Preferred Provider Organization (PPO)

PORAC Police & Fire Health Plan
BC PPO (non-California resident) Plan

Combined Evidence of Coverage and Disclosure Form
for the Basic Plan

Effective January 1, 2010

Sponsored by Insurance and Benefits Trust of PORAC
(Peace Officers Research Association of California)

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

COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM

Anthem Blue Cross Life and Health Insurance Company
(Anthem Blue Cross Life and Health)
21555 Oxnard Street
Woodland Hills, California 91367

Your health care coverage is insured by Anthem Blue Cross Life and Health Insurance Company (Anthem Blue Cross Life and Health), an affiliate of Anthem Blue Cross. Anthem Blue Cross Life and Health has a Group Policy (Policy) with the Insurance and Benefits Trust of the Peace Officers Research Association of California (PORAC). The following pages describe your health care benefits and include the limitations and all other Policy provisions which apply to you. The Member is referred to as "you" or "your," and Anthem Blue Cross Life and Health as "we," "us" or "our." All capitalized words have specific Policy definitions. These definitions can be found in the DEFINITIONS section of this Evidence of Coverage.

This Combined Evidence of Coverage and Disclosure Form (Evidence of Coverage) is a summary of the important terms of your health plan. The Group Policy, of which this Evidence of Coverage is a part, must be consulted to determine the exact terms and conditions of coverage. If you have special health care needs, you should read those sections of the Evidence of Coverage that apply to those needs. However, this statement of benefits, exclusions and limitations in this Evidence of Coverage is complete and is incorporated by reference into the Policy.

The Group Policy is an attachment to the Memorandum of Agreement between the Insurance and Benefits Trust of PORAC and the Board of Administration of the California Public Employees' Retirement System (CalPERS). The Memorandum of Agreement is on file and available for review in the office of the Insurance and Benefits Trust of PORAC , 4010 Truxel Road, Sacramento, CA 95834, or you may request a copy by writing to PORAC. A copy of the Memorandum of Agreement may be purchased from PORAC for a reasonable duplication charge.

If you have questions regarding your benefits, please call the PORAC - Anthem Blue Cross Life and Health customer service toll-free telephone number at:

1-800-288-6928

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ADMINISTRATIVE AND BENEFIT CHANGES

Effective January 1, 2010, the following changes have been made to your plan.

Administrative Changes

1. **Other Health Care Provider Definition.** Definition of Other Health Care Provider is changed to delete ambulatory surgical center, home health agency, facility which provides diagnostic imaging services, durable medical equipment outlet, skilled nursing facility, clinical laboratory, ad home infusion therapy provider. These providers are added to the definitions of Participating Provider and Non-Participating Provider. When a type of provider is not represented in the PPO network in the state where the Member receives services, the Participating Provider copayment level applies. See the TYPES OF PROVIDERS section on page 3 and the GENERAL DEFINITIONS section starting on page 89.

2. **Revoking or modifying an authorization.** Pre-service sections have been updated to explain how an authorization may be revoked or modified. See UTILIZATION REVIEW PROGRAMS section starting on page 35 and Prescription Drug Formulary under the PRESCRIPTION DRUG BENEFITS section on starting on page 43.

3. **Prosthetic Devices.** Removed "Therapeutic shoes and inserts for the prevention and treatment of feet complications in Members with diabetes" from the Durable Medical Equipment provision and placed it under the Prosthetic Devices provision. Shoes and inserts are considered prosthetic devices. See the MEDICAL CARE THAT IS COVERED section on page 26.

4. **Personal Items and Services exclusion.** For benefit clarification, "This exclusion does not apply to counseling for the treatment of anorexia nervosa or bulimia nervosa" was added to the Personal Items and Services exclusion. See the MEDICAL CARE THAT IS NOT COVERED section on page 32.

5. **Dental Care exclusion.** The dental care exclusion is updated to add reference to dental implant. Dental implants are not covered under the plan. See the MEDICAL CARE THAT IS NOT COVERED section on page 32.

6. **Weight Alteration Programs (Inpatient and Outpatient) exclusion.** For benefit clarification, the exclusion is re-written to clarify that dietary evaluations and counseling for the treatment of anorexia nervosa or bulimia nervosa is covered. See the MEDICAL CARE THAT IS NOT COVERED section on page 33.

7. **TTY/TTD Customer Service Number for Prescription Drugs and the Mail Service Program Address.** The Prescription Drug Benefits section has been updated to include a TTY/TDD customer service number and the mail service program is updated to reflect the current mailing address for mail-order prescription drugs. See the PRESCRIPTION DRUG BENEFITS section starting on page 43.

8. **Specialty Pharmacy Drug Program.** The customer service number for the Specialty Pharmacy Drug Program is changed to 1-877-241-3489. See Specialty Pharmacy Program under the PRESCRIPTION DRUG BENEFITS section starting on page 44.

Benefit Changes

1. **Mental or Nervous Disorders, Severe Mental Disorders and Substance Abuse.** The Mental or Nervous Disorders or Substance Abuse provision is revised to add reference to Severe Mental Disorders. All mental or nervous disorders, severe mental disorders and substance abuse will be covered as regular medical benefits. Any separate benefit limitations applicable to the Mental or Nervous Disorders and Substance Abuse benefits are deleted and the benefits will be subject to regular medical benefit and/or lifetime maximums. Changes are reflected throughout the Evidence of Coverage.

ADMINISTRATIVE AND BENEFIT CHANGES

2. **HIV Testing.** HIV testing regardless of whether the testing is related to a primary diagnosis will be covered according to the terms and conditions of this plan that apply to all other medical conditions. the MEDICAL CARE THAT IS COVERED section on page 20.

3. **CME and Transplant Services.** A Centers of Medical Excellence (CME) is added for transplant services and Members will have access to CME networks nationwide. In connection with the addition of a CME network, the Organ and Tissue Transplant provision is deleted and replaced by the Transplant Services provision. The Transplant Services are separated into non-investigational human organ or tissue transplants and Special transplants. A maximum of $30,000 per transplant is added to unrelated donor services for covered bone marrow/stem cell transplants. Specified transplants will only be covered if provided in a CME facility. Benefits for Transplant Travel in conjunction with an approved Specified transplant are added. Transplant travel is limited to $10,000 per transplant. Changes are reflected throughout the Evidence of Coverage.

Refer to the back cover for phone numbers and addresses of the plan.

