Certificate.
Personal Items. Any supplies for comfort, hygiene or beautification.
Education or Counseling. Educational services or nutritional counseling, except as specified as covered in the Certificate. This exclusion does not apply to counseling for the treatment of anorexia nervosa or bulimia nervosa.
Food or Dietary Supplements. Nutritional and/or dietary supplements, except as provided in this plan or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not requirement either a written prescription or dispensing by a licensed pharmacist.
Gene Therapy. Gene therapy as well as any drugs, procedures, health care services related to it that introduce or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material.
Telephone and Facsimile Machine Consultations. Consultations provided by telephone or facsimile machine.
Routine Exams or Tests. Routine physical exams or tests which do not directly treat an actual illness, injury or condition, including those required by employment or government authority, except as specified as covered in the Certificate.
Acupuncture. Acupuncture treatment, except as specified as covered in the Certificate. Acupressure or massage to control pain, treat illness or promote health by applying pressure to one or more specific areas of the body based on dermatomes or acupuncture points.
Eye Surgery for Refractive Defects. Any eye surgery solely or primarily for the purpose of correcting refractive defects of the eye such as nearsightedness (myopia) and/or astigmatism. Contact lenses and Eye glasses required as a result of this surgery.
Physical Therapy or Physical Medicine. Services of a physician for physical therapy or physical medicine, except when provided during a covered inpatient confinement or as specified as covered in the Certificate.
Outpatient Prescription Drugs and Medications. Outpatient prescription drugs or medications and insulin, except as specified as covered in the Certificate. Any non-prescription, over-the-counter patent or proprietary drug or medicine. Cosmetics, health or beauty aids.
Specialty Pharmacy Drugs. Specialty pharmacy drugs that must be obtained from the specialty pharmacy program, but, which are obtained from a retail pharmacy, are not covered by this plan. Member will have to pay the full cost of the specialty pharmacy drugs obtained from a retail pharmacy that should have been obtained from the specialty pharmacy program.
Contraceptive Devices. Contraceptive devices prescribed for birth control except as specified as covered in the Certificate.
Diabetic Supplies. Prescription and non-prescription diabetic supplies except as specified as covered in the Certificate.
Private Duty Nursing. Private duty nursing services.
Residential accommodations. Residential accommodations to treat medical or behavioral health conditions, except when provided in a hospital, hospice, skilled nursing facility or residential treatment center.
Lifestyle Programs. Programs to alter one's lifestyle which may include but are not limited to diet, exercise, imagery or nutrition. This exclusion will not apply to cardiac rehabilitation programs approved by us.
Medical Equipment, Devices and Supplies. This plan does not cover the following:
• Replacement or repair of purchased or rental equipment because of misuse, abuse, or loss/theft.
• Surgical supports, corsets, or articles of clothing unless needed to recover from surgery or injury.
• Enhancements to standard equipment and devices that is not medically necessary.
• Supplies, equipment and appliances that include comfort, luxury, or convenience items or features that exceed what is medically necessary in your situation.
This exclusion does not apply to the medically necessary treatment as specifically stated as covered in the EOC/Certificate.
Varicose Vein Treatment. Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) when services are rendered for cosmetic purposes.
Wigs.
Third Party Liability: Anthem Blue Cross Life and Health Insurance Company is entitled to reimbursement of benefits paid if the member recovers damages from a legally liable third party.
Coordination of Benefits. The benefits of this plan may be reduced if the member has any other group health or dental coverage so that the services received from all group coverages do not exceed 100% of the covered expense.
Medicare. For which benefits are payable under Medicare Parts A and/or B, or would have been payable if you had applied for Parts A and/or B, except as listed or as required by federal law, as described in the EOC. If you do not enroll in Medicare Part B, we will calculate benefits as if you had enrolled. You should sign up for Medicare Part B as soon as possible to avoid large out of pocket costs.
Residential accommodations. Residential accommodations to treat medical or behavioral health conditions, except when provided in a hospital, hospice, skilled nursing facility or residential treatment center. This exclusion includes procedures, equipment, services, supplies or charges for the following:

• Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
• Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
• Services or care provided or billed by a school, custodial care center for the developmentally disabled, or outward bound programs, even if psychotherapy is included.
• Wilderness camps.

Services Received from Providers on a Federal or State Exclusion List. Any service, drug, drug regimen, treatment, or supply furnished, ordered or prescribed by a provider identified as an excluded individual or entity on the U.S. Department of Health and Human Services Office of Inspector General List of Excluded Individuals/Entities (OIG List), the General Services Administration System for Award Management (GSA List), State Medicaid exclusion lists or other exclusion/sanctioned lists as published by Federal or State regulatory agencies. This exclusion does not apply to an emergency medical condition.

Drugs Given to you by a Doctor. The following exclusions apply to drugs you receive from a doctor:
• Delivery Charges. Charges for the delivery of prescription drugs.
• Clinically-Equivalent Alternatives. Certain prescription drugs may not be covered if you could use a clinically equivalent drug, unless required by law. "Clinically equivalent" means drugs that for most members, will give you similar results for a disease or condition. If you have questions about whether a certain drug is covered and which drugs fall into this group, please call the number on the back of your Identification Card, or visit our website at www.anthem.com.

If you or your doctor believes you need to use a different prescription drug, please have your doctor or pharmacist get in touch with us. We will cover the other prescription drug only if we agree that it is medically necessary and appropriate over the clinically equivalent drug. We will review benefits for the prescription drug from time to time to make sure the drug is still medically necessary.
• Compound Drugs. Compound drugs unless all of the ingredients are FDA-approved in the form in which they are used in the compound drug and as designated in the FDA's Orange Book: Approved Drug Products with Therapeutic Equivalence Evaluations, require a prescription to dispense, and the compound drug is not essentially the same as an FDA-approved product from a drug manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants.
• Drugs Contrary to Approved Medical and Professional Standards. Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.
• Drugs Over Quantity or Age Limits. Drugs which are over any quantity or age limits set by the plan or us.
• Drugs Over the Quantity Prescribed or Refills After One Year. Drugs in amounts over the quantity prescribed or for any refill given more than one year after the date of the original prescription.
• Drugs Prescribed by Providers Lacking Qualifications, Registrations and/or Certifications. Prescription drugs prescribed by a provider that does not have the necessary qualifications, registrations and/or certifications as determined by us.
• Drugs That Do Not Need a Prescription. Drugs that do not need a prescription by federal law (including drugs that need a prescription by state law, but not by federal law), except for injectable insulin. This exclusion does not apply to over-the-counter drugs that we must cover under state law, or federal law when recommended by the U.S. Preventive Services Task Force, and prescribed by a doctor.
• Lost or Stolen Drugs. Refills of lost or stolen drugs.
• Non-Approved Drugs. Drugs not approved by the FDA.

This plan includes custom benefits that may supersede some of the information included in this list of Exclusions and Limitations. Please see your EOC for full details on your covered benefits.

anthem.com/ca Anthem Blue Cross; (NP) Effective 01-2020 Printed 10-2019 LE2001 2019-01 -C MGSIG (City of Livingston)

Your Summary of Benefits
Classic PPO

Anthem Blue Cross

Modified Classic PPO 250/20/10

This Summary of Benefits is a brief overview of your plan's benefits only. The benefits listed are for both in state and out of state members, there may be differences in benefits depending on where you reside. For more detailed information about the benefits in your plan, please refer to your Certificate of Insurance or Evidence of Coverage (EOC), which explains the full range of covered services, as well as any exclusions and limitations for your plan.

In addition to dollar and percentage copays, members are responsible for deductibles, as described below. Please review the deductible information to know if a deductible applies to a specific covered service. Certain Covered Services have maximum visit and/or day limits per year. The number of visits and/or days allowed for these services will begin accumulating on the first visit and/or day, regardless of whether your Deductible has been met. Members are also responsible for all costs over the plan maximums. Plan maximums and other important information appear in italics. Benefits are subject to all terms, conditions, limitations, and exclusions of the Policy.

Subject to Utilization Review
Certain services are subject to the utilization review program. Before scheduling services, the member must make sure utilization review is obtained. If utilization review is not obtained, benefits may be reduced or not paid, according to the plan.

Explanation of Maximum Allowed Amount
Maximum Allowed Amount is the total reimbursement payable under the plan for covered services received from Participating and Non-Participating Providers. It is the payment towards the services billed by a provider combined with any applicable deductible, copayment or coinsurance.

PPO Providers—The rate the provider has agreed to accept as reimbursement for covered services. Members are not responsible for the difference between the provider's usual charges & the maximum allowed amount.

Non-PPO Providers—For non-emergency care, reimbursement amount is based on: an Anthem Blue Cross rate or fee schedule, a rate negotiated with the provider, information from a third party vendor, or billed charges. Members are responsible for the difference between the provider's usual charges & the maximum allowed amount.

For Medical Emergency care rendered by a Non-Participating Provider or Non-Contracting Hospital, reimbursement is based on the reasonable and customary value. Members may be responsible for any amount in excess of the reasonable and customary value.

When using Non-PPO and Other Health Care Providers, members are responsible for any difference between the covered expense & actual charges, as well as any deductible & percentage copay.	
Calendar year deductible for all providers	$250/member; $750/family
Additional deductible for non-Anthem Blue Cross PPO hospital or residential treatment center if utilization review not obtained	$500/admission *(waived for emergency admission)*
Deductible for emergency room services	$150/visit *(waived if admitted directly from ER)*
Annual Out-of-Pocket Maximums *(no cross application)*	
∘ PPO Providers & Other Health Care Providers	$2,500/member; $5,000/family
∘ Non-PPO Providers	$6,500/member; $13,000/family

The following do not apply to out-of-pocket maximums: non-covered expenses. After an annual out-of-pocket maximum is met for medical and prescription drugs during a calendar year, the individual member or family will no longer be required to pay a copay or coinsurance for medical and prescription drug covered expenses for the remainder of that year. The member remains responsible for non-covered expenses.

Lifetime Maximum	Unlimited

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay†
Preventive Care Services Preventive Care Services including*, physical exams, preventive screenings *(including screenings for cancer, HPV, diabetes, cholesterol, blood pressure, hearing and vision, immunizations, health education, intervention services, HIV testing),* and additional preventive care for women provided for in the guidelines supported by the Health Resources and Services Administration. *This list is not exhaustive. This benefit includes all Preventive Care Services required by federal and state law.	No copay *(deductible waived)*	30%
Physician Medical Services • Office & home visits *(includes retail health clinic)* • Preferred Online Visit *(includes Mental/Behavioral Health and Substance Abuse)* • Hospital & skilled nursing facility visits • Surgeon & surgical assistant; anesthesiologist or anesthetist • Drugs administered by a medical provider *(certain drugs are subject to utilization review)*	 $20/visit *(deductible waived)* ‡ $20/visit *(deductible waived)* 10% 10% 10%	 30% 30% 30% 30% 30%
Diabetes Education Programs *(requires physician supervision)* ‡ • Teach members & their families about the disease process, the daily management of diabetic therapy & self-management training	$20/visit *(deductible waived)*	30%
Physical Therapy, Physical Medicine & Occupational Therapy	10%	30%
Chiropractic Services *(limited to 30 visits /calendar year)* ††	$20/visit *(deductible waived)*	30%
Speech Therapy	10%	30%
Acupuncture • Services for the treatment of disease, illness or injury *(limited 20 visits/calendar year)*	$20/visit *(deductible waived)*	30%
Diagnostic X-ray & Lab • Other diagnostic x-ray & lab	 10%	 30%
Advanced Imaging *(subject to utilization review)*	10%	30% *(benefit limited to $800/procedure)*
Urgent Care *(physician services)* ‡	$20/visit (*deductible waived*)	30%
Emergency Care • Emergency room services & supplies *($150 deductible waived if admitted)* • Physician services	 10% 10%	 10% 10%
Hospital Medical Services *(subject to utilization review for inpatient and certain outpatient services; waived for emergency admissions)* • Semi-private or private room, medically necessary services & supplies • Outpatient medical care, surgical services & supplies *(hospital care other than emergency room care)*	 10% 10%	 30% *(benefit limited to $1,000/day for non-emergency admission)* 30% *(benefit limited to $350/admit)*
Skilled Nursing Facility *(subject to utilization review)* • Semi-private room, services & supplies *(limited to 100 days/calendar year; limit does not apply to mental health and substance abuse)*	10%	30%

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay[†]
Related Outpatient Medical Services & Supplies		
• Ground or air ambulance transportation, services & disposable supplies *(air ambulance in a non-medical emergency is subject to pre-service review and benefit limited to $50,000 for non-PPO)*	10%	In an emergency or with an authorized referral: 10%; Non-emergency: 30%
• Blood transfusions, blood processing & the cost of unreplaced blood & blood products [§]	20%	20%
• Autologous blood *(self-donated blood collection, testing, processing & storage for planned surgery)* [§]	20%	20%
Ambulatory Surgical Centers *(certain surgeries are subject to utilization review)*		
• Outpatient surgery, services & supplies	10%	30% *(benefit limited to $350/admit)*
Pregnancy & Maternity Care		
• Physician office visits	$20/visit[‡] (*deductible waived*)	30%
• Prescription drug for abortion (*mifepristone*)	10%	30%
Normal delivery, cesarean section, complications of pregnancy & abortion. Refer to the Physician & Hospital Medical Services benefits for both inpatient and outpatient hospital coverage.		
Mental or Nervous Disorders and Substance Abuse		
• Inpatient facility care (*subject to utilization review; waived for emergency admissions*)	10%	30% *(benefit limited to $1,000/day for non-emergency admission)*
• Inpatient physician visits	10%	30%
• Outpatient facility care	10%	30%
• Physician office visits *(Behavioral Health treatment for Autism or Pervasive Development disorders require pre-service review)*	$20/visit (*deductible waived*)[‡]	30%
Durable Medical Equipment *(may be subject to utilization review)*		
• Rental or purchase of DME *(breast pump and supplies are covered under preventive care at no charge for in-network)*	10%	30%
Home Health Care *(subject to utilization review)*		
• Services & supplies from a home health agency *(limited to 100 visits/calendar year, one visit by a home health aide equals four hours or less)*	10%	30%
Home Infusion Therapy *(subject to utilization review)*		
• Includes medication, ancillary services & supplies; caregiver training & visits by provider to monitor therapy; durable medical equipment; lab services	10%	30% (*benefit limited to $600/day*)
Hemodialysis		
• Outpatient hemodialysis services & supplies	10%	30% *(benefit limited to $350/visit for free standing hemodialysis center)*
Hospice Care		
• Inpatient or outpatient services; family bereavement services	No copay *(deductible waived)*	30%
Bariatric Surgery *(subject to utilization review; covered only when performed at a Centers of Medical Excellence [CME] for California; Blue Distinction Centers for Specialty Care [BDCSC] for out of California)*		
• Inpatient services provided in connection with medically necessary surgery for weight loss, only for morbid obesity	10%	Not covered[f]
• Travel expenses for an authorized, specified surgery *(recipient & companion transportation limited to $3,000 per surgery)*	No copay (*deductible waived*)	Not covered[f]

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay†
Organ & Tissue Transplants *(subject to utilization review; specified transplants covered only when performed at Centers of Medical Excellence [CME] for California; Blue Distinction Centers for Specialty Care [BDCSC] for out of California)*		
• Inpatient services provided in connection with non-investigative organ or tissue transplants	10%	Not covered*f*
• Transplant travel expense for an authorized, specified transplant *(recipient & companion transportation limited to $10,000 per transplant)*	No copay (*deductible waived*)	Not covered*f*
• Unrelated donor search, limited to $30,000 per transplant		
Prosthetic Devices • Coverage for breast prostheses; prosthetic devices to restore a method of speaking; surgical implants; artificial limbs or eyes; the first pair of contact lenses or eyeglasses when required as a result of eye surgery; & therapeutic shoes & inserts for members with diabetes	10%	30%

Certain types of physicians may not be represented in the PPO network in the state where the member receives services. If such physician is not available in the service area, the member's copay is the same as for PPO (with and without pre-notification, if applicable). Member is responsible for applicable copays, deductibles and charges which exceed covered expense.
In addition to the benefits described above, coverage may include additional benefits, depending upon the member's home state. The benefits provided in this summary are subject to federal and California laws. There are some states that require more generous benefits be provided to their residents, even if the master policy was not issued in their state. If the member's state has such requirements, we will adjust the benefits to meet the requirements.