BENEFITS OF THIS PLAN ARE AVAILABLE ONLY FOR SERVICES AND SUPPLIES FURNISHED DURING THE TERM THE PLAN IS IN EFFECT AND WHILE THE BENEFITS YOU ARE CLAIMING ARE ACTUALLY COVERED BY THIS PLAN.

IF BENEFITS ARE MODIFIED, THE REVISED BENEFITS (INCLUDING ANY REDUCTION IN BENEFITS OR ELIMINATION OF BENEFITS) APPLY TO SERVICES OR SUPPLIES FURNISHED ON OR AFTER THE EFFECTIVE DATE OF MODIFICATION. THERE IS NO VESTED RIGHT TO RECEIVE THE BENEFITS OF THIS PLAN.

TYPES OF PROVIDERS

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED. IF YOU HAVE SPECIAL HEALTH CARE NEEDS, YOU SHOULD CAREFULLY READ THOSE SECTIONS THAT APPLY TO THOSE NEEDS. THE MEANINGS OF WORDS AND PHRASES IN CAPITAL LETTERS ARE DESCRIBED IN THE SECTION OF THIS BOOKLET ENTITLED DEFINITIONS.

Participating Providers. There are two kinds of Participating Providers a Member can select in this plan:

- **PPO Providers** are Hospitals and Physicians who participate in a Blue Cross and/or Blue Shield Plan. These Physicians and Hospitals have agreed to provide you with health care services at a discounted rate that is generally lower than the rate charged by Traditional Providers. The amount of benefits payable under this plan will be different for Non-Participating Providers than for Participating Providers.
- **Traditional Providers** are providers who might not participate in a Blue Cross and/or Blue Shield Plan, but have agreed to provide PPO Members with health care services at a discounted rate.

Depending on the Participating Provider a Member selects, the level of benefits payable under this plan is determined as follows:

- If your identification card shows a PPO suitcase logo and:
  - You select a PPO Provider, you will get the higher level of benefits of this plan.
  - You select a Traditional Provider because there are no PPO Providers in your area, you will get the higher level of benefits of this plan.
- If your ID card does NOT have a PPO suitcase logo, you must select a Traditional Provider to get the higher level of benefits of this plan.

A directory of Participating Providers is available. You can get a directory from Anthem Blue Cross Life and Health or PORAC.

Certain categories of providers defined in this Evidence of Coverage as Participating Providers may not be available in the Blue Cross and/or Blue Shield Plan in the service area where you receive services. See How Covered Expense Is Determined in the YOUR MEDICAL BENEFITS section for additional information on how health care services you obtain from such providers are covered.

Centers of Medical Excellence. Anthem Blue Cross Life and Health is providing access to Centers of Medical Excellence (CME) network facilities to provide services for the following specified transplants: heart, liver, lung, combination heart-lung, kidney, pancreas, simultaneous pancreas-kidney, or bone marrow/stem cell and similar procedures. The CME network is comprised of the Anthem Centers of Medical Excellence and the Blue Distinction Centers for Transplant. The Centers of Medical Excellence (CME) meets specific participation criteria and offer comprehensive services through coordinated, streamlined referral management. **The specified transplants are covered only at a CME**. A participating provider in the Blue Cross and/or Blue Shield Plan is not necessarily a CME facility.

Non-Participating Providers. Non-Participating Providers are Hospitals and Physicians which have not agreed to participate in a Blue Cross and/or Blue Shield Plan. They have not agreed to the Negotiated Rates and other provisions of a Participating Provider agreement.

TYPES OF PROVIDERS

Physicians. "Physician" means more than an M.D. Certain other practitioners are included in this term as it is used throughout the plan. This doesn't mean they can provide every service that a medical doctor could; it just means that we'll cover expense you incur from them when they're practicing within their specialty the same as we would if the care were provided by a medical doctor.

Other Health Care Providers. Other Health Care Providers are neither Physicians nor Hospitals. See the definition of Other Health Care Providers in the DEFINITIONS section for a complete list of those providers. Other Health Care Providers are not participating providers.

Participating and Non-Participating Pharmacies. "Participating Pharmacies" agree to charge only the Prescription Drug Negotiated Rate (defined on page 55) to fill the prescription. You pay only your copayment amount.

"Non-Participating Pharmacies" have not agreed to the Prescription Drug Negotiated Rate. The amount that will be covered as Prescription Drug Covered Expense (defined on page 55) is significantly lower than what these providers customarily charge.

SUMMARY OF BENEFITS

THE BENEFITS OF THIS EVIDENCE OF COVERAGE ARE PROVIDED ONLY FOR SERVICES WHICH ARE CONSIDERED TO BE MEDICALLY NECESSARY. THE FACT THAT A PHYSICIAN PRESCRIBES OR ORDERS THE SERVICE DOES NOT, IN ITSELF, MAKE IT MEDICALLY NECESSARY OR A COVERED EXPENSE.

This summary provides a brief outline of your benefits. You need to refer to the entire Evidence of Coverage for complete information about the benefits, conditions, limitations and exclusions of your plan.

All benefits are subject to coordination with benefits under certain other plans.

The benefits of this plan may be subject to the THIRD PARTY LIABILITY section.

SUMMARY OF BENEFITS

MEDICAL BENEFITS

Covered Expense and the terms of this MEDICAL BENEFITS subsection do not include any amount payable under the section entitled PRESCRIPTION DRUG BENEFITS.

Calendar Year Deductibles

- Primary Deductible:

  Member Deductible.....**$300**

  Family Deductible **$900**

- For Non-Participating Providers:

  Per Member.....**Primary Deductible**
  plus Additional **$300**
  Total Calendar Year deductible for
  these providers will not exceed $600.

  Per Family .....**Primary Deductible**
  plus Additional **$900**
  Total Calendar Year deductible for
  these providers will not exceed $1,800.

Exceptions:

1. The Calendar Year Deductibles will not apply to the following services:

   a. Office visit charges by a Physician who is a Participating Provider. (This applies only to the charge for the visit itself. Deductible will apply to any other charges made during that visit, such as testing procedures, surgery, etc.)
   - The deductible WILL apply to Non-Participating Providers -

   b. Diabetes education program services provided by a Physician who is a Participating Provider.
   - The deductible WILL apply to Non- Participating Providers -

   c. Services under Routine Physical Exams.

   d. Services under Well-Child Care (preventive care).

   e. Services under Smoking Cessation Programs and Nicotine Patches.

   f. Services under Hearing Aid Benefits.

   g. Services under Nonprescription Medical Formulas.

   h. Covered Expense incurred for mammograms to detect breast cancer or prostate cancer screenings.

   i. Services for prenatal care.

   j. Covered travel expenses in connection an authorized transplant procedure at an approved Centers of Medical Excellence. Transplant travel expense coverage is available when the closest CME is 75 miles or more from the recipient's or donor's residence.

Calendar Year Deductibles (continued)

2. The following services are NOT subject to the Non-Participating Provider Deductible:
   a. Emergency or Accidental Injury services; or
   b. Charges by a type of Physician not represented in a Blue Cross and/or Blue Shield Plan (for example, an audiologist).

SUMMARY OF BENEFITS

Co-Payments

The following co-payments will apply for Covered Expense in excess of any applicable Deductible. All co-payments are subject to any maximum amounts stated under MEDICAL BENEFIT MAXIMUMS.

- **Well Child Care, Routine Physical Exams, Prenatal Care and Smoking Cessation Programs** ..... **No Co-payment**
- **Office Visits to a Participating Provider** **$20**
  (Office visits to Non-Participating Providers are subject to the 10% co-payment)
- **Diabetes Education Program services by a Physician who is a Participating Provider** **$20**
  (Non-Participating Provider services are subject to the 10% co-payment)
- **Ambulance, Durable Medical Equipment, Prosthetic Devices, Blood, Special Duty Nursing and Hearing Aid Benefits** (as shown on pages 17, 20, & 26) **20%**
- **Non-Emergency Use of Hospital Emergency Room** **50%**
- **Nicotine Patches** **50%**

ALL OTHER SERVICES NOT LISTED ABOVE:

- **For All Covered Expense** **10%**

Exceptions:

– You will not be required to pay a co-payment for transplant travel expenses in connection with an approved specified transplant performed in a CME. Transplant travel expense coverage is available when the closest CME is 75 miles or more from the recipient's or donor's residence.

– You will not be required to pay a co-payment for mammograms to detect breast cancer.

Important Note: In addition to the co-payments shown above, you will be required to pay any amount in excess of Covered Expense for the services of an Other Health Care Provider or Non-Participating Provider. In addition, expense which is applied toward any deductible, which is incurred for non-covered services or supplies, or which is in excess of the amount of Covered Expense, is the Member's responsibility and will not be applied toward your Out-of-Pocket Expense Amount.

SUMMARY OF BENEFITS

Out-Of-Pocket Expense Amount

After your or your Family Members have made the following total out-of-pocket payments for Covered Expense incurred during a Calendar Year, you will no longer be required to pay a co-payment for the remainder of that Calendar Year, but you remain responsible for costs in excess of Covered Expense for covered services provided by Non-Prudent Buyer Plan Providers and Other Health Care Providers.

- **Per Member** **$3,000***
- **Two or more Members of the same family** ..... **$6,000***†

  † Not to exceed $3,000 for any one Member.

***Exceptions:**

– Any co-payments made for the non-Emergency use of a Hospital emergency room or for Nicotine Patches will not be applied toward satisfaction of your Out-of-Pocket Expense Amount. In addition, you are required to continue to pay the co-payment for such treatment even after you have reached that amount.

– Any co-payments made for office visits to a Physician who is a Participating Provider will not be applied toward the satisfaction of your Out-of-Pocket Expense Amount. In addition, you will be required to continue to pay the co-payment for such visits even after you have reached that amount.

– Any co-payments made for diabetes education program services provided by a Physician who is a Participating Provider will not be applied toward the satisfaction of your Out-of-Pocket Expense Amount. In addition, you will be required to continue to pay the co-payment for such services even after you have reached that amount.

– Any co-payments made for donor searches for transplants will not be applied toward the satisfaction of your Out-of-Pocket Expense Amount. In addition, you will be required to continue to pay the co-payment for such services even after you have reached that amount.

– Expense which is applied toward any deductible, which is incurred for non-covered services or supplies, or which is in excess of the amount of Covered Expense, will not be applied toward your Out-of-Pocket Expense Amount.

Please read the definition of Out-of-Pocket Expense carefully, and refer to DETERMINATION OF COVERED EXPENSE to see how Covered Expense is determined.

SUMMARY OF BENEFITS

Medical Benefit Maximums

Benefits will be provided for the following services and supplies, up to the maximum amounts, or for the maximum number of days or visits shown below:

Skilled Nursing Facility

- For covered Skilled Nursing Facility care ..... **100 days** per Calendar Year

Home Health Care

- For covered Home Health Care services ..... **100 visits** per Calendar Year

Transplant Travel Expense

- For all travel expense in connection with an authorized specified transplant performed at a designated CME..... **$ 10,000** per transplant

Unrelated Donor Searches

- For all charges for unrelated donor searches for covered bone marrow/stem cell transplants..... **$ 30,000** per transplant

Physical Therapy - Physical Medicine

- For all covered services when provided by a Participating Provider ..... **20 visits** per Calendar Year
- For each covered visit when provided by a Non-Participating Provider ..... **$ 35** per visit
- For all covered services when provided by a Non-Participating Provider ..... **$ 700** per Calendar Year

SUMMARY OF BENEFITS

Medical Benefit Maximums (continued)

Well-Child Care

- For children under age 12 ..... **Unlimited visits**
- For children age 12 or over, limited to ..... **3 visits** per Calendar Year

Routine Physical Exams (for Insured Employee and spouse only)

- For all covered services and supplies ..... **$ 500** per Calendar Year

Smoking Cessation Programs

- For all covered services ..... **$ 100** during the Member's lifetime

Ambulance

- For transportation of a newborn child ..... **$ 1,000**

Hearing Aid Services

- For covered hearing aids ..... **$ 450** for each ear during any 36 month period
- Evaluation and audio metric exams provided in conjunction with purchase of a hearing aid ..... **$ 50** per visit

Nicotine Patches

- For all covered services ..... **$ 175** during the Member's lifetime, further limited to a maximum of one 90-day supply during the Member's lifetime

SUMMARY OF BENEFITS

PRESCRIPTION DRUG BENEFITS

Prescription Drug Copayments

You are responsible to pay the following copayments for each Prescription:

	Participating Pharmacy	Non-Participating Pharmacy
Retail Pharmacies		
Generic Drug	$10	$10
Formulary Brand Name Drug*	$25	$25
Non-Formulary Brand Name Drug*	$45	$45
Compound Medication	$45	Not Covered
Mail Service Program		
Generic Drug	$20	$20
Formulary Brand Name Drug*	$40	$40
Non-Formulary Brand Name Drug*	$75	$75
Specialty Pharmacy Program		
Generic Drug	$10	Not Covered
Formulary Brand Name Drug*	$25	Not Covered
Non-Formulary Brand Name Drug*	$45	Not Covered

*** Note Regarding Brand Name Drugs:** When the prescriber has not specified “dispense as written”, you will pay the copayment amount indicated above plus the difference of the Prescription Drug Covered Expense between the Generic Drug and the Brand Name Drug.