This Summary of Benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits. This proposed benefit summary is subject to the approval of the California Department of Insurance and the California Department of Managed Health Care.

† The percentage copay for non-emergency services from Non-Anthem Blue Cross PPO providers is based on the scheduled amount.

‡ The dollar copay applies only to the visit itself. An additional copay applies for any services performed in office (i.e., X-ray, lab, surgery), after any applicable deductible.

§ These providers may not be represented in the PPO network in the state where the member receives services.

f Exception: If service is performed at a Centers of Medical Excellence [CME] for California or Blue Distinction Centers for Speciality Care [BDCSC] for out of California, the services will be covered same as the PPO (in-network) benefit.

†† Additional visits as authorized if medically necessary; pre-service review must be obtained prior to receiving the services.

Exclusions and Limitations

Not Medically Necessary. Services or supplies that are not medically necessary, as defined.
Experimental or Investigative. Any experimental or investigative procedure or medication. But, if member is denied benefits because it is determined that the requested treatment is experimental or investigative, the member may request an independent medical review, as described in the Certificate.
Services Received Outside of the United States. Services rendered by providers located outside the United States, unless the services are for an emergency, emergency ambulance or urgent care.
Crime or Nuclear Energy. Conditions that result from (1) the member's commission of or attempt to commit a felony, as long as any injuries are not a result of a medical condition or an act of domestic violence; or (2) any release of nuclear energy, whether or not the result of war, when government funds are available for the treatment of illness or injury arising from the release of nuclear energy.
Not Covered. Services received before the member's effective date. Services received after the member's coverage ends, except as specified as covered in the Certificate.
Excess Amounts. Any amounts in excess of covered expense or any medical benefit maximum.
Work-Related. Any injury, condition or disease arising out of employment for which benefits or payments are covered by any worker's compensation law or similar law. If we provide benefits for such injuries, conditions or diseases we shall be entitled to establish a lien or other recovery under section 4903 of the California Labor Code or any other applicable law, as specified in the EOC/Certificate.
Government Treatment. Any services the member actually received that were provided by a local, state or federal government agency, except when payment under this plan is expressly required by federal or state law. We 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.
Services of Relatives. Professional services received from a person living in the member's home or who is related to the member by blood or marriage, except as specified as covered in the Certificate.
Voluntary Payment. Services for which the member has no legal obligation to pay, or for which no charge would be made in the absence of insurance coverage or other health plan coverage, except services received at a non-governmental charitable research hospital. Such a hospital must meet the following guidelines:1. it must be internationally known as being devoted mainly to medical research;2. at least 10% of its yearly budget must be spent on research not directly related to patient care;3. at least one-third of its gross income must come from donations or grants other than gifts or payments for patient care;4. it must accept patients who are unable to pay; and5. Two-thirds of its patients must have conditions directly related to the hospital's research.
Private Contracts. Services or supplies provided pursuant to a private contract between the member and a provider, for which reimbursement under Medicare program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act.
Inpatient Diagnostic Tests. Inpatient room and board charges in connection with a hospital stay primarily for diagnostic tests which could have been performed safely on an outpatient basis.
Mental or Nervous Disorders. Academic or educational testing, counseling, and remediation. Mental or nervous disorders or substance abuse, including rehabilitative care in relation to these conditions, except as specified as covered in the Certificate.
Orthodontia. Braces, other orthodontic appliances or orthodontic services.
Dental Services or Supplies. For dental treatment, regardless of origin or cause, except as specified below. "Dental treatment" includes but is not limited to preventative care and fluoride treatments; dental x rays, supplies, appliances, dental implants and all associated expenses; diagnosis and treatment related to the teeth, jawbones or gums, including but not limited to:
1. Extraction, restoration, and replacement of teeth; 2. Services to improve dental clinical outcomes.
This exclusion does not apply to the following:
1. Services which we are required by law to cover; 2. Services specified as covered in this booklet;
3. Dental services to prepare the mouth for radiation therapy to treat head and/or neck cancer.
Hearing Aids or Tests. Hearing aids and routine hearing tests, except as specified as covered in the Certificate.
Optometric Services or Supplies. Optometric services, eye exercises including orthoptics. Routine eye exams and routine eye refractions, as specified as covered in the Certificate. Eyeglasses or contact
lenses, except as specified as covered in the Certificate.
Outpatient Occupational Therapy. Outpatient occupational therapy, except by a home health agency, hospice, or home infusion therapy provider, as specified as covered in the Certificate.
Outpatient Speech Therapy. Outpatient speech therapy, except as specified as covered in the Certificate.
Cosmetic Surgery. Cosmetic surgery or other services performed to alter or reshape normal (including aged) structures or tissues of the body to improve appearance
Commercial Weight Loss Programs. Weight loss programs, whether or not they are pursued under medical or physician supervision, unless specifically listed as covered in this plan. This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs. This exclusion does not apply to medically necessary treatments for morbid obesity or dietary evaluations and counseling, and behavioral modification programs for the treatment of anorexia nervosa or bulimia nervosa. Surgical treatment for morbid obesity is covered as described in the Certificate.
Sterilization Reversal.
Infertility Treatment. Any services or supplies furnished in connection with the diagnosis and treatment of infertility, including, but not limited to diagnostic tests, medication, surgery, artificial insemination, in vitro fertilization, sterilization reversal and gamete intrafallopian transfer, except as specified as covered in the Certificate.
Surrogate Mother Services. For any services or supplies provided to a person not covered under the plan in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).
Orthopedic shoes and shoe inserts. This exclusion does not apply to orthopedic footwear used as an integral part of a brace, shoe inserts that are custom molded to the patient, or therapeutic shoes and inserts designed to treat foot complications due to diabetes, as specifically stated in the EOC/Certificate.
Air Conditioners. Air purifiers, air conditioners or humidifiers.
Custodial Care or Rest Cures. Inpatient room and board charges in connection with a hospital stay primarily for environmental change or physical therapy. Services provided by a rest home, a home for the aged, a nursing home or any similar facility. Services provided by a skilled nursing facility or custodial care or rest cures, except as specified as covered in the Certificate.
Clinical Trials - Services and supplies in connection with clinical trials, except as specified as covered in the Certificate or EOC.
Health Club Memberships. Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment or facilities used for developing or maintaining physical fitness, even if ordered by a physician. This exclusion also applies to health spas, except as specified as covered in the Certificate.
Personal Items. Any supplies for comfort, hygiene or beautification.
Education or Counseling. Educational services or nutritional counseling, except as specified as covered in the Certificate. This exclusion does not apply to counseling for the treatment of anorexia nervosa or bulimia nervosa.
Food or Dietary Supplements. Nutritional and/or dietary supplements, except as provided in this plan or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not requirement either a written prescription or dispensing by a licensed pharmacist.
Gene Therapy. Gene therapy as well as any drugs, procedures, health care services related to it that introduce or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material.
Telephone and Facsimile Machine Consultations. Consultations provided by telephone or facsimile machine.
Routine Exams or Tests. Routine physical exams or tests which do not directly treat an actual illness, injury or condition, including those required by employment or government authority, except as specified as covered in the Certificate.
Acupuncture. Acupuncture treatment, except as specified as covered in the Certificate. Acupressure or massage to control pain, treat illness or promote health by applying pressure to one or more specific areas of the body based on dermatomes or acupuncture points.
Eye Surgery for Refractive Defects. Any eye surgery solely or primarily for the purpose of correcting refractive defects of the eye such as nearsightedness (myopia) and/or astigmatism. Contact lenses and Eye glasses required as a result of this surgery.
Physical Therapy or Physical Medicine. Services of a physician for physical therapy or physical medicine, except when provided during a covered inpatient confinement or as specified as covered in the Certificate.
Outpatient Prescription Drugs and Medications. Outpatient prescription drugs or medications and insulin, except as specified as covered in the Certificate. Any non-prescription, over-the-counter patent or proprietary drug or medicine. Cosmetics, health or beauty aids.
Specialty Pharmacy Drugs. Specialty pharmacy drugs that must be obtained from the specialty pharmacy program, but, which are obtained from a retail pharmacy, are not covered by this plan. Member will have to pay the full cost of the specialty pharmacy drugs obtained from a retail pharmacy that should have been obtained from the specialty pharmacy program.
Contraceptive Devices. Contraceptive devices prescribed for birth control except as specified as covered in the Certificate.
Diabetic Supplies. Prescription and non-prescription diabetic supplies except as specified as covered in the Certificate.
Private Duty Nursing. Private duty nursing services.
Lifestyle Programs. Programs to alter one's lifestyle which may include but are not limited to diet, exercise, imagery or nutrition. This exclusion will not apply to cardiac rehabilitation programs approved by us.
Medical Equipment, Devices and Supplies. This plan does not cover the following:
• Replacement or repair of purchased or rental equipment because of misuse, abuse, or loss/theft.
• Surgical supports, corsets, or articles of clothing unless needed to recover from surgery or injury.
• Enhancements to standard equipment and devices that is not medically necessary.
• Supplies, equipment and appliances that include comfort, luxury, or convenience items or features that exceed what is medically necessary in your situation.
This exclusion does not apply to the medically necessary treatment as specifically stated as covered in the EOC/Certificate.
Varicose Vein Treatment. Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) when services are rendered for cosmetic purposes.
Wigs.
Third Party Liability: Anthem Blue Cross Life and Health Insurance Company is entitled to reimbursement of benefits paid if the member recovers damages from a legally liable third party.
Coordination of Benefits. The benefits of this plan may be reduced if the member has any other group health or dental coverage so that the services received from all group coverages do not exceed 100% of the covered expense.
Medicare. For which benefits are payable under Medicare Parts A and/or B, or would have been payable if you had applied for Parts A and/or B, except as listed or as required by federal law, as described in the EOC. If you do not enroll in Medicare Part B, we will calculate benefits as if you had enrolled. You should sign up for Medicare Part B as soon as possible to avoid large out of pocket costs.
Residential accommodations. Residential accommodations to treat medical or behavioral health conditions, except when provided in a hospital, hospice, skilled nursing facility or residential treatment center. This exclusion includes procedures, equipment, services, supplies or charges for the following:
• Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.

• Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
• Services or care provided or billed by a school, custodial care center for the developmentally disabled, or outward bound programs, even if psychotherapy is included.
• Wilderness camps.

Services Received from Providers on a Federal or State Exclusion List. Any service, drug, drug regimen, treatment, or supply furnished, ordered or prescribed by a provider identified as an excluded individual or entity on the U.S. Department of Health and Human Services Office of Inspector General List of Excluded Individuals/Entities (OIG List), the General Services Administration System for Award Management (GSA List), State Medicaid exclusion lists or other exclusion/sanctioned lists as published by Federal or State regulatory agencies. This exclusion does not apply to an emergency medical condition.

Drugs Given to you by a Doctor. The following exclusions apply to drugs you receive from a doctor:
• Delivery Charges. Charges for the delivery of prescription drugs.
• Clinically-Equivalent Alternatives. Certain prescription drugs may not be covered if you could use a clinically equivalent drug, unless required by law. "Clinically equivalent" means drugs that for most members, will give you similar results for a disease or condition. If you have questions about whether a certain drug is covered and which drugs fall into this group, please call the number on the back of your Identification Card, or visit our website at www.anthem.com.

If you or your doctor believes you need to use a different prescription drug, please have your doctor or pharmacist get in touch with us. We will cover the other prescription drug only if we agree that it is medically necessary and appropriate over the clinically equivalent drug. We will review benefits for the prescription drug from time to time to make sure the drug is still medically necessary.
• Compound Drugs. Compound drugs unless all of the ingredients are FDA-approved in the form in which they are used in the compound drug and as designated in the FDA's Orange Book: Approved Drug Products with Therapeutic Equivalence Evaluations, require a prescription to dispense, and the compound drug is not essentially the same as an FDA-approved product from a drug manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants.
• Drugs Contrary to Approved Medical and Professional Standards. Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.
• Drugs Over Quantity or Age Limits. Drugs which are over any quantity or age limits set by the plan or us.
• Drugs Over the Quantity Prescribed or Refills After One Year. Drugs in amounts over the quantity prescribed or for any refill given more than one year after the date of the original prescription.
• Drugs Prescribed by Providers Lacking Qualifications, Registrations and/or Certifications. Prescription drugs prescribed by a provider that does not have the necessary qualifications, registrations and/or certifications as determined by us.
• Drugs That Do Not Need a Prescription. Drugs that do not need a prescription by federal law (including drugs that need a prescription by state law, but not by federal law), except for injectable insulin. This exclusion does not apply to over-the-counter drugs that we must cover under state law, or federal law when recommended by the U.S. Preventive Services Task Force, and prescribed by a doctor.
• Lost or Stolen Drugs. Refills of lost or stolen drugs.
• Non-Approved Drugs. Drugs not approved by the FDA.

This plan includes custom benefits that may supersede some of the information included in this list of Exclusions and Limitations. Please see your EOC for full details on your covered benefits.

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Effective 01-2020 Printed 10-2019 LP2009 -D

Your Summary of Benefits
Classic PPO

Anthem Blue Cross

Modified Classic PPO 750/30/20

This Summary of Benefits is a brief overview of your plan's benefits only. The benefits listed are for both in state and out of state members, there may be differences in benefits depending on where you reside. For more detailed information about the benefits in your plan, please refer to your Certificate of Insurance or Evidence of Coverage (EOC), which explains the full range of covered services, as well as any exclusions and limitations for your plan.

In addition to dollar and percentage copays, members are responsible for deductibles, as described below. Please review the deductible information to know if a deductible applies to a specific covered service. Certain Covered Services have maximum visit and/or day limits per year. The number of visits and/or days allowed for these services will begin accumulating on the first visit and/or day, regardless of whether your Deductible has been met. Members are also responsible for all costs over the plan maximums. Plan maximums and other important information appear in italics. Benefits are subject to all terms, conditions, limitations, and exclusions of the Policy.

Subject to Utilization Review
Certain services are subject to the utilization review program. Before scheduling services, the member must make sure utilization review is obtained. If utilization review is not obtained, benefits may be reduced or not paid, according to the plan.

Explanation of Maximum Allowed Amount
Maximum Allowed Amount is the total reimbursement payable under the plan for covered services received from Participating and Non-Participating Providers. It is the payment towards the services billed by a provider combined with any applicable deductible, copayment or coinsurance.

PPO Providers—The rate the provider has agreed to accept as reimbursement for covered services. Members are not responsible for the difference between the provider's usual charges & the maximum allowed amount.

Non-PPO Providers—For non-emergency care, reimbursement amount is based on: an Anthem Blue Cross rate or fee schedule, a rate negotiated with the provider, information from a third party vendor, or billed charges. Members are responsible for the difference between the provider's usual charges & the maximum allowed amount.

For Medical Emergency care rendered by a Non-Participating Provider or Non-Contracting Hospital, reimbursement is based on the reasonable and customary value. Members may be responsible for any amount in excess of the reasonable and customary value.

When using Non-PPO and Other Health Care Providers, members are responsible for any difference between the covered expense & actual charges, as well as any deductible & percentage copay.	
Calendar year deductible *(no cross application)*	
∘ PPO Providers & Other Health Care Providers	$750/member; $2,250/family
∘ Non-PPO providers	$1,500/member; $4,500/family
Additional deductible for non-Anthem Blue Cross PPO hospital or residential treatment center if utilization review not obtained	$500/admission *(waived for emergency admission)*
Deductible for emergency room services	$150/visit *(waived if admitted directly from ER)*
Annual Out-of-Pocket Maximums *(no cross application)*	
∘ PPO Providers & Other Health Care Providers	$5,000/member; $10,000/family
∘ Non-PPO Providers	$10,000/member; $20,000/family

The following do not apply to out-of-pocket maximums: non-covered expenses. After an annual out-of-pocket maximum is met for medical and prescription drugs during a calendar year, the individual member or family will no longer be required to pay a copay or coinsurance for medical and prescription drug covered expenses for the remainder of that year. The member remains responsible for non-covered expenses.