YOUR MEDICAL BENEFITS

HOW COVERED EXPENSE IS DETERMINED

We will pay for Covered Expense you incur under this plan. A charge is incurred when the service or supply giving rise to the charge is rendered or received. Covered Expense for medical benefits is based on a maximum charge for each covered service or supply that will be accepted by us for each different type of provider. It is not necessarily the amount a provider bills for the service.

Participating Providers and Centers of Medical Excellence (CME). The maximum Covered Expense for services provided by a participating provider or CME will be the lesser of the billed charge or the Negotiated Rate. Participating providers and CMEs have agreed not to charge you more than the Negotiated Rate for covered services. When you choose a Participating Provider, you will not be responsible for any amount in excess of the Negotiated Rate. If you receive an authorized, specified transplant at a CME, you will not be responsible for any amount in excess of the Negotiated Rate for the covered services of a CME.

If you go to a Hospital which is a Participating Provider, you should not assume all providers in that Hospital are also Participating Providers. To receive the greater benefits afforded when covered services are provided by a Participating Provider, you should request that all your provider services be performed by Participating Providers whenever you enter a Hospital.

Note: If you receive covered medical services from a type of provider listed in the DEFINITIONS section under Other Health Care Provider and that provider is of a type represented in the network of the on-site Blue Cross and/or Blue Shield Plan at the time you receive services, such provider will be considered a Participating Provider for the purposes of determining Covered Expense.

If a provider defined in this Evidence of Coverage as a Participating Provider is of a type not represented in the local Blue Cross and/or Blue Shield Plan at the time you receive services, such provider will be considered a Non-Participating Provider for the purposes of determining Covered Expense.

Non-Participating Providers and Other Health Care Providers. The maximum Covered Expense for services provided by a Non-Participating Provider or Other Health Care Provider will always be the lesser of the billed charge or (1) for a Physician, the Customary and Reasonable Charge or (2) for other than a Physician, the Reasonable Charge. You will be responsible for any billed charge which exceeds the Customary and Reasonable Charge or the Reasonable Charge.

The maximum Covered Expense for Non-Participating Providers for services and supplies provided in connection with Cancer Clinical Trials will be the lesser of the billed charge or the amount that ordinarily applies when services are provided by a Participating Provider.

Exception: If Medicare is the primary payer, Covered Expense does not include any charge:

1. By a Hospital, in excess of the approved amount as determined by Medicare; or
2. By a Physician or Other Health Care Provider, in excess of the lesser of the maximum Covered Expense stated above, or:
    a. For providers who accept Medicare assignment, the approved amount as determined by Medicare; or
    b. For providers who do not accept Medicare assignment, the limiting charge as determined by Medicare.

YOUR MEDICAL BENEFITS

You will always be responsible for expense incurred which is not covered under this plan.

DEDUCTIBLES, CO-PAYMENTS, OUT-OF-POCKET EXPENSE AMOUNT AND MEDICAL BENEFIT MAXIMUMS

After we subtract any applicable deductible and your co-payment, we will pay benefits up to the amount of Covered Expense, not to exceed the applicable Medical Benefit Maximum. The Deductible amounts, Co-Payments, Out-of-Pocket Expense Amount and Medical Benefit Maximums are set forth in the SUMMARY OF BENEFITS.

DEDUCTIBLES

Each deductible under this plan is separate and distinct from the other. Only charges that are considered Covered Expense will apply toward satisfaction of any deductible.

Primary Deductible: Each Member must initially meet a deductible amount of $300.00 each calendar Year for applicable services (see pages 6 & 7 for services which are not subject to the deductible). Once that amount has been reached there is no further deductible for that Member that Year for covered expense incurred when services are received from the following providers:

1. Participating Providers and CMEs,
2. Other Health Care Providers,
3. Non-Participating Provider Physicians whose specialty is not represented in the Blue Cross and/or Blue Shield Plan, and
4. Non-Participating Provider Physicians/Hospitals for Emergency Care or Accidental Injury.

A family must initially meet a deductible amount of $900.00 each calendar Year. Once that amount has been reached, there is no further deductible required for that family for the remainder of that Year when covered services are received from the providers listed above.

Non-Participating Provider Deductible. Charges for covered expense incurred for services rendered by a Non-Participating Provider Hospital or Non-Participating Provider Physician (except as stated above) are subject to an additional $300.00 deductible for each Member and to an additional $900.00 deductible for each family. **In no event will the deductible exceed $600.00 for each Member or $1,800.00 for each family during a Year.**

Deductible Carryover. Covered Expense incurred during October, November or December of any Year and applied toward the deductible for that Year will also apply toward the deductible for the next Year.

YOUR MEDICAL BENEFITS

CO-PAYMENTS

After you have satisfied any applicable deductible, we will subtract your co-payment from the amount of Covered Expense remaining.

If your co-payment is a percentage, we will apply the applicable percentage to the amount of Covered Expense remaining after any deductible has been met. This will determine the dollar amount of your co-payment.

If you receive services from an Other Health Care Provider of a type participating in a Blue Cross and/or Blue Shield Plan, your Co-Payment if you go to a provider participating in the Blue Cross and/or Blue Shield Plan will be the same as for a Participating Provider shown in the section SUMMARY OF BENEFITS CO-PAYMENTS.

OUT-OF-POCKET EXPENSE AMOUNT

Satisfaction of the Out-of-Pocket Expense Amount. If, after you have met your Calendar Year Deductible, you pay co-payments equal to the Out-of-Pocket Expense Amount per Member during a Calendar Year, you will no longer be required to make co-payments for any additional Covered Expense you incur during the remainder of that Year. If two or more Members in a family pay co-payments during a Year equal to the Out-of-Pocket Expense Amount shown for two or more Members of the same family, no further co-payments will be required from any Member of that family for the remainder of that Year.

Charges Which Do Not Apply Toward the Out-of-Pocket Expense Amount. Only charges that are considered Covered Expense will apply toward satisfaction of any Out-of-Pocket Amount. In addition, any expense applied to a deductible will not be applied toward an Out-of-Pocket Amount.

Any co-payments made for the non-Emergency use of a Hospital emergency room, Nicotine Patches, diabetes education program services by a Physician who is a Participating Provider, donor searches for transplants, and office visits to Physicians who are Participating Providers will not be applied toward satisfaction of your Out-of-Pocket Expense Amount. In addition, you will be required to continue to pay the co-payment for such services even after you have reached that amount.

MEDICAL BENEFIT MAXIMUMS

We do not make benefit payments for any Member in excess of any of the Medical Benefit Maximums.

YOUR MEDICAL BENEFITS

CONDITIONS OF COVERAGE

The following conditions of coverage must be met for expense incurred for services or supplies to be considered as Covered Expense.

1. You must incur this expense while you are covered under this plan. Expense is incurred on the date you receive the service or supply for which the charge is made.
2. The expense must be for a medical service or supply furnished to you as a result of illness or injury or pregnancy, unless a specific exception is made.
3. The expense must be for a medical service or supply included in MEDICAL CARE THAT IS COVERED. Additional limits on Covered Expense are included under specific benefits and in the SUMMARY OF BENEFITS.
4. The expense must not be for a medical service or supply listed in MEDICAL CARE THAT IS NOT COVERED. If the service or supply is partially excluded, then only that portion which is not excluded will be considered Covered Expense.
5. The expense must not exceed any of the maximum benefits or limitations of this plan.
6. Any services received must be those which are regularly provided and billed by the provider. In addition, those services must be consistent with the illness, injury, degree of disability and your medical needs. Benefits are provided only for the number of days required to treat your illness or injury.
7. All services and supplies must be ordered by a Physician.

YOUR MEDICAL BENEFITS

MEDICAL CARE THAT IS COVERED

The benefits provided in this Evidence of Coverage are subject to applicable 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 your state has such requirements, we will adjust your benefits to meet the minimum requirements.

Subject to the Medical Benefit Maximums in the SUMMARY OF BENEFITS, the requirements set forth under CONDITIONS OF COVERAGE and the exclusions or limitations listed under MEDICAL CARE THAT IS NOT COVERED, we will provide benefits for the following services and supplies:

Acupuncture. The services of a Physician for acupuncture treatment to treat a disease, illness or injury, including a patient history visit, physical examination, treatment planning and treatment evaluation, electro-acupuncture, cupping and moxibustion.

Allergy. Allergy testing and Physician services for allergy injections.

Ambulance. The following ambulance services:

1. Base charge, mileage and non-reusable supplies of a licensed ambulance company for ground service to transport a Member to and/or from a Hospital or Skilled Nursing Facility.
2. Emergency services or transportation services that are provided to a Member by a licensed ambulance company as a result of a "911" emergency response system* request for assistance if the Member believes they have an Emergency medical condition requiring such assistance.
3. Base charge, mileage and non-reusable supplies of an air ambulance from the area where the Member is first disabled to transport a Member to the nearest Hospital or Skilled Nursing Facility where appropriate treatment is provided, and only if, such services are Medically Necessary and ground ambulance service is inadequate.
4. Monitoring, electrocardiograms (EKGs or ECGs), cardiac defibrillation, cardiopulmonary resuscitation (CPR) and administration of oxygen and intravenous (IV) solutions in connection with ambulance service. An appropriately licensed person must render the services.
5. With respect to a newborn child, we will pay up to a maximum of **$1,000** for transportation to and from the nearest facility qualified to treat a newborn child's condition when certified by the Physician (M.D.) as Medically Necessary.

∗ If you have an Emergency medical condition that requires an emergency response, please call the "911" emergency response system if you are in an area where the system is established and operating.

Biofeedback Procedures.

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

Breast Cancer. Services and supplies provided in connection with the screening for, diagnosis of, and treatment for breast cancer, including:

1. Routine and diagnostic mammogram examinations.

2. Mastectomy and lymph node dissection; complications from a mastectomy including lymphedema.
3. Reconstructive surgery performed to restore and achieve symmetry following a Medically Necessary mastectomy.
4. Breast prostheses following a mastectomy (see the Prosthetic Devices provision on page 26).

Cancer Clinical Trials. Coverage is provided for services and supplies for routine patient care costs, as defined below, in connection with phase I, phase II, phase III and phase IV cancer clinical trials if all of the following conditions are met:

1. The treatment provided in a clinical trial must either:
   a. Involve a Drug that is exempt under federal regulations from a new drug application, or
   b. Be approved by (i) one of the National Institutes of Health, (ii) the federal Food and Drug Administration (FDA) in the form of an investigational new drug application, (iii) the United States Department of Defense, or (iv) the United States Veteran's Administration.
2. You must be diagnosed with cancer to be eligible for participation in these clinical trials.
3. Participation in such clinical trials must be recommended by your Physician after determining participation has a meaningful potential to benefit the Member.
4. For the purpose of this provision, a clinical trial must have a therapeutic intent. Clinical trials to just test toxicity are not included in this coverage.

Routine patient care costs means the costs associated with the provision of services, including drugs, items, devices and services which would otherwise be covered under the plan, including health care services which are:

1. Typically provided absent a clinical trial.
2. Required solely for the provision of the investigational drug, item, device or service.
3. Clinically appropriate monitoring of the investigational item or service.
4. Prevention of complications arising from the provision of the investigational drug, item, device, or service.
5. Reasonable and necessary care arising from the provision of the investigational drug, item, device, or service, including the diagnosis or treatment of the complications.

Routine patient care costs do not include the costs associated with any of the following:

1. Drugs or devices not approved by the FDA that are associated with the clinical trial.
2. Services other than health care services, such as travel, housing, companion expenses and other nonclinical expenses that you may require as a result of the treatment provided for the purposes of the clinical trial.
3. Any item or service provided solely to satisfy data collection and analysis needs not used in the clinical management of the patient.