Lifetime Maximum	Unlimited

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay†
Preventive Care Services Preventive Care Services including*, physical exams, preventive screenings *(including screenings for cancer, HPV, diabetes, cholesterol, blood pressure, hearing and vision, immunizations, health education, intervention services, HIV testing),* and additional preventive care for women provided for in the guidelines supported by the Health Resources and Services Administration. *This list is not exhaustive. This benefit includes all Preventive Care Services required by federal and state law.	No copay *(deductible waived)*	40%
Physician Medical Services • Office & home visits *(includes retail health clinic)* • Preferred Online Visit (*includes Mental/Behavioral Health and Substance Abuse)* • Hospital & skilled nursing facility visits • Surgeon & surgical assistant; anesthesiologist or anesthetist • Drugs administered by a medical provider *(certain drugs are subject to utilization review)*	 $30/visit ‡ (*deductible waived*) $30/visit (*deductible waived*) 20% 20% 20%	 40% 40% 40% 40% 40%
Diabetes Education Programs *(requires physician supervision)* ‡ • Teach members & their families about the disease process, the daily management of diabetic therapy & self-management training	$30/visit *(deductible waived)*	40%
Physical Therapy, Physical Medicine & Occupational Therapy	20%	40%
Chiropractic Services *(limited to 30 visits /calendar year)* ††	$30/visit *(deductible waived)*	40%
Speech Therapy	20%	40%
Acupuncture • Services for the treatment of disease, illness or injury *(limited 20 visits/calendar year)*	$30/visit *(deductible waived)*	40%
Diagnostic X-ray & Lab • Other diagnostic x-ray & lab	 20%	 40%
Advanced Imaging *(subject to utilization review)*	20%	40% (*benefit limited to $800/procedure)*
Urgent Care *(physician services)* ‡	$30/visit (*deductible waived*)	40%
Emergency Care • Emergency room services & supplies *($150 deductible waived if admitted inpatient)* • Physician services	 20% 20%	 20% 20%
Hospital Medical Services *(subject to utilization review for inpatient and certain outpatient services; waived for emergency admissions)* • Semi-private or private room, medically necessary services & supplies • Outpatient medical care, surgical services & supplies *(hospital care other than emergency room care)*	 20% 20%	 40% *(benefit limited to $1,000/day for non-emergency admission)* 40% *(benefit limited to $350/admit)*
Skilled Nursing Facility *(subject to utilization review)* • Semi-private room, services & supplies *(limited to 100 days/calendar year; limit does not apply to mental health and substance abuse)*	 20%	 40%

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay†
Related Outpatient Medical Services & Supplies		
∘ Ground or air ambulance transportation, services & disposable supplies *(air ambulance in a non-medical emergency is subject to pre-service review and benefit limited to $50,000 for non-PPO)*	20%	*In an emergency or with an authorized referral: 20%; Non-emergency: 40%*
∘ Blood transfusions, blood processing & the cost of unreplaced blood & blood products §	20%	20%
∘ Autologous blood *(self-donated blood collection, testing, processing & storage for planned surgery)* §	20%	20%
Ambulatory Surgical Centers *(certain surgeries are subject to utilization review)*		
∘ Outpatient surgery, services & supplies	20%	40% *(benefit limited to $350/admit)*
Pregnancy & Maternity Care		
∘ Physician office visits	$30/visit (*deductible waived*) ‡	40%
∘ Prescription drug for abortion (*mifepristone*)	20%	40%
Normal delivery, cesarean section, complications of pregnancy & abortion. Refer to the Physician & Hospital Medical Services benefits for both inpatient and outpatient hospital coverage.		
Mental or Nervous Disorders and Substance Abuse		
∘ Inpatient facility care (*subject to utilization review; waived for emergency admissions*)	20%	40% *(benefit limited to $1,000/day for non-emergency admission)*
∘ Inpatient physician visits	20%	40%
∘ Outpatient facility care	20%	40%
∘ Physician office visits *(Behavioral Health treatment for Autism or Pervasive Development disorders require pre-service review)*	$30/visit (*deductible waived*) ‡	40%
Durable Medical Equipment *(may be subject to utilization review)*		
∘ Rental or purchase of DME *(breast pump and supplies are covered under preventive care at no charge for in-network)*	20%	40%
Home Health Care *(subject to utilization review)*		
∘ Services & supplies from a home health agency *(limited to 100 visits/calendar year, one visit by a home health aide equals four hours or less)*	20%	40%
Home Infusion Therapy *(subject to utilization review)*		
∘ Includes medication, ancillary services & supplies; caregiver training & visits by provider to monitor therapy; durable medical equipment; lab services	20%	40% (*benefit limited to $600/day*)
Hemodialysis		
∘ Outpatient hemodialysis services & supplies	20%	40% *(benefit limited to $350/visit for free standing hemodialysis center)*
Hospice Care		
∘ Inpatient or outpatient services; family bereavement services	No copay *(deductible waived)*	40%

Covered Services	PPO: Per Member Copay	Non-PPO: Per Member Copay[†]
Bariatric Surgery *(subject to utilization review; covered only when performed at a Centers of Medical Excellence [CME] for California; Blue Distinction Centers for Specialty Care [BDCSC] for out of California)*		
∘ Inpatient services provided in connection with medically necessary surgery for weight loss, only for morbid obesity	20%	Not covered[*f*]
∘ Travel expenses for an authorized, specified surgery *(recipient & companion transportation limited to $3,000 per surgery)*	No copay (*deductible waived*)	Not covered[*f*]
Organ & Tissue Transplants *(subject to utilization review; specified transplants covered only when performed at Centers of Medical Excellence [CME] for California; Blue Distinction Centers for Specialty Care [BDCSC] for out of California)*		
∘ Inpatient services provided in connection with non-investigative organ or tissue transplants	20%	Not covered[*f*]
∘ Transplant travel expense for an authorized, specified transplant *(recipient & companion transportation limited to $10,000 per transplant)*	No copay (*deductible waived*)	Not covered[*f*]
∘ Unrelated donor search, limited to $30,000 per transplant		
Prosthetic Devices		
∘ Coverage for breast prostheses; prosthetic devices to restore a method of speaking; surgical implants; artificial limbs or eyes; the first pair of contact lenses or eyeglasses when required as a result of eye surgery; & therapeutic shoes & inserts for members with diabetes	20%	40%

Certain types of physicians may not be represented in the PPO network in the state where the member receives services. If such physician is not available in the service area, the member's copay is the same as for PPO (with and without pre-notification, if applicable). Member is responsible for applicable copays, deductibles and charges which exceed covered expense.

In addition to the benefits described above, coverage may include additional benefits, depending upon the member's home state. The benefits provided in this summary are subject to federal and California laws. There are some states that require more generous benefits be provided to their residents, even if the master policy was not issued in their state. If the member's state has such requirements, we will adjust the benefits to meet the requirements.

This Summary of Benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this Summary of Benefits. This Summary of Benefits, as updated, is subject to the approval of the California Department of Insurance and the California Department of Managed Health Care (as applicable).

† The percentage copay for non-emergency services from Non-Anthem Blue Cross PPO providers is based on the scheduled amount.

‡ The dollar copay applies only to the visit itself. An additional copay applies for any services performed in office (i.e., X-ray, lab, surgery), after any applicable deductible.

§ These providers may not be represented in the PPO network in the state where the member receives services.

f Exception: If service is performed at a Centers of Medical Excellence [CME] for California or Blue Distinction Centers for Speciality Care [BDCSC] for out of California, the services will be covered same as the PPO (in-network) benefit.

†† Additional visits as authorized if medically necessary; pre-service review must be obtained prior to receiving the services.

Exclusions and Limitations

Not Medically Necessary. Services or supplies that are not medically necessary, as defined**.**

Experimental or Investigative. Any experimental or investigative procedure or medication. But, if member is denied benefits because it is determined that the requested treatment is experimental or investigative, the member may request an independent medical review, as described in the Certificate.

Services Received Outside of the United States. Services rendered by providers located outside the United States, unless the services are for an emergency, emergency ambulance or urgent care.

Crime or Nuclear Energy. Conditions that result from (1) the member's commission of or attempt to commit a felony, as long as any injuries are not a result of a medical condition or an act of domestic violence; or (2) any release of nuclear energy, whether or not the result of war, when government funds are available for the treatment of illness or injury arising from the release of nuclear energy.

Not Covered. Services received before the member's effective date. Services received after the member's coverage ends, except as specified as covered in the Certificate.

Excess Amounts. Any amounts in excess of covered expense or any medical benefit maximum.

Work-Related. Any injury, condition or disease arising out of employment for which benefits or payments are covered by any worker's compensation law or similar law. If we provide benefits for such injuries, conditions or diseases we shall be entitled to establish a lien or other recovery under section 4903 of the California Labor Code or any other applicable law, as specified in the EOC/Certificate.

Government Treatment. Any services the member actually received that were provided by a local, state or federal government agency, except when payment under this plan is expressly required by federal or state law. We 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.

Services of Relatives. Professional services received from a person living in the member's home or who is related to the member by blood or marriage, except as specified as covered in the Certificate.

Voluntary Payment. Services for which the member has no legal obligation to pay, or for which no charge would be made in the absence of insurance coverage or other health plan coverage, except services received at a non-governmental charitable research hospital. Such a hospital must meet the following guidelines:1. it must be internationally known as being devoted mainly to medical research;2. at least 10% of its yearly budget must be spent on research not directly related to patient care;3. at least one-third of its gross income must come from donations or grants other than gifts or payments for patient care;4. it must accept patients who are unable to pay; and5. Two-thirds of its patients must have conditions directly related to the hospital's research.

Private Contracts. Services or supplies provided pursuant to a private contract between the member and a provider, for which reimbursement under Medicare program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act.

Inpatient Diagnostic Tests. Inpatient room and board charges in connection with a hospital stay primarily for diagnostic tests which could have been performed safely on an outpatient basis.

Mental or Nervous Disorders. Academic or educational testing, counseling, and remediation. Mental or nervous disorders or substance abuse, including rehabilitative care in relation to these conditions, except as specified as covered in the Certificate.

Orthodontia. Braces, other orthodontic appliances or orthodontic services.

Dental Services or Supplies. For dental treatment, regardless of origin or cause, except as specified below. "Dental treatment" includes but is not limited to preventative care and fluoride treatments; dental x rays, supplies, appliances, dental implants and all associated expenses; diagnosis and treatment related to the teeth, jawbones or gums, including but not limited to:

1. Extraction, restoration, and replacement of teeth; 2. Services to improve dental clinical outcomes.

This exclusion does not apply to the following:

1. Services which we are required by law to cover; 2. Services specified as covered in this booklet;

3. Dental services to prepare the mouth for radiation therapy to treat head and/or neck cancer.

Hearing Aids or Tests. Hearing aids and routine hearing tests, except as specified as covered in the Certificate.

Optometric Services or Supplies. Optometric services, eye exercises including orthoptics. Routine eye exams and routine eye refractions, as specified as covered in the Certificate. Eyeglasses or contact
lenses, except as specified as covered in the Certificate.

Outpatient Occupational Therapy. Outpatient occupational therapy, except by a home health agency, hospice, or home infusion therapy provider, as specified as covered in the Certificate.

Outpatient Speech Therapy. Outpatient speech therapy, except as specified as covered in the Certificate.

Cosmetic Surgery. Cosmetic surgery or other services performed to alter or reshape normal (including aged) structures or tissues of the body to improve appearance

Commercial Weight Loss Programs. Weight loss programs, whether or not they are pursued under medical or physician supervision, unless specifically listed as covered in this plan. This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs. This exclusion does not apply to medically necessary treatments for morbid obesity or dietary evaluations and counseling, and behavioral modification programs for the treatment of anorexia nervosa or bulimia nervosa. Surgical treatment for morbid obesity is covered as described in the Certificate.

Sterilization Reversal.

Infertility Treatment. Any services or supplies furnished in connection with the diagnosis and treatment of infertility, including, but not limited to diagnostic tests, medication, surgery, artificial insemination, in vitro fertilization, sterilization reversal and gamete intrafallopian transfer, except as specified as covered in the Certificate.

Surrogate Mother Services. For any services or supplies provided to a person not covered under the plan in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

Orthopedic shoes and shoe inserts. This exclusion does not apply to orthopedic footwear used as an integral part of a brace, shoe inserts that are custom molded to the patient, or therapeutic shoes and inserts designed to treat foot complications due to diabetes, as specifically stated in the EOC/Certificate.

Air Conditioners. Air purifiers, air conditioners or humidifiers.

Custodial Care or Rest Cures. Inpatient room and board charges in connection with a hospital stay primarily for environmental change or physical therapy. Services provided by a rest home, a home for the aged, a nursing home or any similar facility. Services provided by a skilled nursing facility or custodial care or rest cures, except as specified as covered in the Certificate.

Clinical Trials - Services and supplies in connection with clinical trials, except as specified as covered in the Certificate or EOC.

Health Club Memberships. Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment or facilities used for developing or maintaining physical fitness, even if ordered by a physician. This exclusion also applies to health spas, except as specified as covered in the Certificate.

Personal Items. Any supplies for comfort, hygiene or beautification.

Education or Counseling. Educational services or nutritional counseling, except as specified as covered in the Certificate. This exclusion does not apply to counseling for the treatment of anorexia nervosa or bulimia nervosa.

Food or Dietary Supplements. Nutritional and/or dietary supplements, except as provided in this plan or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not requirement either a written prescription or dispensing by a licensed pharmacist.

Gene Therapy. Gene therapy as well as any drugs, procedures, health care services related to it that introduce or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material.

Telephone and Facsimile Machine Consultations. Consultations provided by telephone or facsimile machine.

Routine Exams or Tests. Routine physical exams or tests which do not directly treat an actual illness, injury or condition, including those required by employment or government authority, except as specified as covered in the Certificate.

Acupuncture. Acupuncture treatment, except as specified as covered in the Certificate. Acupressure or massage to control pain, treat illness or promote health by applying pressure to one or more specific areas of the body based on dermatomes or acupuncture points.

Eye Surgery for Refractive Defects. Any eye surgery solely or primarily for the purpose of correcting refractive defects of the eye such as nearsightedness (myopia) and/or astigmatism. Contact lenses and Eye glasses required as a result of this surgery.

Physical Therapy or Physical Medicine. Services of a physician for physical therapy or physical medicine, except when provided during a covered inpatient confinement or as specified as covered in the Certificate.

Outpatient Prescription Drugs and Medications. Outpatient prescription drugs or medications and insulin, except as specified as covered in the Certificate. Any non-prescription, over-the-counter patent or proprietary drug or medicine. Cosmetics, health or beauty aids.

Specialty Pharmacy Drugs. Specialty pharmacy drugs that must be obtained from the specialty pharmacy program, but, which are obtained from a retail pharmacy, are not covered by this plan. Member will have to pay the full cost of the specialty pharmacy drugs obtained from a retail pharmacy that should have been obtained from the specialty pharmacy program.

Contraceptive Devices. Contraceptive devices prescribed for birth control except as specified as covered in the Certificate.

Diabetic Supplies. Prescription and non-prescription diabetic supplies except as specified as covered in the Certificate.

Private Duty Nursing. Private duty nursing services.

Lifestyle Programs. Programs to alter one's lifestyle which may include but are not limited to diet, exercise, imagery or nutrition. This exclusion will not apply to cardiac rehabilitation programs approved by us.

Medical Equipment, Devices and Supplies. This plan does not cover the following:

• Replacement or repair of purchased or rental equipment because of misuse, abuse, or loss/theft.