4. Health care services that, except for the fact they are provided in a clinical trial, are otherwise specifically excluded from the plan.
5. Health care services customarily provided by the research sponsors free of charge to Members enrolled in the trial.

Note: You will be financially responsible for the costs associated with non-covered services.

Disagreements regarding the coverage or medical necessity of possible clinical trial services may be subject to Special Independent Medical Reviews as described in CLAIMS REVIEW / GRIEVANCE PROCEDURES.

Cervical Cancer Screening. Services and supplies provided in connection with a routine test to detect cervical cancer, including pap smears, human papillomavirus (HPV) screening, and any cervical cancer screening test approved by the FDA will be covered upon referral by your Physician.

Contraceptives. Services and supplies provided in connection with the following methods of contraception:

1. Injectable drugs and implants for birth control, administered in a Physician's office, if Medically Necessary.
2. Intrauterine contraceptive devices (IUDs) and diaphragms, dispensed by a Physician if Medically Necessary.
3. Professional services of a Physician in connection with the prescribing, fitting, and insertion of intrauterine contraceptive devices or diaphragms.

If your Physician determines that none of these contraceptive methods are appropriate for you based on your medical or personal history, coverage will be provided for another prescription contraceptive method that is approved by the FDA and prescribed by your Physician.

Dental Care

1. **Admissions for Dental Care.** Listed inpatient Hospital services during a Hospital Stay or Ambulatory Surgical Center services when required for dental treatment and ordered by a Physician (M.D.) and a Dentist (D.D.S. or D.M.D.). We will make the final determination as to whether the dental treatment could have been safely rendered in another setting due to the nature of the procedure or your medical condition. Hospital Stays for the purpose of administering general anesthesia are not considered Medically Necessary and are not covered except as specified below.
2. **General Anesthesia.** General anesthesia and associated facility charges when your clinical status or underlying medical condition requires that dental procedures be rendered in a Hospital or Ambulatory Surgical Center. This applies only if (a) the Member is less than eight years old, (b) the Member is developmentally disabled, (c) the Member's health is compromised and general anesthesia is Medically Necessary, or (d) the Member has suffered extensive facial or dental trauma. Charges for the dental procedure itself, including professional fees of a dentist, are not covered.
3. **Dental Injury.** Services of a Physician (M.D.) or Dentist (D.D.S. or D.M.D.) solely to treat an Accidental Injury to natural teeth. Coverage shall be limited to only such services that are Medically Necessary to repair the damage done by the Accidental Injury and/or restore function lost as a direct result of the Accidental Injury. Damage to natural teeth due to chewing or biting is not Accidental Injury.

Diabetes Education Program. A diabetes education program which: (1) is designed to teach a Member who is a patient and covered Members of the patient's family about the disease process and the daily management of diabetic therapy; (2) includes self-management training, education, and medical nutrition therapy to enable the Member to properly use the equipment, supplies, and medications necessary to manage the disease; and (3) is supervised by a Physician. Diabetes education services are covered under plan benefits for office visits to Physicians.

Diagnostic Services. Outpatient diagnostic radiology and laboratory services, including Infertility testing. Certain imaging procedures, including, but not limited to, Magnetic Resonance Imaging (MRI), Computer Axial Tomography (CAT scans), Positron Emission Tomography (PER scan), Magnetic Resonance Spectroscopy (MRS scan), Magnetic Resonance Angiogram (MRA scan) and Nuclear Cardiac Imaging are subject to pre-service review to determine medical necessity. See the UTILIZATION REVIEW PROGRAMS section beginning on page 35 for details.

Durable Medical Equipment. Rental or purchase of dialysis equipment. Dialysis supplies. Nebulizers, including face masks and tubing, when required for the Medically Necessary treatment of pediatric asthma. Rental or purchase of other durable medical equipment and supplies which are:

a. Ordered by a Physician, and

b. Of no further use when medical need ends (but not disposable), and

c. Usable only by the patient, and

d. Not primarily for the Member's comfort or hygiene, and

e. Not for environmental control, and

f. Not for exercise, and

g. Manufactured specifically for medical use.

Rental charges that exceed the reasonable purchase price of the equipment are not covered. We will determine whether the item meets the above conditions.

Hearing Aid Services. The following hearing aid services:

1. Hearing aids, including replacements, only when purchased as a result of a written recommendation by a Physician certified as either an otologist, an otolaryngologist or a state certified audiologist. Benefits are limited to one hearing aid per ear during any **36** month period. Benefits are further limited to a maximum payment of **$450** for each hearing aid.

2. Evaluation and audio-metric examinations to measure the extent of hearing loss and determine the most appropriate make and model of hearing aid, up to a maximum payment of **$50** per visit.

HIV Testing. Human immunodeficiency virus (HIV) testing, regardless of whether the testing is related to a primary diagnosis. This coverage is provided according to the terms and conditions of this plan that apply to all other medical conditions.

Home Health Care. The following services and supplies when provided by a Home Health Care Agency:

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

2. Services of a licensed therapist for physical therapy, occupational therapy, respiratory therapy or speech therapy.
3. Services of a medical social service worker.
4. Services of a health aide who is employed by (or under arrangement with) a Home Health Agency. Services must be ordered and supervised by a registered nurse employed by the Home Health Agency as professional coordinator. These services are only covered if the Member is also receiving the services listed in 1. or 2. above.
5. Necessary medical supplies provided by the Home Health Agency.

Benefits are limited to a combined number of **100 visits** for all providers of service listed above during a Calendar Year. A home health visit is defined as a skilled nursing visit (RN or LVN) or other professional visit (physical therapist, speech therapist, social worker or respiratory therapist). Four hours of service by the certified home health aide is defined as one home health visit.

The Member must be confined at home under the active medical supervision of the Physician ordering home health care and treating the illness or injury for which that care is needed. Services must not be provided for Custodial Care.

Home Infusion Therapy. The following services and supplies when provided by a Home Infusion Therapy Provider in the Member's home for the intravenous administration of a Member's total daily nutritional intake or fluid requirements, medication related to illness or injury, chemotherapy, antibiotic therapy, aerosol therapy, tocolytic therapy, special therapy, intravenous hydration, or pain management:

1. Medication, ancillary medical supplies and supply delivery, (not to exceed a 14-day supply); however, medication which is delivered but not administered is not covered;
2. Pharmacy compounding and dispensing services (including pharmacy support) for intravenous solutions and medications;
3. Hospital and home clinical visits related to the administration of infusion therapy, including skilled nursing services including those provided for: (a) patient or alternative caregiver training; and (b) visits to monitor the therapy;
4. Rental and purchase charges for durable medical equipment (as shown below); maintenance and repair charges for such equipment;
5. Laboratory services to monitor the patient's response to therapy regimen.