• Surgical supports, corsets, or articles of clothing unless needed to recover from surgery or injury.

• Enhancements to standard equipment and devices that is not medically necessary.

• Supplies, equipment and appliances that include comfort, luxury, or convenience items or features that exceed what is medically necessary in your situation.

This exclusion does not apply to the medically necessary treatment as specifically stated as covered in the EOC/Certificate.

Varicose Vein Treatment. Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) when services are rendered for cosmetic purposes.

Wigs.

Third Party Liability: Anthem Blue Cross Life and Health Insurance Company is entitled to reimbursement of benefits paid if the member recovers damages from a legally liable third party.

Coordination of Benefits. The benefits of this plan may be reduced if the member has any other group health or dental coverage so that the services received from all group coverages do not exceed 100% of the covered expense.

Medicare. For which benefits are payable under Medicare Parts A and/or B, or would have been payable if you had applied for Parts A and/or B, except as listed or as required by federal law, as described in the EOC. If you do not enroll in Medicare Part B, we will calculate benefits as if you had enrolled. You should sign up for Medicare Part B as soon as possible to avoid large out of pocket costs.

Residential accommodations. Residential accommodations to treat medical or behavioral health conditions, except when provided in a hospital, hospice, skilled nursing facility or residential treatment center. This exclusion includes procedures, equipment, services, supplies or charges for the following:

• Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.

• Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.

• Services or care provided or billed by a school, custodial care center for the developmentally disabled, or outward bound programs, even if psychotherapy is included.

• Wilderness camps.

Services Received from Providers on a Federal or State Exclusion List. Any service, drug, drug regimen, treatment, or supply furnished, ordered or prescribed by a provider identified as an excluded individual or entity on the U.S. Department of Health and Human Services Office of Inspector General List of Excluded Individuals/Entities (OIG List), the General Services Administration System for Award Management (GSA List), State Medicaid exclusion lists or other exclusion/sanctioned lists as published by Federal or State regulatory agencies. This exclusion does not apply to an emergency medical condition.

Drugs Given to you by a Doctor. The following exclusions apply to drugs you receive from a doctor:

• Delivery Charges. Charges for the delivery of prescription drugs.

• Clinically-Equivalent Alternatives. Certain prescription drugs may not be covered if you could use a clinically equivalent drug, unless required by law. "Clinically equivalent" means drugs that for most members, will give you similar results for a disease or condition. If you have questions about whether a certain drug is covered and which drugs fall into this group, please call the number on the back of your Identification Card, or visit our website at www.anthem.com.

If you or your doctor believes you need to use a different prescription drug, please have your doctor or pharmacist get in touch with us. We will cover the other prescription drug only if we agree that it is medically necessary and appropriate over the clinically equivalent drug. We will review benefits for the prescription drug from time to time to make sure the drug is still medically necessary.

• Compound Drugs. Compound drugs unless all of the ingredients are FDA-approved in the form in which they are used in the compound drug and as designated in the FDA's Orange Book: Approved Drug Products with Therapeutic Equivalence Evaluations, require a prescription to dispense, and the compound drug is not essentially the same as an FDA-approved product from a drug manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants.

• Drugs Contrary to Approved Medical and Professional Standards. Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.

• Drugs Over Quantity or Age Limits. Drugs which are over any quantity or age limits set by the plan or us.

• Drugs Over the Quantity Prescribed or Refills After One Year. Drugs in amounts over the quantity prescribed or for any refill given more than one year after the date of the original prescription.

• Drugs Prescribed by Providers Lacking Qualifications, Registrations and/or Certifications. Prescription drugs prescribed by a provider that does not have the necessary qualifications, registrations and/or certifications as determined by us.

• Drugs That Do Not Need a Prescription. Drugs that do not need a prescription by federal law (including drugs that need a prescription by state law, but not by federal law), except for injectable insulin. This exclusion does not apply to over-the-counter drugs that we must cover under state law, or federal law when recommended by the U.S. Preventive Services Task Force, and prescribed by a doctor.

• Lost or Stolen Drugs. Refills of lost or stolen drugs.

• Non-Approved Drugs. Drugs not approved by the FDA.

This plan includes custom benefits that may supersede some of the information included in this list of Exclusions and Limitations. Please see your EOC for full details on your covered benefits.

anthem.com/ca Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company;(P-NP) Effective 01-2020 Printed 10-2019 LP2075 -D

CompleteCare™
A Keenan Solution

PACE CompleteCare

What is CompleteCare?

CompleteCare reimburses you (the employee) and your dependents for eligible health care expenses and premium expenses incurred under alternate group health coverage.

CompleteCare Benefits

- Co-pays, deductibles and co-insurance reimbursed by CompleteCare up to $7,350/single and $14,700/family per year.
- No premium contribution deducted from your paycheck.
- You will be reimbursed for the premium contribution paid for the alternate coverage if it exceeds the premium contribution that you would have paid to remain on the PACE medical plan up to a monthly maximum of $100/single, $200/2-party and $300/family.

If the cost of alternate coverage is less than you would have paid for the PACE medical plan, the premium contribution reimbursement is $0.

IRS Rules

- You may be enrolled in an HRA or FSA. You CANNOT be reimbursed from both CompleteCare and your HRA or FSA.
- You are NOT eligible for CompleteCare if your alternate coverage is:
  - a high deductible health plan (HDHP) with active contributions to a Health Savings Account (HSA);
  - Medicare, Medicaid, Tricare (Retiree only) or an Individual Policy.

How Does CompleteCare Work?

ENROLL

Enroll in the alternate group medical plan

Complete the CompleteCare Enrollment Form

Complete the Attestation Form

Provide proof of your premium cost for the alternate group medical plan

INCUR

Co-pays

Deductibles

Co-insurance

FILE

Present your alternate medical plan ID Card.

Next, present your CompleteCare ID Card for Co-pays, Deductibles and Out-of-Pocket qualified expenses.

Your Provider will file claims with your alternate Medical Plan and CompleteCare (Walgreens, CVS and Mail Order will not accept the CompleteCare ID Card and will require you to file a paper claim).

GET REIMBURSED

Most claims will be paid directly to the provider through use of the ID card. If you pay an out-of-pocket eligible expense, you may submit a paper claim for reimbursement. You will receive a check mailed to your home.

Premium reimbursements will be issued and mailed to your home. If your spouse's contributions are pre-tax, you will receive an IRS Form 1099 at year end.

PACE
A Keenan Solution

Keenan & Associates
License No. 0451271

J&K CONSULTANTS

CompleteCare™
A Keenan Solution

Are you eligible for CompleteCare?

Do you have access to an alternate Group Health Plan* that is not an HSA, plus your spouse is not an employee of another PACE Agency or MCSIG School District?

YES
Continue to see if you are eligible to enroll in CompleteCare...

NO
I am not eligible to enroll in CompleteCare and may remain or enroll in PACE's Health Plan.

Are you currently enrolled in your employer's group health plan

OR

Are you a New Employee?

YES
I am eligible to enroll in CompleteCare.

Only the employee and the dependents currently covered by PACE's group health plan are eligible to be enrolled in CompleteCare.

NO
I am not eligible to enroll in CompleteCare unless I enroll in PACE's Health Plan for one year.

*If at any point an employee loses access to their alternate group health plan – a Qualifying Event – you will be able to enroll in PACE's group health plan

For more information, please contact your Keenan representative at 310.212.0363 ext. 3621 or J&K Consultants at 877.872.4232.

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J&K CONSULTANTS

Public Agency Coalition Enterprise (PACE)

Prescription Benefit Plan

EPO 15 Plan

PACE

A Keenan Solution

EmpiRx Health Member Services

1-877-262-7435

TDD: 1-888-907-0020

24 hours a day, 7 days a week

Your Prescription Benefit Program

Annual Maximum Out of Pocket Amount

There is no calendar year pharmacy deductible. Your plan includes a $1,500 individual / $3,000 family annual maximum out of pocket amount. Prescription drug cost shares, such as copayments, apply towards the medical out-of-pocket maximum amount. Coupon amounts redeemed at the mail order pharmacy will not be attributed to the annual out of pocket maximum amount.

Retail Pharmacy Copayment

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

$10.00 for a Generic Medication
$25.00 for a Preferred Brand Medication
$45.00 for a Non-Preferred Brand Medication

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

Retail quantities will be dispensed according to your physician's instructions written on the prescription up to a maximum of a 30-day supply.

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

Mail Order Pharmacy Copayment

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

$10.00 for a Generic Medication
$50.00 for a Preferred Brand Medication
$90.00 for a Non-Preferred Brand Medication

Specialty Medication Copayment

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

Tier	Retail	Mail Order
Generic Specialty Medication	20% (maximum $150 copay per fill)	20% (maximum $150 copay per fill)
Preferred Brand Specialty Medication	20% (maximum $150 copay per fill)	20% (maximum $150 copay per fill)
Non-Preferred Brand Specialty Medication	20% (maximum $150 copay per fill)	20% (maximum $150 copay per fill)

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

Retail Pharmacy Network

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

Mail Order Pharmacy

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

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

To order refills you have three options:

- **Internet**: Visit www.empirxhealth.com. If you have not yet registered, click on Register. If you are a registered user, log in and select Mail Order.
- **Phone**: Call Member Services toll-free, 1-877-262-7435 24 hours a day, 7 days a week and use the prompts to order your refills. Have your identification number and credit card information ready.
- **Mail**: Send the Refill Request Order Form provided with your last shipment back to Benecard Central Fill mail service in the pre-addressed envelope.

EmpiRx Health does NOT automatically refill your prescriptions.

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

Specialty Pharmacy

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

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

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

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

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

Where Can I Ship My Medications?

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

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

Save with Generic Medications

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

ID Cards

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

Direct Member Reimbursement

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

Preferred Medication List

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

Exclusions

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

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

Online Member Tools

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

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

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

EmpiRx HEALTH

Powered by

Frequently Asked Questions

How do I find a participating network pharmacy?

You can use your EmpiRx Health ID card at over 68,000 pharmacies nationwide including all pharmacy chains. You can find a network pharmacy by logging onto www.empirxhealth.com or call 1-877-262-7435.

What is a prior authorization and why is it necessary?

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

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

Call 1-877-262-7435 to speak to a representative who can assist you with drug coverage questions or log onto www.empirxhealth.com for details.

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

Log into the member portal at www.empirxhealth.com and select "Drug Pricing." Search your medication and if there is a generic available, you will see the cost for both the brand as well as the generic. You can also call 1-877-262-7435 to speak to a representative who can assist you, or consult your physician or pharmacist to determine if generic equivalents are available for your prescription.

Why does my copay change from month to month?

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

CDPK.90.1800.000
Standard Brochure 1.2018

DELTA DENTAL PPO℠: YOUR SMILE IS COVERED

GO PPO

Visit a PPO[1] dentist to maximize your savings.[2] These dentists have agreed to reduced fees, and you won't get charged more than your expected share of the bill.[3] Find a PPO dentist at **deltadentalins.com**.[4]

ACCESS ONLINE SERVICES

Get information about your plan anytime, anywhere by signing up for an Online Services account at **deltadentalins.com**. This free service lets you check benefits and eligibility information, find a network dentist and more.

CHECK IN WITH EASE

You don't need a Delta Dental ID card when you visit the dentist. Just provide your name, birth date and enrollee ID or social security number. If your family members are covered under your plan, they will need your name, birth date and enrollee or social security number. Prefer to take a paper or electronic ID card with you? Simply sign in to Online Services, where you can view or print your card with the click of a button. If you're covered under two plans, ask your dental office to include information about both plans with your claim, and we'll handle the rest.

UNDERSTAND TRANSITION OF CARE

Did you start on a dental treatment plan before your PPO coverage kicked in? Multi-stage procedures are only covered under your current plan if treatment began after your plan's effective date of coverage.[5] You can find this date by logging in to Online Services.

NEWLY COVERED? Visit **deltadentalins.com/welcome**.

SAVE WITH A PPO DENTIST

PPO

NON-PPO

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

[1] In Texas, Delta Dental Insurance Company offers a Dental Provider Organization (DPO) plan.

[2] You can still visit any licensed dentist, but your out-of-pocket costs may be higher if you choose a non-PPO dentist. Network dentists are paid contracted fees.

[3] You are responsible for any applicable deductibles, coinsurance, amounts over plan maximums and charges for non-covered services.

[4] Verify that your dentist is a PPO dentist before each appointment.

[5] Applies only to procedures covered under your plan. If you began treatment prior to your effective date of coverage, you or your prior carrier are responsible for any costs. Group- and state-specific exceptions may apply. Enrollees currently undergoing active orthodontic treatment may be eligible to continue treatment under Delta Dental PPO. Review your Evidence of Coverage, Summary Plan Description or Group Dental Service Contract for specific details about your plan.

Plan Benefit Highlights for: Superior Court of California, County of El Dorado

Group No: 06140

DELTA DENTAL PPO℠

BENEFIT HIGHLIGHTS

Eligibility	Primary enrollee, spouse (includes domestic partner) and eligible dependent children to the end of the month dependent turns age 26			
Deductibles Deductibles waived for Diagnostic & Preventive (D &P) and Orthodontics?	$25 per person / $50 per family each calendar year Yes			
Maximums	$1,600 per person each calendar year			
Waiting Period(s)	Basic Benefits None	Major Benefits None	Prosthodontics None	Orthodontics None

Benefits and Covered Services*	Delta Dental PPO dentists** In-PPO Network	Non-PPO dentists** Out-of-PPO Network
Diagnostic & Preventive Services (D & P) Exams, cleanings and x-rays	100 %	90 %
Basic Services Fillings, simple tooth extractions and sealants	80 %	70 %
Endodontics (root canals)	80 %	70 %
Periodontics (gum treatment)	80 %	70 %
Oral Surgery	80 %	70 %
Major Services Crowns, inlays, onlays and cast restorations	80 %	50 %
Prosthodontics Bridges, dentures and implants	80 %	50 %
Orthodontic Benefits Adults and dependent children	60 %	50 %
Orthodontic Maximums	$1,500 Lifetime	$1,500 Lifetime

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

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

Delta Dental of California
100 First St.
San Francisco, CA 94105

Customer Service
800-765-6003

Claims Address
P.O. Box 997330
Sacramento, CA 95899-7330

deltadentalins.com

This benefit information is not intended or designed to replace or serve as the plan's Evidence of Coverage or Summary Plan Description. If you have specific questions regarding the benefits, limitations or exclusions for your plan, please consult your company's benefits representative.

Get the best in eyecare and eyewear with CSAC EIA / SUPERIOR COURTS OF EL DORADO and VSP® Vision Care.

At VSP, we invest in the things you value most—the best care at the lowest out-of-pocket costs. Because we're the only national not-for-profit vision care company, you can trust that we'll always put your wellness over profit.

You'll like what you see with VSP.

- **Value and Savings.** You'll enjoy more value and the lowest out-of-pocket costs.
- **High Quality Vision Care.** You'll get the best care from a VSP doctor including a WellVision Exam®—the most comprehensive exam designed to detect eye and health conditions.
- **Choice of Providers.** The decision is yours to make—choose a VSP doctor, retail chain affiliate, or any other provider.
- **Great Eyewear.** It's easy to find the perfect frame at a price that fits your budget.

Using your VSP benefit is easy.

- **Find an eyecare provider who's right for you.** To find a VSP doctor or retail chain affiliate, visit **vsp.com** or call **800.877.7195**.
- **Review your benefit information.** Once your benefit is effective, visit **vsp.com** to review your plan coverage before your appointment.
- **At your appointment, tell them you have VSP.** There's no ID card necessary.