Hospice Care. The following services and supplies are covered when provided by an approved Hospice for the palliative treatment of pain and other symptoms associated with a terminal illness. The Member must be suffering from a terminal illness for which the prognosis of life expectancy is one year or less, as certified by a Physician and submitted to us. Covered services are available on a 24-hour basis for the management of the condition.

1. Interdisciplinary team care with the development and maintenance of an appropriate plan of care.
2. Short-term inpatient Hospital care, including services and supplies, when required in periods of crisis or as respite care. Coverage of inpatient respite care is provided on an occasional basis and is limited to a maximum of five consecutive days per admission.

3. Skilled nursing services provided by or under the supervision of a registered nurse.
4. Services of a licensed therapist for physical therapy, occupational therapy, respiratory therapy and speech therapy.
5. Social services and counseling services provided by a qualified social worker.
6. Certified home health aide services and homemaker services provided under the supervision of a registered nurse.
7. Nutritional support such as intravenous feeding or hyperalimentation.
8. Dietary and nutritional guidance.
9. Bereavement services, including assessment of the needs of the bereaved family and development of a care plan to meet those needs, both prior to and following the Member's death. Bereavement services are available to surviving members of the immediate family for a period of one year after the Member's death. Immediate family means spouse, children, step-children, parents and siblings.
10. Pharmaceuticals, medical equipment and supplies necessary for the management of your condition. Oxygen and related respiratory therapy supplies.
11. Volunteer service provided by trained Hospice volunteers under the direction of a Hospice staff member.12. Palliative care (care which controls pain and relieves symptoms but does not cure) which is appropriate for the Member's illness.

The Member's Physician must consent to care by the Hospice and must be consulted in the development of the treatment plan. The Hospice must submit a written patient treatment plan to us every 30 days.

Special Hospice Care Exclusions. In addition to the MEDICAL CARE THAT IS NOT COVERED listed elsewhere in this Evidence of Coverage, the following exclusions apply:

1. Food, home-delivered meals or housing charges.
2. Transportation charges.
3. Any services which would normally be provided free of charge.
4. Services provided in the areas of both legal and/or financial advice (preparation and execution of wills; estate planning and liquidation; financial investment, etc.).
5. Counseling by clergy or any volunteer group.
6. Personal comfort items.
7. Private duty nursing (a continuous bedside nursing service rendered by one nurse to one patient, either in a Hospital, Hospice facility or patient's home, as opposed to a general-duty nurse, who renders services to a number of Hospital or Hospice facility patients), except during periods of crisis to provide management of acute medical symptoms.

Hospital - Inpatient. The following services and supplies are a covered expense when provided by a Hospital:

1. Accommodations in a room of two or more beds, or the prevailing charge for two-bed room accommodations in that Hospital if a private room is used, unless your Physician orders, and we authorize, a private room as Medically Necessary.

2. Services in Special Care Units.
3. Operating, delivery and special treatment rooms.
4. Supplies and ancillary services including laboratory, cardiology, pathology and radiology. Professional component fees for these services will be covered only if a separate charge for professional interpretation is determined by us to be Medically Necessary.
5. Physical therapy, radiation therapy, chemotherapy and hemodialysis treatment.
6. Drugs and medicines approved for general use by the FDA which are supplied by the Hospital for use during the Member's Stay.
7. Blood transfusions, including blood processing and the cost of unreplaced blood and blood products.

Inpatient Hospital services are subject to utilization review to determine medical necessity. Please refer to the UTILIZATION REVIEW PROGRAMS section beginning on page 35 for information on how to obtain the proper reviews.

Hospital - Outpatient. The following services and supplies, when provided by a Hospital.

1. Emergency room use, supplies, ancillary services, professional services, drugs and medicines as listed above.
2. Care received when outpatient surgery is performed. Covered services are operating room use, supplies, ancillary services, drugs and medicines as listed above. These services are also payable when outpatient surgery is performed at an Ambulatory Surgical Center.
3. Radiation therapy, chemotherapy and dialysis treatment.
4. Routine radiology and laboratory exams received within seven days prior to a covered Stay for inpatient or outpatient surgery. The exams must be needed for the illness, injury or condition necessitating the Stay, and must be provided and billed by the Hospital or Ambulatory Surgical Center where the surgery is to take place.

Infertility Treatment. Services and supplies provided in connection with diagnosis and treatment of Infertility, provided that:

1. The Infertility procedure is non-Experimental. Such procedures include, but are not limited to: (a) artificial insemination; (b) in vitro fertilization and embryo placement; and (c) sperm, egg and/or inseminated egg procurement, processing and banking, to the extent such charges are not covered by the donor's own coverage.
2. You are presumably otherwise healthy but are unable to conceive or produce conception during a period of at least one year prior to the beginning of treatment.
3. The procedures are performed at a medical facility that meets (a) the American College of Obstetric and Gynecology guidelines for Infertility clinics; or (b) the American Fertility Society's minimal standards for Infertility programs.

Covered Expense will not include charges if: (1) the Infertility resulted from voluntary sterilization; (2) the embryo is implanted for any period of time in a woman other than the Member; or (3) the procedure is Experimental.

Jaw Joint Disorders. We will pay for splint therapy or surgical treatment for disorders or conditions of the joints linking the jawbones and the skull (the temporomandibular joints), including the complex of muscles, nerves and other tissues related to those joints.

Mental or Nervous Disorders, Severe Mental Disorders or Substance Abuse. Covered services shown below for the treatment of Mental or Nervous Disorders, Severe Mental Disorders or substance abuse, provided such services offer a reasonable expectation of improvement, and are the lowest level of care consistent with safe medical practice.

1. Inpatient Hospital services as stated in the "Hospital" provision of this section and services from a Residential Treatment Center.
2. Visits to a Day Treatment Center.
3. Physician's visits during a covered inpatient Stay or for outpatient psychotherapy or psychological testing or outpatient rehabilitative care (such as physical therapy, occupational therapy, or speech therapy) for the treatment of Mental or Nervous Disorders, Severe Mental Disorders or substance abuse.