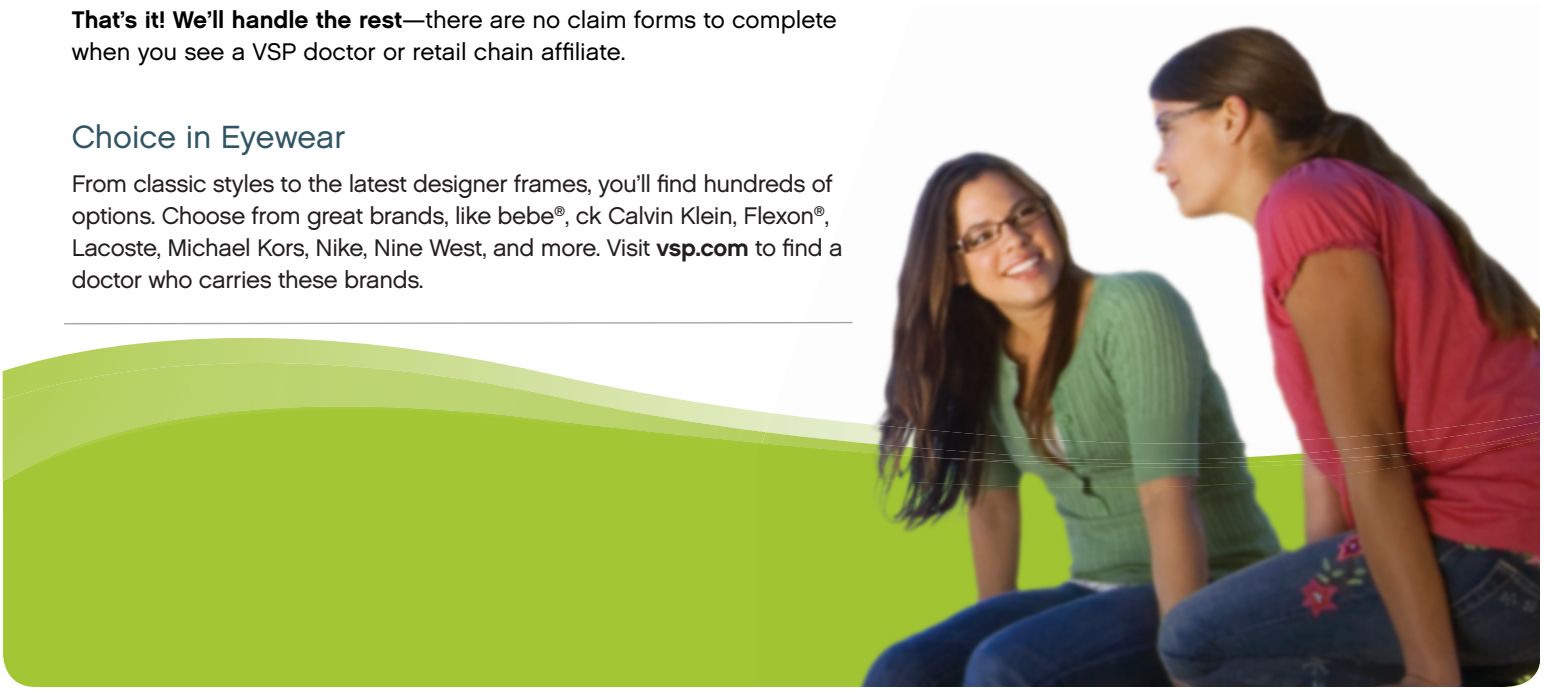
That's it! We'll handle the rest—there are no claim forms to complete when you see a VSP doctor or retail chain affiliate.

Choice in Eyewear

From classic styles to the latest designer frames, you'll find hundreds of options. Choose from great brands, like bebe®, ck Calvin Klein, Flexon®, Lacoste, Michael Kors, Nike, Nine West, and more. Visit **vsp.com** to find a doctor who carries these brands.

See why we're consumers' #1 choice in vision care.

Contact us.
vsp.com | 800.877.7195



Your VSP Vision Benefits Summary

Superior Courts of El Dorado and VSP provide you with an affordable eyecare plan.

VSP Doctor Network: VSP Signature

Visit **vsp.com** for more details on your vision benefit and for exclusive savings and promotions for VSP members.

Benefit	Description	Copay	Frequency
Your Coverage with VSP Doctors and Affiliate Providers*			
WellVision Exam	• Focuses on your eyes and overall wellness	$10 for exam and glasses	Every 12 Months
Prescription Glasses			
Frame	• $130 allowance for a wide selection of frames • $150 allowance for featured frame brands like bebe®, ck Calvin Klein, Flexon®, Lacoste, Michael Kors, Nike, Nine West, and more • 20% savings on the amount over your allowance • $70 allowance for Costco frames	Combined with exam	Every 12 Months
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Tints and Photochromics • Polycarbonate lenses for dependent children	Combined with exam	Every 12 Months
Lens Enhancements	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 35-40% on other lens enhancements	$50 $80 - $90 $120 - $160	Every 12 Months
Contacts (instead of glasses)	• $130 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation)	Up to $60	Every 12 Months
Diabetic Eyecare Plus Program	• Services related to diabetic eye disease, glaucoma and age-related macular degeneration (AMD). Retinal screening for eligible members with diabetes. Limitations and coordination with medical coverage may apply. Ask your VSP doctor for details.	$20	As needed
Extra Savings	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. Go to vsp.com/specialoffers for details. • 30% savings on additional glasses and sunglasses, including lens enhancements, from the same VSP doctor on the same day as your WellVision Exam. Or get 20% from any VSP doctor within 12 months of your last WellVision Exam. **Laser Vision Correction** • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities		

Your Coverage with Other Providers

Visit vsp.com for details, if you plan to see a provider other than a VSP doctor.

Exam.....up to $50	Single Vision Lenses.....up to $50	Lined Trifocal Lenses.....up to $100	Tints.....up to $5
Frame.....up to $70	Lined Bifocal Lenses.....up to $75	Progressive Lenses.....up to $75	Contacts.....up to $105

***Coverage with a retail chain affiliate may be different. Once your benefit is effective, visit vsp.com for details.**
Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location.

See why we're consumers' #1 choice in vision care.

Contact us. **vsp.com | 800.877.7195**

California Region Group Enrollment/Change Form

Please print or type in black ink only. See instructions on reverse before completing this form. Make a copy for your records.

TO BE COMPLETED BY EMPLOYER

Company name		Hire date (mm/dd/yyyy)
Group number 600705	Enrollment unit	Effective enrollment/ change date (mm/dd/yyyy)

A. ENROLLMENT/CHANGE REASON *(see Change Table for assistance)* New group: ■ Yes ❑ No

❑ New Hire *(complete sections A, B, C, D)* ❑ Open Enrollment *(complete sections A, B, C, D)*

Health Plan *(Check one)* ■ HMO Plan ❑ Deductible Plan ❑ Other PACE HMO 15

❑ Loss of Other Coverage *(complete sections A, B, C, D)* ❑ Other *(please specify)* _____

❑ Name Change *(complete sections A, B, C, D)* From: _____ To: _____

Event Date (mm/dd/yyyy) _____

B. EMPLOYEE Have you ever been a Kaiser Permanente member? ❑ Yes ❑ No

Medical Record No. *(if known)* | Social Security No.

Name (Last, First, MI) | Birth Date (mm/dd/yyyy) | Gender ❑ M ❑ F

Home Address | City | State | ZIP

Work Phone | Home Phone | Email

Ethnicity | Preferred Language

C. FAMILY For additional dependents, attach a separate sheet with employee's name at top. (Last, First, MI)

❑ Add ❑ Delete ❑ Spouse ❑ Domestic partner Spouse/domestic partner name: Former last name *(if any)*:	Gender ❑ M ❑ F	Social Security No. Birth Date (mm/dd/yyyy) Medical Record No.
❑ Add ❑ Delete ❑ Child ❑ Student Dependent name: Relationship:	Gender ❑ M ❑ F	Social Security No. Birth Date (mm/dd/yyyy) Medical Record No.
❑ Add ❑ Delete ❑ Child ❑ Student Dependent name: Relationship:	Gender ❑ M ❑ F	Social Security No. Birth Date (mm/dd/yyyy) Medical Record No.
❑ Add ❑ Delete ❑ Child ❑ Student Dependent name: Relationship:	Gender ❑ M ❑ F	Social Security No. Birth Date (mm/dd/yyyy) Medical Record No.

Do any of dependents above live at another address? ❑ Yes ❑ No If yes, complete the following:

Name (Last, First, MI): Address:

D. Kaiser Foundation Health Plan, Inc., and Kaiser Permanente Insurance Company Arbitration Agreement*

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if I am enrolled in coverage that is subject to the ERISA claims procedure regulation, or any claims that cannot be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), Kaiser Permanente Insurance Company (KPIC),* any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP or coverage by KPIC, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the Evidence of Coverage and in the Certificate of Insurance.

*Disputes arising from any of the following KPIC products are not subject to binding arbitration: 1) Tiers 2 & 3 of the Point-of-Service (POS) Plan; 2), the Preferred Provider Organization (PPO) and Out-of-Area Indemnity (OOA) Plans; and 3), the KPIC Dental Plans.

Signature Required for all Kaiser Permanente Plans (Excluding KPIC PPO, KPIC OOA, and KPIC Dental Plans) Date

KAISER PERMANENTE®

California Region Group Enrollment/Change Form

General instructions

1. Please print firmly and legibly in black ink.
2. To enroll, the subscriber must reside or work within one of the ZIP codes listed on the enclosed sheet.
3. The employer must complete the first section titled "To be completed by employer."
4. The employer is responsible for confirming all information prior to submitting, especially effective dates, as these affect your Health Plan dues.
5. The employee/subscriber must complete Sections A and B. See right column for detailed instructions.
6. Be sure to sign and date the bottom of the form.
7. Once the form is complete (including employer section), the subscriber should make a copy for his or her records, and to use as a temporary ID card, after the effective date.
8. All changes to accounts, including effective dates and child or student status, will be made in accordance with the contractual agreement between the purchaser and Kaiser Permanente.

Instructions for completing employer and new enrollment sections and sections A through D:

To be completed by employer: The employer must complete all fields to ensure we have correct account and enrollment information.

Section A: The subscriber must complete this section.

Section B: The subscriber must always complete this section. Use the Change Table (below) for assistance.

Section C: The subscriber must indicate the requested change to the account and complete all fields for any dependents being enrolled. We will verify the eligibility of these dependents during the enrollment process. Be sure to include any former last names for both spouses and dependents. Also indicate the appropriate role. The student role should be marked only if the dependent qualifies as an "overage dependent" attending school. Please contact your employer regarding rules for overage dependent students. A completed *Student Certification* form may be required.

Section D: The subscriber must sign and date this section.

Change Table

Add dependent	**Event date**
Acquired student status*	Student status date
Family adoption*	Adoption date
Loss of coverage	Coverage loss date
New spouse (marriage)	Marriage date
Moved into service area	Move date
Newborn addition	Birth date
Open enrollment	Open enrollment effective date

Delete dependent	**Event date**
Loss of student status	Status change date
Divorce	Divorce date
Member deceased*	Death date
Delete dependent(s)	Dependent termination date
Open enrollment	Open enrollment effective date

Demographic Change	**Event date**
Address change, telephone number change	Status change date
Demographic (name, birthdate, social security number) change	Status change date

*Additional documentation may be required.

KAISER PERMANENTE®

88350
Revision date 09/2013

Anthem BlueCross

Anthem Blue Cross Enrollment Form

Please return the completed enrollment form to your employer.

anthem.com/ca
GC4050 Rev. 1/16

Anthem Blue Cross Enrollment Form

Effective date | Group no.

Anthem BlueCross

Purpose: ☐ New enrollment ☐ Re-hire ☐ Part-time to full-time ☐ Open enrollment ☐ Family addition ☐ Change ☐ COBRA ☐ Cal-COBRA

SECTION 1: TYPE OF COVERAGE — Select from only the coverages offered by your employer.

Medical

Anthem Blue Cross plans:

- ☐ HMO (CaliforniaCare)[1]
- ☐ Preferred HMO (CaliforniaCare PLUS)[1]
- ☐ Advantage HMO[1]
- ☐ Priority Select HMO[1]
- ☐ Select HMO[1]
- ☐ Vivity HMO[1]
- ☐ Elements Choice EQ HMO[1]
- ☐ Other: _____

Anthem Blue Cross Life and Health Insurance Company plans:

- ☐ PPO (Prudent Buyer) 250 or 750
- ☐ EPO (Prudent Buyer Exclusive) 25
- ☐ POS (Blue Cross Plus)[1]
- ☐ Elements Choice EQ PPO
- ☐ Medicare
- ☐ CareAdvocate PPO
- ☐ Select PPO
- ☐ BC PPO (non-California resident)
- ☐ BC Exclusive (non-California resident)
- ☐ BC CareAdvocate PPO (non-California resident)
- ☐ Lumenos® (select one of the following)
  - ☐ H.S.A.[2] ☐ H.R.A.
  - ☐ H.I.A. ☐ H.I.A. Plus
- ☐ Elements Choice EQ HSA

1 Indicate Medical Group/IPA No. in the ***Employee and Family Information*** section.
2 Anthem Blue Cross will facilitate the opening of a Health Savings Account in your name, if directed by your employer.

Dental

Anthem Blue Cross plans:

- ☐ Dental Net HMO[3]
- ☐ **Choice Dental** (select one of the following)
  - ☐ Dental Net HMO[3] ☐ PPO Dental
- ☐ Other: _____

Anthem Blue Cross Life and Health Insurance Company plans:

- ☐ Dental Blue PPO
- ☐ PPO Dental
- ☐ Voluntary PPO Dental
- ☐ Dental Blue Complete Incentive
- ☐ Dental Prime
- ☐ Dental Complete
- ☐ Dental Prime Voluntary
- ☐ Dental Complete Voluntary
- ☐ National Dental Blue PPO
- ☐ National PPO Dental
- ☐ National Voluntary PPO Dental

3 Indicate Dental Office No. in the ***Employee and Family Information*** section.

☐ UniAccount (Flexible Spending account)[4]
(Indicate payroll deductions)
I authorize payroll deductions on the following:
☐ Health Care Account $_____
☐ Dependent Care $_____

4 Anthem Blue Cross PPO, drug and dental plan enrollees, will have out-of-pocket expenses, automatically deducted from their Health Care FSA account. Automatic FSA processing is not possible for HMO enrollees and those with coverage through another health plan. Reminder: Automatic FSA processing is the equivalent of signing and submitting an FSA claim form, which states that you are eligible for FSA reimbursement and that you will not claim FSA reimbursed expenses on your income tax return.

Vision

☐ Blue View Vision (offered by Anthem Blue Cross Life and Health Insurance Company)

Life Insurance

All the coverages listed may not be offered under your plan. To elect dependent coverage, the corresponding employee coverage must be selected. List all life insurance beneficiaries in the ***Life Insurance Beneficiary Designation Information*** section.

Annual salary $

Elected Benefit	Benefit Amount	Elected Benefit	Benefit Amount	Elected Benefit	Benefit Amount
☐ Basic Life (AD&D)	$_____	☐ Optional Life - Employee	$_____	☐ Optional AD&D - Employee	$_____
☐ Dependent Life - Spouse	$_____	☐ Optional Dependent Life/Spouse	$_____	☐ Optional AD&D - Spouse	$_____
☐ Dependent Life - Child	$_____	☐ Optional Dependent Life/Child	$_____	☐ Optional AD&D - Child	$_____
		☐ Short Term Disability	$_____	☐ Voluntary Short Term Disability	$_____
		☐ Long Term Disability	$_____	☐ Voluntary Long Term Disability	$_____

LANGUAGE CHOICE (optional) ☐ English ☐ Spanish ☐ Chinese ☐ Korean ☐ Other – please specify: _____

SECTION 2: APPLICANT'S PERSONAL INFORMATION — Social Security numbers are required under CMS Regulations and by the IRS.

Last name	First name	M.I.	Marital status ☐ Single ☐ Married ☐ Domestic Partner (DP)	Social Security or ID no.[5] (required)
Mailing address		Apt. no.	# of dependents including spouse	Spouse/DP Social Security or ID no.[5] (required)
City		State	ZIP code	Home phone no.

Hire date/Rehire date Part-time to Full-time date	Employer name	Job title	Class	Dept. no.	Email address

SECTION 3: EMPLOYEE AND FAMILY INFORMATION — Please list yourself and all eligible family members to be enrolled. Attach additional sheets if necessary.

Sex	Last Name	First Name	M.I.	Birthdate (MM/DD/YYYY)	Social Security or ID no.[5] (required)	Full-time student (if applicable, for non-medical plans)	If children are age 26 or over you must check the appropriate boxes below	HMO & POS ONLY IPA/Primary Care Physician Code	Current MD?	Dental Net ONLY Office No.
☐ M ☐ F	Employee								☐ Yes ☐ No	
☐ M ☐ F	Spouse/DP						IRS Qualified Dependent		☐ Yes ☐ No	
☐ M ☐ F						☐ Yes ☐ No	☐ Yes ☐ No		☐ Yes ☐ No	
☐ M ☐ F						☐ Yes ☐ No	☐ Yes ☐ No		☐ Yes ☐ No	
☐ M ☐ F						☐ Yes ☐ No	☐ Yes ☐ No		☐ Yes ☐ No	
☐ M ☐ F						☐ Yes ☐ No	☐ Yes ☐ No		☐ Yes ☐ No	

To be eligible as a Domestic Partner, the Subscriber and Domestic Partner must have properly filed a Declaration of Domestic Partnership with the California Secretary of State pursuant to the California Family Code, or have properly filed an equivalent document in accordance with the laws of another jurisdiction recognizing the creation of domestic partnerships.
5 Anthem is required by the Internal Revenue Service to collect this information.

Social Security or ID no.[1] (required)

SECTION 4: DECLINATION — To be completed if any coverage is declined or refused by an eligible employee and/or their eligible dependents.

A. Medical coverage declined for: ☐ Myself ☐ Spouse/DP ☐ Child(ren)
B. Dental coverage declined for: ☐ Myself ☐ Spouse/DP ☐ Child(ren)
C. Vision coverage declined for: ☐ Myself ☐ Spouse/DP ☐ Child(ren)
D. Life insurance coverage declined for: ☐ Myself ☐ Spouse/DP ☐ Child(ren)

Reason for declining coverage – check one
☐ Covered by spouse's group coverage. Carrier name and ID no.: _____
☐ Covered by Anthem Blue Cross Individual policy
☐ Spouse covered by employer's group medical coverage. Carrier name: _____
☐ Enrolled in Tricare
☐ Enrolled in any other insurance carrier plan. Carrier name: _____
☐ Medicare
☐ Other (Explain): _____

I acknowledge that the available coverages have been explained to me by my employer and I know that I have every right to apply for coverage. I have been given the chance to apply for this coverage and I have decided not to enroll myself and/or my dependent(s), if any. I have made this decision voluntarily, and no one has tried to influence me or put any pressure on me to decline coverage. **BY DECLINING THIS GROUP MEDICAL COVERAGE (UNLESS EMPLOYEE AND/OR DEPENDENTS HAVE GROUP MEDICAL COVERAGE ELSEWHERE) I ACKNOWLEDGE THAT MY DEPENDENTS AND I MAY HAVE TO WAIT UNTIL THE NEXT OPEN ENROLLMENT PERIOD TO BE ENROLLED IN THIS GROUP MEDICAL AND/OR GROUP LIFE INSURANCE PLAN.**

Signature if declining coverage for employee/dependent(s)	Date
X	

SECTION 5: COBRA/CAL-COBRA COVERAGE INFORMATION — Complete only if enrolling in COBRA/Cal-COBRA.

Reason for COBRA/Cal-COBRA coverage

Federal COBRA qualifying event date	Federal COBRA coverage begin date	Federal COBRA coverage end date
Cal-COBRA qualifying event date	Cal-COBRA coverage begin date	Cal-COBRA coverage end date

SECTION 6: OTHER COVERAGE FOR ALL ENROLLING EMPLOYEES AND DEPENDENTS — All questions must be answered.

A. Do any persons on this application intend to continue other group coverage if this application is accepted? ☐ Yes ☐ No
If yes, name of person: _____ Insurance company: _____

B. Does any person applying for coverage currently have **health** insurance coverage? ☐ Yes ☐ No
Has any person applying for coverage had health insurance coverage at any time in the past six months? ☐ Yes ☐ No
If yes, applicant/family member name(s): _____
Type of continuous coverage: ☐ Group ☐ Individual ☐ Other: _____
Insurance company: _____ Date coverage began: _____ Date ended: _____

C. Does any person applying for coverage currently have **dental** insurance coverage? ☐ Yes ☐ No
If yes, applicant/family member name(s): _____
Type of continuous coverage: ☐ Group ☐ Individual ☐ Other: _____
Insurance company: _____ Date coverage began: _____ Date ended: _____

D. Does any person applying for coverage currently have **vision** insurance coverage? ☐ Yes ☐ No
If yes, applicant/family member name(s): _____
Type of continuous coverage: ☐ Group ☐ Individual ☐ Other: _____
Insurance company: _____ Date coverage began: _____ Date ended: _____

E. Is any person applying for coverage eligible for Medicare or currently receiving Medicare benefits? ☐ Yes ☐ No
Note: If you are eligible for Medicare, Anthem Blue Cross may not duplicate Medicare benefits.

SECTION 7: MEDICARE SECTION — Complete if you, your spouse or dependent child(ren) have Medicare coverage. Attach additional sheets if necessary.

Name	Part A Effective Date	Part B Effective Date	Reason for Disability if Under Age 65	Medicare Claim No.

SECTION 8: PRIOR COVERAGE FOR PPO PLANS ONLY — Attach additional sheets if necessary.

Please fill out the following information to receive proper credit for **PREVIOUS COVERAGE** (if immediately prior to becoming eligible for this plan, you have a dependent child(ren) over the age of 26 who cannot get a self-sustaining job due to a physical or mental condition and was covered under any public or private health care coverage, including MediCal or individual coverage). **NOTE**: If this section is left blank, there may be delays in the processing of claims for these dependents.

Name	Coverage Begin Date	Coverage End Date	Carrier Name	Reason for Ending Coverage
Child				
Child				
Child				

1 Anthem is required by the Internal Revenue Service to collect this information.

Social Security or ID no.[1] (required)

SECTION 9: LIFE INSURANCE BENEFICIARY DESIGNATION INFORMATION

Note: Dependent Life payments are always paid to the employee.

Primary Beneficiary – First to receive payment (required) If more than one beneficiary is named, enter a % for each. If no percentage is shown, equal shares are assumed.

Name	Birthdate	Social Security no.	Relationship	%
Street address		City	State	ZIP code
Name	Birthdate	Social Security no.	Relationship	%
Street address		City	State	ZIP code

SECTION 10: PLEASE READ CAREFULLY – Signature required.

I attest by signing below that I have reviewed the information provided on this application and to the best of my knowledge and belief, it is true and accurate with no omissions or misstatements.

DEDUCTION AUTHORIZATION: If applicable, I authorize my employer to deduct from my wages the required subscription charges/premiums.

NON-PARTICIPATING PROVIDER: I understand that I am responsible for a greater portion of my medical costs when I use a non-participating provider.

HIV TESTING PROHIBITED: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance.

EFFECTIVE DATE: The effective date of coverage is subject to Anthem Blue Cross approval.

COBRA/CAL-COBRA CONTINUATION COVERAGE

You may continue your health care coverage by: 1) completing the remainder of this form; 2) signing your name in the blank space below; 3) paying your Total Monthly Continuation Payment; and 4) mailing this form to Anthem Blue Cross, no later than sixty (60) days after the date you receive this notice. If you fail to choose COBRA Continuation Coverage within sixty (60) days after the date you receive this notice, your qualification for coverage will end. If you do choose COBRA Continuation Coverage, your current coverage will be continued until the earliest of the following dates:

1. The date eligibility for COBRA Continuation Coverage ends, or
2. The date you fail to make timely payments of your premium for COBRA Continuation Coverage, or
3. The date your employer discontinues coverage with Anthem Blue Cross, or
4. The date you become entitled to Medicare on the basis of age (65 years), or the date thirty (30) months after you become entitled to Medicare on the basis of end stage renal disease, or
5. The date you become covered under another group health plan as a result of employment, re-employment, remarriage, or otherwise.

If, at any time during the first sixty (60) days of your COBRA Continuation Coverage, you are determined under Title II or XVI of the United States Social Security Act to be disabled, you may be entitled to continue coverage while you are disabled for up to 29 months from the date you first qualified for Continuation Coverage under COBRA. Contact the Health Plan Administrator at your previous employer for full information.

The Monthly Continuation Payment is the cost of continued coverage for the month beginning on the date after the Date of Loss of Coverage. If you do not pay your initial monthly premium within 45 days after your election of COBRA Continuation Coverage, or if payment of succeeding premiums are not received within the 30-day grace period thereafter, your coverage will end.

Note: If you do not elect available COBRA Continuation of Medical Coverage, you will lose certain rights under federal law (HIPAA) to guaranteed issue individual coverage.

W–9 Certification Language

I certify each Social Security number listed on this application is correct.

REQUIREMENT FOR BINDING ARBITRATION (Not applicable to Life and Disability coverage)

ALL DISPUTES BETWEEN YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY, INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY AND CLAIMS OF MEDICAL MALPRACTICE, MUST BE RESOLVED BY BINDING ARBITRATION, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT AND THE DISPUTE CAN BE SUBMITTED TO BINDING ARBITRATION UNDER APPLICABLE FEDERAL AND STATE LAW, INCLUDING BUT NOT LIMITED TO, THE PATIENT PROTECTION AND AFFORDABLE CARE ACT. California Health and Safety Code Section 1363.1 and Insurance Code Section 10123.19 require specified disclosures in this regard, including the following notice: *It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as permitted and provided by federal and California law, including but not limited to, the Patient Protection and Affordable Care Act, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.* YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY AGREE TO BE BOUND BY THIS ARBITRATION PROVISION. YOU ACKNOWLEDGE THAT FOR DISPUTES THAT ARE SUBJECT TO ARBITRATION UNDER STATE OR FEDERAL LAW THE RIGHT TO A JURY TRIAL, THE RIGHT TO A BENCH TRIAL UNDER CALIFORNIA BUSINESS AND PROFESSIONS CODE SECTION 17200, AND/OR THE RIGHT TO ASSERT AND/OR PARTICIPATE IN A CLASS ACTION ARE ALL WAIVED BY YOU. Enforcement of this arbitration clause, including the waiver of class actions, shall be determined under the Federal Arbitration Act ("FAA"), including the FAA's preemptive effect on state law. By providing your "wet or electronic" signature below, you acknowledge that such signature is valid and binding.

Signature (Required)

Applicant X	Date

1 Anthem is required by the Internal Revenue Service to collect this information.

CompleteCare Enrollment Form

PACE
A Keenan Solution

EMPLOYER INFORMATION

Employer Name:

Please send completed form and mail or fax information to:

J & K Consultants, Inc.
2605 Nicholson Road, Suite 1140
Sewickley, PA 15143

TOLL FREE FAX: 877-599-3724
TELEPHONE: 877-872-4232
EMAIL: rachelt@jandkcons.com

I am enrolling in the CompleteCare for: ____Self Only ____Self & Child(ren) ____Child(ren) Only ____Spouse Only ____ Self & Spouse ____Self & Family ____Spouse & Child(ren)

PARTICIPANT INFORMATION

Employee Name:	Birthdate:	Hire Date:
Social Security No:	Gender: ☐ M ☐ F	Date Eligible for CompleteCare:
Home Street Address:		
City:	State:	Zip Code:
Home Phone:	Work Phone:	Cell Phone:
Email Address:		

SPOUSE INFORMATION

Spouse Name:	Birthdate:	Gender: ☐ M ☐ F
Social Security No:	Spouse's Employer:	

Spouse's Pay Period for Health Premium Contribution: ☐ Monthly ☐ Semi-Monthly ☐ Bi-Weekly ☐ Weekly

Please indicate if the medical deduction DOES NOT come out of every paycheck. Some may only be once a month or the first two pays of the month.

Spouse's Health Premium Contribution per Pay Period: $_____ **** INCLUDE DOCUMENTATION, I.E. PAYSTUB OR BENEFIT STATEMENT**

Are Spouse's Health Premium Contribution / Deductions: ☐ Before Taxes **(OR)** ☐ After Taxes

* Contribution per pay period should include the cost for Medical only; Dental & Vision are not covered under this plan.
If submitting a spousal paystub, please circle the contribution/deduction amount on the submitted paystub.
* DO NOT BLACKOUT THE PAY PERIOD.
** Send a copy of your spouse's paystub that shows the NEW contribution/deduction as of the CompleteCare effective date listed above. This amount should reflect the cost of adding you and/or any dependents to the spouse's plan.
*** If your spouse's plan has a High Deductible with a Health Savings Account (HSA), you are not eligible to participate in the CompleteCare, unless the employer allows your spouse to drop the HSA portion of the plan. Written documentation required. Also, if your primary health coverage is through Medicare or Tricare, you are not eligible for the CompleteCare.**

DEPENDENT INFORMATION: (Attach a separate sheet if additional space is needed for additional dependents)

Name:	Date of Birth:	Gender: ☐ Male ☐ Female
Social Security No:		
Name:	Date of Birth:	Gender: ☐ Male ☐ Female
Social Security No:		
Name:	Date of Birth:	Gender: ☐ Male ☐ Female

PARTICIPANT AUTHORIZATION

I hereby authorize my employer to enroll me into the employer sponsored CompleteCare.. I agree to comply with the terms and conditions of the plan. I understand that if the health premium contributions are deducted on an After-Tax Basis, this will result in all premium reimbursements being income tax free. However, if the contributions are on a Pre-Tax Basis, the premium reimbursements will be fully taxable. In either case, the deductible, co-pay and co-insurance reimbursements will remain tax free. **I further understand that if any current contributions are made to a Health Savings Account (HSA) by my spouse or his/her Employer, I am *not eligible* to participate in the CompleteCare offered though my employer.**

Employee Signature: **Date:**

PACE
A Keenan Solution

ATTESTATION OF ENROLLMENT
IN A NON-PACE EMPLOYER GROUP HEALTH PLAN

Employee Name: _____ Work Phone:_____

Work Location: _____ Email:_____

This form applies to individuals who participate in the ConpleteCare and who waive coverage in the PACE Health Plan.

To participate in this program, employees, spouses, and dependents, who are not enrolled in the PACE Health Plan, must provide proof of enrollment in a non- PACE employer group health plan. By signing below, I certify that:

-- PACE has offered me a group health plan that does not consist solely of "excepted benefits" under the Patient Protection and Affordable Care Act of 2010 ("PPACA").

-- I am enrolled in a group health plan of another employer (such as my spouse's employer) that does not consist solely of "excepted benefits" under PPACA (such as limited-scope dental or vision coverage), nor does it consist solely of a "health reimbursement arrangement" (reimbursement of health care expenses up to a dollar limit).

-- I understand that by enrolling in CompleteCare, I am waiving participation in the PACE Health Plan.

For confirmation that the other plan meets the IRS's definition of minimum value and does not consist solely of an HRA, please contact the benefits coordinator at the other employer.

I further certify that my alternate coverage is not:

- a high deductible health plan (HDHP) with active contributions to a health savings account (HSA)
- Medicare or Tricare (retiree only), Medicaid
- Health Insurance Coverage made available thru the Affordable Care Act
- Individual Policy
- Limited Benefit Health Plans

_____ _____

Employee Signature Date

_____ _____

Spouse's Signature Date

For more information, please contact J & K Consultants, Inc. @ 877-872-4232

PLEASE COMPLETE THIS FORM AND SEND TO _____ VIA FAX, EMAIL OR MAIL:

J & K CONSULTANTS, INC.
2605 Nicholson Road, Suite 1140
Sewickley, PA 15143
Rachelt@jandkcons.com
Toll Free Fax 877-599-3724

DELTA DENTAL®

ENROLLMENT/CHANGE FORM - CA

Delta Dental of California

Delta Dental of California
P.O. Box 429086
San Francisco, CA 94142-9086
www.deltadentalins.com

VERY IMPORTANT - Please Print Legibly

FOR GROUP USE ONLY

Group No.	Division	State
Effective Date / /	Hire Date / /	
Name of Employer		
Location	Pay Code	Benefit Package

Enrollee/Change Information

❑ New Enrollment ❑ Marital Status Change ❑ Terminate Enrollee Coverage ❑ SSN/Enrollee ID Number Correction or previous ID under which benefits are received

❑ Add/Delete Dependent ❑ Address Change ❑ Other _____

Enrollee Classification

❑ Full-Time ❑ Hourly ❑ Certified
❑ Part-Time ❑ Salaried ❑ Classified
❑ Retired ❑ Member/Other _____

Primary Enrollee Information

Social Security Number	Enrollee ID Number (if applicable)	Date of Birth	Gender	Marital Status
		/ /	❑ Male ❑ Female	❑ Single ❑ Married

First Name	Last Name	Middle Initial

Mailing Address (Street)	City	State	Zip Code

E-mail Address (internal use only)	Phone Number ( ) -	Phone Type Cell ❑ Work ❑ Home ❑

Name of Other Dental Carrier	Policy Holder Name (first/last)	Date of Birth
		/ /

Effective Date of Other Policy	Policy Holder Street Address	City	State	Zip Code
/ /				

COBRA (if applicable)

❑ Termination
❑ Reduction in Hours
❑ Divorce/Legal Separation*
❑ Widowed/Surviving Dependent*
❑ Dependent Child No Longer Eligible*

Indicate qualifying date: / /

*If a dependent is enrolling under his/her social security number, the **SSN currently enrolled under must be provided**.

Dependent Information

Relationship	Dependent First Name (Last only if different from enrollee)	Add / Term	Social Security Number	Date of Birth	Male / Female	Student / Disabled**	Name of School (overage student)**
Spouse/Partner		❑ ❑		/ /	❑ ❑	❑ ❑	
Dependent		❑ ❑		/ /	❑ ❑	❑ ❑	
Dependent		❑ ❑		/ /	❑ ❑	❑ ❑	
Dependent		❑ ❑		/ /	❑ ❑	❑ ❑	
Dependent		❑ ❑		/ /	❑ ❑	❑ ❑	

Please attach a separate sheet for additional dependent information. All dependents listed will be considered enrolled. **Additional documentation will be required for disabled and student status.

❑ I authorize any payroll deduction that may be required towards the cost of this coverage. I certify that the above information is true and correct to the best of my knowledge. I understand that changes can only be made if I experience a qualifying family status change, in which case the change must be consistent with that event, or as may otherwise be provided by the group contract.

❑ I decline coverage at this time.

Signature of Enrollee _____ Date _____/_____/_____

VISION SERVICE PLAN

MEMBERSHIP ENROLLMENT FORM

(Please Print or Type)

Name of Group _____ Department _____ Date of enrollment _____

1	SOCIAL SECURITY NO.	MEMBER LAST NAME	MEMBER FIRST NAME	MIDDLE INITIAL	DATE OF BIRTH MO. DAY YEAR

2				3			
	Do you have dependent children?	☐ Yes	☐ No		Does your spouse have a vision plan?	☐ Yes	☐ No
	Do your dependent children, if over age 18, attend school full time?	☐ Yes	☐ No				
	Are you enrolling your dependents in the VSP plan?	☐ Yes	☐ No		If yes, who is covered?	☐ Yourself ☐ Spouse ☐ Dependent	

PLEASE LIST ALL OF YOUR DEPENDENTS (IF FAMILY COVERAGE IS AVAILABLE AND SELECTED BY YOU)

4	LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY NO.	DATE OF BIRTH
	2. SPOUSE				
	3. CHILDREN (INCLUDE SURNAME IF DIFFERENT)				

PLEASE RETURN TO YOUR HUMAN RESOURCES DEPARTMENT. DO NOT RETURN TO VSP.

3/99 EML447

☐ Delete Coverage Effective: _____

Add Dependents: ☐ Spouse/DP ☐ Child(ren) Effective: _____

Delete Dependents: ☐ Spouse/DP ☐ Child(ren) Effective: _____

Spouse: Name _____ Date of Birth: _____

Address: _____

City/State/Zip: _____

Child: Name _____ Date of Birth: _____

Address: _____

City/State/Zip: _____

Child: Name _____ Date of Birth: _____

Address: _____

City/State/Zip: _____

Child: Name _____ Date of Birth: _____

Address: _____

City/State/Zip: _____

Signed: _____ Date: _____

Revised 4-30-10

Glossary of Health Coverage and Medical Terms

- This glossary has many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any such case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)
- Bold blue text indicates a term defined in this Glossary.
- See page 4 for an example showing how deductibles, co-insurance and out-of-pocket limits work together in a real life situation.

Allowed Amount

Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)

Appeal

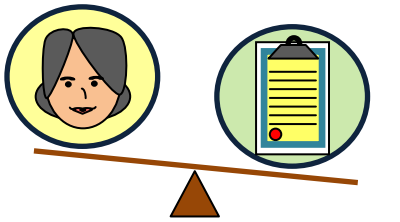
A request for your health insurer or plan to review a decision or a grievance again.

Balance Billing

When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may ***not*** balance bill you for covered services.

Co-insurance

Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay co-insurance ***plus*** any deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your co-insurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.



Jane pays 20% | Her plan pays 80%

(See page 4 for a detailed example.)

Complications of Pregnancy

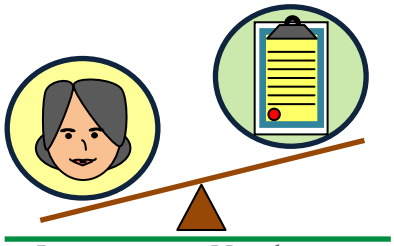
Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section aren't complications of pregnancy.

Co-payment

A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Deductible

The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.



Jane pays 100% | Her plan pays 0%

(See page 4 for a detailed example.)

Durable Medical Equipment (DME)

Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Emergency Medical Condition

An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

Emergency Medical Transportation

Ambulance services for an emergency medical condition.

Emergency Room Care

Emergency services you get in an emergency room.

Emergency Services

Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146

Excluded Services
Health care services that your health insurance or plan doesn't pay for or cover.

Grievance
A complaint that you communicate to your health insurer or plan.

Habilitation Services
Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance
A contract that requires your health insurer to pay some or all of your health care costs in exchange for a premium.

Home Health Care
Health care services a person receives at home.

Hospice Services
Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization
Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Hospital Outpatient Care
Care in a hospital that usually doesn't require an overnight stay.

In-network Co-insurance
The percent (for example, 20%) you pay of the allowed amount for covered health care services to providers who contract with your health insurance or plan. In-network co-insurance usually costs you less than out-of-network co-insurance.

In-network Co-payment
A fixed amount (for example, $15) you pay for covered health care services to providers who contract with your health insurance or plan. In-network co-payments usually are less than out-of-network co-payments.

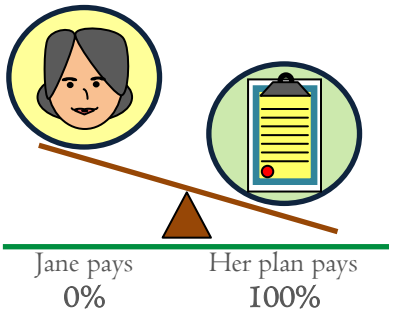
Medically Necessary
Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

Network
The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Non-Preferred Provider
A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your health insurance or plan, or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers.

Out-of-network Co-insurance
The percent (for example, 40%) you pay of the allowed amount for covered health care services to providers who do ***not*** contract with your health insurance or plan. Out-of-network co-insurance usually costs you more than in-network co-insurance.

Out-of-network Co-payment
A fixed amount (for example, $30) you pay for covered health care services from providers who do ***not*** contract with your health insurance or plan. Out-of-network co-payments usually are more than in-network co-payments.

Out-of-Pocket Limit


(See page 4 for a detailed example.)

The most you pay during a policy period (usually a year) before your health insurance or plan begins to pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges or health care your health insurance or plan doesn't cover. Some health insurance or plans don't count all of your co-payments, deductibles, co-insurance payments, out-of-network payments or other expenses toward this limit.

Physician Services
Health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan
A benefit your employer, union or other group sponsor provides to you to pay for your health care services.

Preauthorization
A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Preferred Provider
A provider who has a contract with your health insurer or plan to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

Premium
The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly or yearly.

Prescription Drug Coverage
Health insurance or plan that helps pay for prescription drugs and medications.

Prescription Drugs
Drugs and medications that by law require a prescription.

Primary Care Physician
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

Primary Care Provider
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

Provider
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), health care professional or health care facility licensed, certified or accredited as required by state law.

Reconstructive Surgery
Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

Rehabilitation Services
Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Skilled Nursing Care
Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

Specialist
A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.

UCR (Usual, Customary and Reasonable)
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

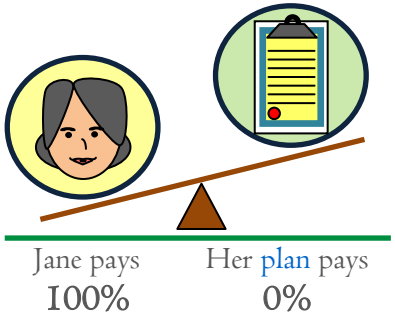
Urgent Care
Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

How You and Your Insurer Share Costs - Example

Jane's Plan Deductible: $1,500 **Co-insurance:** 20% **Out-of-Pocket Limit:** $5,000

January 1st
Beginning of Coverage Period

December 31st
End of Coverage Period

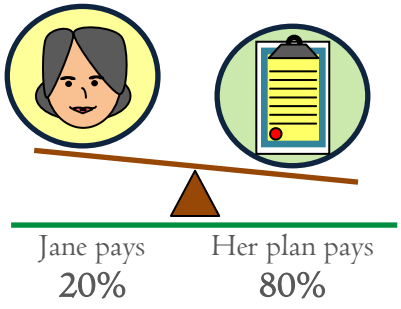


Jane hasn't reached her $1,500 deductible yet

Her plan doesn't pay any of the costs.

Office visit costs: $125
Jane pays: $125
Her plan pays: $0

more costs

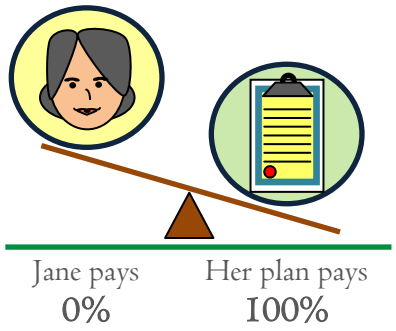


Jane reaches her $1,500 deductible, co-insurance begins

Jane has seen a doctor several times and paid $1,500 in total. Her plan pays some of the costs for her next visit.

Office visit costs: $75
Jane pays: 20% of $75 = $15
Her plan pays: 80% of $75 = $60

more costs



Jane reaches her $5,000 out-of-pocket limit

Jane has seen the doctor often and paid $5,000 in total. Her plan pays the full cost of her covered health care services for the rest of the year.

Office visit costs: $200
Jane pays: $0
Her plan pays: $200

2020

IMPORTANT NOTICES

SUPERIOR COURT OF CALIFORNIA
COUNTY OF EL DORADO

Important Notices

Newborns' and Mothers' Health Protection Act (NMHPA)

Benefits for pregnancy hospital stay (for delivery) for a mother and her newborn generally may not be restricted to less than 48 hours following a vaginal delivery or 96 hours following a cesarean section. Also, any utilization review requirements for inpatient hospital admissions will not apply for this minimum length of stay and early discharge is only permitted if the attending health care provider, in consultation with the mother, decides an earlier discharge is appropriate.

Women's Health and Cancer Rights Act (WHCRA) Annual Notice

Your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. For more information, you should review the Summary Plan Description or call your Plan Administrator at Anthem 800.727.2762 or Kaiser 800.464.6000 for more information.

Patient Protections

The medical plan requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, the plan will designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, please contact your carrier

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, please contact your carrier.

Networks/Claims/Appeals

The major medical plans described in this booklet have provider networks with Anthem. The listing of provider networks will be available to you automatically and free of charge. A list of network providers can be accessed immediately by using the Internet address found in the Summary of Benefits and Coverage that relates to the Plan. You have a right to appeal denials of claims, and a right to a response within a reasonable amount of time. Claims that are not submitted within a reasonable time may be denied. Please review your Summary Plan Description or contact the Plan Administrator for more details.

If a dependent child qualifies for the Michelle's Law extension of eligibility, the Plan will treat the dependent child as eligible for coverage until the earlier of:

- *One year after the first day of the leave of absence; or*
- *The date that Plan coverage would otherwise terminate (for reasons other than failure to be a full-time student).*

COBRA Continuation Coverage

This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally does not accept late enrollees.

Important Notices

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "Qualifying Event." Specific Qualifying Events are listed later in this notice. After a Qualifying Event, COBRA continuation coverage must be offered to each person who is a "Qualified Beneficiary." You, your spouse, and your dependent children could become Qualified Beneficiaries if coverage under the Plan is lost because of the Qualifying Event. Under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a Qualified Beneficiary if you lose coverage under the Plan because of the following Qualifying Events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan because of the following Qualifying Events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or,
- You become divorced or legally separated from your spouse.

Your dependent children will become Qualified Beneficiaries if they lose coverage under the Plan because of the following Qualifying Events:

- The parent-employee dies;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or,
- The child stops being eligible for coverage under the Plan as a "dependent child."

WHEN IS COBRA CONTINUATION COVERAGE AVAILABLE?

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator has been notified that a Qualifying Event has occurred. The employer must notify the Plan Administrator of the following Qualifying Events:

- The end of employment or reduction of hours of employment;
- Death of the employee; or,
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other Qualifying Events (e.g., divorce or legal separation of the employee and spouse, or a dependent child's losing eligibility for coverage as a dependent child, etc.), you must notify the Plan Administrator within 60 days after the Qualifying Event occurs. You must provide this notice to your employer.

Life insurance, accidental death and dismemberment benefits, and weekly income or long-term disability benefits (if part of the employer's plan), are not eligible for continuation under COBRA.

NOTICE AND ELECTION PROCEDURES

Each type of notice or election to be provided by a covered employee or a Qualified Beneficiary under this COBRA Continuation Coverage Section must be in writing, must be signed and dated, and must be mailed or hand-delivered to the Plan Administrator, properly addressed, no later than the date specified in the election form, and properly addressed to the Plan Administrator.

Each notice must include all of the following items: the covered employee's full name, address, phone number and Social Security Number; the full name, address, phone number and Social Security Number of each affected dependent, as well as the dependent's relationship to the covered employee; a description of the Qualifying Event or disability determination that has occurred; the date the Qualifying Event or disability determination occurred; a copy of the Social Security Administration's written disability determination, if applicable; and the name of this Plan. The Plan Administrator may establish specific forms that must be used to provide a notice or election.

Important Notices

ELECTION AND ELECTION PERIOD

COBRA continuation coverage may be elected during the period beginning on the date Plan coverage would otherwise terminate due to a Qualifying Event and ending on the later of the following: (1) 60 days after coverage ends due to a Qualifying Event, or (2) 60 days after the notice of the COBRA continuation coverage rights is provided to the Qualified Beneficiary.

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage rights, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver will be an election of COBRA continuation coverage. However, if a waiver is revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered to be made on the date they are sent to the employer or Plan Administrator.

HOW IS COBRA CONTINUATION COVERAGE PROVIDED?

Once the Plan Administrator receives notice that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the Qualified Beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation on behalf of their dependent children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain Qualifying Events, or a second Qualifying Event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

DISABILITY EXTENSION OF THE 18-MONTH PERIOD OF COBRA CONTINUATION COVERAGE

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. This disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF COBRA CONTINUATION COVERAGE

If your family experiences another Qualifying Event during the 18 months of COBRA continuation of coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation of coverage, for a maximum of 36 months, if the Plan is properly notified about the second Qualifying Event. This extension may be available to the spouse and any dependent children receiving COBRA continuation of coverage if the employee or former employee dies; becomes entitled to Medicare (Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second Qualifying Event would have caused the spouse or the dependent child to lose coverage under the Plan had the first Qualifying Event not occurred.

OTHER 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) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

IF YOU HAVE QUESTIONS

For more information about the Marketplace, visit www.healthcare.gov.

The U.S. Department of Health and Human Services (HHS), through the Centers for Medicare & Medicaid Services (CMS), has jurisdiction with respect to the COBRA continuation coverage requirements of the Public Health Service Act (PHSA) that apply to state and local government employers, including counties, municipalities, public school districts, and the group health plans that they sponsor (Public Sector COBRA). COBRA can be a daunting and complex area of federal law. If you have any questions or issues regarding Public Sector COBRA, you may contact the Plan Administrator or email HHS at phig@cms.hhs.gov.

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Important Notices

EFFECTIVE DATE OF COVERAGE

COBRA continuation coverage, if elected within the period allowed for such election, is effective retroactively to the date coverage would otherwise have terminated due to the Qualifying Event, and the Qualified Beneficiary will be charged for coverage in this retroactive period.

COST OF CONTINUATION COVERAGE

The cost of COBRA continuation coverage will not exceed 102% of the Plan's full cost of coverage during the same period for similarly situated non-COBRA beneficiaries to whom a Qualifying Event has not occurred. The "full cost" includes any part of the cost which is paid by the employer for non-COBRA beneficiaries.

The initial payment must be made within 45 days after the date of the COBRA election by the Qualified Beneficiary. Payment must cover the period of coverage from the date of the COBRA election retroactive to the date of loss of coverage due to the Qualifying Event (or date a COBRA waiver was revoked, if applicable). The first and subsequent payments must be submitted and made payable to the Plan Administrator or COBRA Administrator. Payments for successive periods of coverage are due on the first of each month thereafter, with a 30-day grace period allowed for payment. Where an employee organization or any other entity that provides Plan benefits on behalf of the Plan Administrator permits a billing grace period greater than the 30 days stated above, such period shall apply in lieu of the 30 days. Payment is considered to be made on the date it is sent to the Plan or Plan Administrator.

The Plan will allow the payment for COBRA continuation coverage to be made in monthly installments, but the Plan can also allow for payment at other intervals. The Plan is not obligated to send monthly premium notices.

The Plan will notify the Qualified Beneficiary, in writing, of any termination of COBRA coverage based on the criteria stated in this Section that occurs prior to the end of the Qualified Beneficiary's applicable maximum coverage period. Notice will be given within 30 days of the Plan's decision to terminate.

Such notice shall include the reason that continuation coverage has terminated earlier than the end of the maximum coverage period for such Qualifying Event and the date of termination of continuation coverage.

See the Summary Plan Description or contact the Plan Administrator for more information.

Special Enrollment Rights Notice

CHANGES TO YOUR HEALTH PLAN ELECTIONS

Once you make your benefits elections, they cannot be changed until the next Open Enrollment. Open Enrollment is held once a year.

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if there is a loss of other coverage. However, you must request enrollment no later than 30 days after that other coverage ends.

If you declined coverage while Medicaid or the Children's Health Insurance Program (CHIP) is in effect, you may be able to enroll yourself and / or your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment no later than 60 days after Medicaid or CHIP coverage ends.

If you or your dependents become eligible for Medicaid or CHIP premium assistance, you may be able to enroll yourself and / or your dependents into this plan. However, you must request enrollment no later than 60 days after the determination for eligibility for such assistance.

If you have a change in family status such as a new dependent resulting from marriage, birth, adoption or placement for adoption, divorce (including legal separation and annulment), death or Qualified Medical Child Support Order, you may be able to enroll yourself and / or your dependents. However, you must request enrollment no later than 30 days after the marriage, birth, adoption or placement for adoption or divorce (including legal separation and annulment).

For information about Special Enrollment Rights, please contact:

Human Resources
530.621.7427

Important Notices

Medicare Part D – Important Notice About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Superior Court of California, El Dorado County and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

- **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
- **Anthem and Kaiser have determined that the prescription drug coverage offered by Superior Court of California, El Dorado County Medical Plans is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

WHAT HAPPENS TO YOUR CURRENT COVERAGE IF YOU DECIDE TO JOIN A MEDICARE DRUG PLAN?

If you decide to join a Medicare drug plan, your current Superior Court of California, El Dorado County coverage will not be affected. If you keep this coverage and elect Medicare, the Superior Court of California, El Dorado County coverage will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current Superior Court of California, El Dorado County coverage, be aware that you and your dependents will be able to get this coverage back.

WHEN WILL YOU PAY A HIGHER PREMIUM (PENALTY) TO JOIN A MEDICARE DRUG PLAN?

You should also know that if you drop or lose your current coverage with the Superior Court of California, El Dorado County and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without Creditable Coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (i.e., a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

FOR MORE INFORMATION ABOUT THIS NOTICE OR YOUR CURRENT PRESCRIPTION DRUG COVERAGE

Contact the person listed below for further information. NOTE: You will get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the Superior Court of California, El Dorado County changes. You also may request a copy of this notice at any time.

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

Important Notices

FOR MORE INFORMATION ABOUT MEDICARE PRESCRIPTION DRUG COVERAGE

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number) for personalized help.
- Call 800.MEDICARE (800.633.4227). TTY users should call 877.486.2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 800.772.1213 (TTY 800.325.0778).

REMEMBER

Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained Creditable Coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	October 8, 2019
Name of Entity / Sender:	Superior Court of California, El Dorado County
Contact:	Human Resources
Address:	2850 Fairlane Court, Suite 110 Placerville, CA 95667
Phone:	530.621.7427

Availability of Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices

Superior Court of California, El Dorado County's Group Health Plan (Plan) maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. If you would like a copy of the Plan's Notice of Privacy Practices, please contact Human Resources

Important Notices

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: GENERAL INFORMATION

This notice provides you with information about Superior Court of California, El Dorado County in the event you wish to apply for coverage on the Health Insurance Marketplace. All the information you need from Human Resources is listed in this notice. If you wish to have someone assist you in the application process or have questions about subsidies that you may be eligible to receive, (for California residents only) you can contact KeenanDirect at 855.653.3626 or at www.KeenanDirect.com, or (for everyone) contact the Health Insurance Marketplace directly at www.Healthcare.gov.

WHAT IS THE HEALTH INSURANCE MARKETPLACE?

The Marketplace offers “one-stop shopping” to find and compare private health insurance options. You may also be eligible for a tax credit that lowers your monthly premium right away. Open Enrollment for health insurance coverage through Covered California is anticipated to begin November 1, 2019 and end on the following January 31. Open Enrollment for most other states will begin on November 1 and close on December 15 of each year.

CAN I SAVE MONEY ON MY HEALTH INSURANCE PREMIUMS IN THE MARKETPLACE?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer you coverage, offers medical coverage that is not “Affordable,” or does not provide “Minimum Value.” If the lowest cost plan from your employer that would cover you (and not any other members of your family) is more than 9.78% (for 2020) of your household income for the year, then that coverage is not Affordable. Moreover, if the medical coverage offered covers less than 60% of the benefits costs, then the plan does not provide Minimum Value.

DOES EMPLOYER HEALTH COVERAGE AFFECT ELIGIBILITY FOR PREMIUM SAVINGS THROUGH THE MARKETPLACE?

Yes. If you have an offer of medical coverage from your employer that is both Affordable and provides Minimum Value, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer’s medical plan.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered medical coverage. Also, this employer contribution, as well as your employee contribution to employer-offered coverage, is often excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

PART B: EXCHANGE APPLICATION INFORMATION

In the event you wish to apply for coverage on the Exchange, all the information you need from Human Resources is listed below. If you are located in California and wish to have someone assist you in the application process or have questions about subsidies that you may be eligible to receive, you can contact KeenanDirect at 855.653.3626 or at www.KeenanDirect.com.

3. Employer name Superior Court of California, El Dorado County	**4. Employer Identification Number (EIN)** 68-0459334	
5. Employer address 2850 Fairlane Court, Suite 110	**6. Employer phone number** 530.621.7414	
7. City Placerville	**8. State** CA	**9. ZIP code** 95667
10. Who can we contact about employee health coverage at this job? Human Resources		
11. Phone number (if different from above) 530.621.7427	**12. Email address** HR@eldoradocourt.org	

Important Notices

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 877.KIDS.NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your State if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 866.444.EBSA (3272).

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2019. Contact your State for more information on eligibility.

ALABAMA – Medicaid
Website: http://myalhipp.com/
Phone: 855.692.5447

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 866.251.4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 855.MyARHIPP (855.692.7447)

COLORADO – Health First Colorado
Colorado's Medicaid Program & Child Health Plan Plus (CHIP+)
Healthy First Colorado Website:
https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center: 800.221.3943
TTY: Colorado relay 711
CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus
CHP+ Customer Service: 800.359.1991
TTY: Colorado relay 711

FLORIDA – Medicaid
Website: http://flmedicaidtplrecovery.com/hipp/
Phone: 877.357.3268

GEORGIA – Medicaid
Website: http://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp/
Phone: 678.564.1162, ext. 2131

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 877.438.4479
All other Medicaid
Website: http://www.indianamedicaid.com
Phone: 800.403.0864

IOWA – Medicaid
Website:
http://dhs.iowa.gov/hawki
Phone: 800.257.8563

KANSAS – Medicaid
Website: http://www.kdheks.gov/hcf/
Phone: 785.296.3512

KENTUCKY – Medicaid
Website: http://chfs.ky.gov/agencies/dms
Phone: 800.635.2570

LOUISIANA – Medicaid
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331
Phone: 888.695.2447

MAINE – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 800.442.6003
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website:
http://www.mass.gov/eohhs/gov/departments/masshealth/
Phone: 800.862.4840

MINNESOTA – Medicaid
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp | Phone: 800.657.3739

MISSOURI – Medicaid
Website:
https://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573.751.2005

Important Notices

MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 800.694.3084

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: 855.632.7633
Lincoln: 402.473.7000
Omaha: 402.595.1178

NEVADA – Medicaid
Medicaid Website: https://dhcfp.nv.gov/
Medicaid Phone: 800.992.0900

NEW HAMPSHIRE – Medicaid
Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf
Phone: 603.271.5218
Toll-Free for the HIPP program: 800.852.3345, ext. 5218

NEW JERSEY – Medicaid and CHIP
Medicaid Website:
http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609.631.2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 800.701.0710

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 800.541.2831

NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 919.855.4100

NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 844.854.4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 888.365.3742

OREGON – Medicaid
Websites: http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 800.699.9075

PENNSYLVANIA – Medicaid
Website:
http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm
Phone: 800.692.7462

RHODE ISLAND – Medicaid
Website: http://www.eohhs.ri.gov/
Phone: 855.697.4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov
Phone: 888.549.0820

SOUTH DAKOTA - Medicaid
Website: http://dss.sd.gov
Phone: 888.828.0059

TEXAS – Medicaid
Website: http://gethipptexas.com/
Phone: 800.440.0493

UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 877.543.7669

VERMONT– Medicaid
Website: http://www.greenmountaincare.org/
Phone: 800.250.8427

VIRGINIA – Medicaid and CHIP
Medicaid Website:
http://www.coverva.org/programs_premium_assistance.cfm
Medicaid Phone: 800.432.5924
CHIP Website:
http://www.coverva.org/programs_premium_assistance.cfm
CHIP Phone: 855.242.8282

WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/
Phone: 800.562.3022, ext. 15473

WEST VIRGINIA – Medicaid
Website: http://mywvhipp.com/
Toll-free phone: 855.MyWVHIPP (855.699.8447)

WISCONSIN – Medicaid and CHIP
Website:
https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf
Phone: 800.362.3002

WYOMING – Medicaid
Website: https://wyequalitycare.acs-inc.com/
Phone: 307.777.7531

To see if any other states have added a premium assistance program since July 31, 2019, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
866.444.EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
877.267.2323, Menu Option 4, Ext. 61565

Rules for Benefit Changes During the Year

Other than during annual open enrollment, you may only make changes to your benefit elections if you experience a qualified status change or qualify for a "special enrollment". If you qualify for a mid-year benefit change, you may be required to submit proof of the change or evidence of prior coverage.

Qualified Status Changes include:

- **Change in legal marital status**, including marriage, divorce, legal separation, annulment, and death of a spouse
- **Change in number of dependents**, including birth, adoption, placement for adoption, or death of a dependent child
- **Change in employment status that affects benefit eligibility**, including the start or termination of employment by you, your spouse, or your dependent child
- **Change in work schedule**, including an increase or decrease in hours of employment by you, your spouse, or your dependent child, including a switch between part-time and full-time employment that affects eligibility for benefits
- **Change in a child's dependent status**, either newly satisfying the requirements for dependent child status or ceasing to satisfy them
- **Change in place of residence or worksite**, including a change that affects the accessibility of network providers
- **Change in your health coverage or your spouse's coverage** attributable to your spouse's employment
- **Change in an individual's eligibility for Medicare or Medicaid**
- **A court order** resulting from a divorce, legal separation, annulment, or change in legal custody (including a Qualified Medical Child Support Order) requiring coverage for your child.
- **An event that is a "special enrollment" under the Health Insurance Portability and Accountability Act (HIPAA)** including acquisition of a new dependent by marriage, birth or adoption, or loss of coverage under another health insurance plan**.**
- **An event that is allowed under the Children's Health Insurance Program (CHIP) Reauthorization Act.** Under provisions of the Act, employees have 60 days after the following events to request enrollment:
  - Employee or dependent loses eligibility for Medicaid (known as Medi-Cal in CA) or CHIP (known as Healthy Families in CA).
  - Employee or dependent becomes eligible to participate in a premium assistance program under Medicaid or CHIP.

Two rules apply to making changes to your benefits during the year:

- **Any changes you make must be consistent with the change in status, AND**
- **You must make the changes within 30 days of the date the *event* (marriage, birth, etc.) occurs (unless otherwise noted above).**

Superior Court, County of El Dorado
Benefit Contact Information At-A-Glance

Plan Name	Group Number	Phone Number	Website
Medical Plans			
Anthem Blue Cross of California		*Member Services*: 1.800.727.2762	www.anthem.com/ca
▪ EPO 25	1860UE	*Prescription Drugs*: 1.877.262.7435	www.empirx.com
▪ PPO 250	1860UN		
▪ PPO 750	1862XE		
Kaiser Permanente			
Kaiser HMO 15	600705	*Member Services:* 1.800.464.4000	www.kp.org
CompleteCare		*J&K Consultants* 1.877.872.4232 *Keenan Consultants* 1.310.212.0363 ext. 3621	
Medicare Retirees			
KeenanDirect – ph. (855) 653-3626			
Dental Plan - Delta Dental			
Claims address:			
Delta Dental of California P.O. Box 997330 Sacramento, CA 95899-7330	06140		www.deltadentalins.com
Customer Service		1.800.765.6003	
Vision Plan – VSP (Vision Service Plan)			
Out-of-Network claims:			
Vision Service Plan Attention: Claims Services P.O. Box 385018 Birmingham, AL 35238-5018	12137687-0212		www.vsp.com
VSP Customer Service		1.800.877-7195	
Other Benefits			
Life Insurance: VOYA		1.888.305.0602	
▪ Basic Employee Life and Accidental Death & Dismemberment (AD&D) Insurance	31640-7		
▪ Voluntary Employee Life and AD&D Insurance	31640-7		
▪ Dependent Life Insurance	31640-7		
Disability Plan: VOYA			
▪ Long-Term Disability	31640-7	1.888.305.0602	
Employee Assistance Program (EAP)		1.800.242.6220	www.members.mhn.com
Managed Health Network (MHN)			access code: eldoradocourt