Treatment for substance abuse does not include smoking cessation programs, nor treatment for nicotine dependency or tobacco use.

Nicotine Patches

After successfully completing one of the approved Smoking Cessation Programs specified on pages 27 & 28 and submitting a Certificate of Completion, benefits are provided for one 90-day supply of nicotine patches per lifetime. Benefits are further limited to a maximum of **$175.00** per Member per lifetime.

To qualify for reimbursement of the Nicotine Patch, the Member must pay the full cost of the drug, submit the receipt, Certification of Completion of one of the approved programs specified above, and a completed Reimbursement Form to the PORAC- Claims Unit.

Nonprescription Medical Formulas. Non-prescription medical formulas upon written order of a Physician for:

1. Treatment of impaired absorption of nutrients caused by disorders of the gastrointestinal tract.
2. Treatment of a Member with an inborn error of metabolism that involve amino acid, carbohydrate and fat metabolism. This includes medical foods to be consumed or given enterally under supervision of a Physician that are:
   a. Specifically formulated to be distinct in one or more nutrients present in natural foods; and
   b. Intended for the medical and nutritional management of patients with limited capacity to metabolize ordinary foods or certain nutrients contained in ordinary foods.

Other Cancer Screening Tests. Services and supplies provided in connection with all generally medically accepted cancer screening tests. This coverage is provided according to the terms and conditions of this Evidence of Coverage that apply to all other medical conditions.

Outpatient Drugs and Medicines. Benefits are provided for outpatient drugs and medicines approved for general use by the FDA, including intravenous drugs, that are available only if prescribed by a Physician. The drug or medicine must be:

a. dispensed by a Physician, or

b. administered by a Physician or an individual licensed to administer drugs and medicines under the supervision of a Physician.

Exceptions: The following are not included:

- Drugs which are sold by a retail pharmacy and prescribed for the Member to self-administer. (See pages 43 through 55 for your PRESCRIPTION DRUG BENEFITS.)
- Intravenous drugs in a setting other than a Physician's office or the outpatient department of a Hospital.

Physical Therapy - Physical Medicine. The following services provided by a Physician under a treatment plan:

1. Physical therapy and physical medicine provided on an outpatient basis for the treatment of illness or injury, including therapeutic use of heat, cold, exercise, electricity, ultra violet radiation, manipulation of the spine or massage for the purpose of improving circulation, strengthening muscles, or encouraging the return of motion. (This includes many types of care which are customarily provided by chiropractors, physical therapists and osteopaths.)

2. Occupational therapy provided on an outpatient basis when the ability to perform daily life tasks has been lost or reduced by illness or injury, including programs which are designed to rehabilitate mentally, physically or emotionally handicapped persons. Occupational therapy programs which are designed to maximize or improve a patient's upper extremity function, perceptual motor skills and ability to function in daily living activities.

Benefits are **not** payable for care provided to relieve general soreness or for conditions that are expected to improve without treatment. The Member must not be receiving benefits listed in **Home Health Care** or **Hospice.**

Up to a combined maximum of **20** visits in a Year for all covered services provided by a Participating Provider are payable. But, if an additional period of physical therapy, physical medicine or occupational therapy is Medically Necessary, Anthem Blue Cross Life and Health will specify a specific number of additional visits. For the purposes of this benefit, the term "visit" shall include any visit by a Physician in that Physician's office, or in any other outpatient setting, during which one or more of the services covered under this limited benefit are rendered, even if other services are provided during the same visit.

Such additional visits are not payable if pre-service review is not obtained. (See UTILIZATION REVIEW PROGRAMS beginning on page 35.)

For the services of a Non-Participating Provider only, our maximum payment is limited to **$35** for each visit and **$700** per Member each Calendar Year.

Pregnancy, Maternity Care and Family Planning

1. All medical benefits when provided for pregnancy, maternity care and abortion. Inpatient Hospital benefits in connection with childbirth will be provided for at least 48 hours following a normal delivery or 96 hours following a cesarean section, unless the mother and her Physician decide on an earlier discharge.
2. Services listed under **Hospital** for routine nursery care of a newborn child if the child's natural mother is an enrolled Member.
3. Services provided by an approved Alternative Birth Center and a certified nurse midwife are included.
4. All plan benefits when provided for sterilizations, Infertility studies and treatment of Infertility. In no event will benefits of this Evidence of Coverage be provided for or in connection with sterilization reversal or contraceptive devices (other than Prescription oral contraceptives as stated under PRESCRIPTION DRUG BENEFITS or as specifically stated in **Contraceptives** under MEDICAL CARE THAT IS COVERED).

Professional Services

1. Services of a Physician, including, but not limited to, acupuncture.
2. Services of an anesthetist (M.D. or C.R.N.A.).
3. Services of a registered nurse for special duty nursing care.
4. Education for pediatric asthma, including education to enable the child to properly use nebulizers (covered under Durable Medical Equipment benefits), inhaler spacers and peak flow meters (See PRESCRIPTION DRUG BENEFITS). This education will be covered under the plan's benefit for office visits to a Physician.

Prostate Cancer Screening. Services and supplies provided in connection with routine tests to detect prostate cancer.

Prosthetic Devices

1. Surgical implants including breast prosthesis following a mastectomy.
2. Artificial limbs or eyes, including services of an orthotist and prosthetist in connection with evaluation or fitting of an orthotic or prosthetic device when services are billed as part of the charge for the artificial limbs or eyes.
3. The first pair of contact lenses or the first pair of eyeglasses when required as a result of a covered and Medically Necessary eye surgery.
4. Scalp hair prostheses when required as a result of hair loss due to alopecia areata or alopecia totalis, or permanent hair loss due to injury.
5. Corrective lenses for conditions related to an inborn error of metabolism.
6. Therapeutic shoes and inserts for the prevention and treatment of feet complications in Members with diabetes.

Radiation therapy**, chemotherapy** and **hemodialysis** treatment. See Hospital – Outpatient on page 23 for benefit information.

Reconstructive Surgery. Reconstructive surgery performed to correct deformities caused by congenital or developmental abnormalities, illness, or injury for the purpose of improving bodily function or symptomatology or creating a normal appearance.

Routine Physical Exam (for Insured Employee and spouse only). Physician's services and diagnostic radiology or laboratory services and tests ordered by the examining Physician in connection with a routine physical exam, including pap smears and breast examinations on Physician's referral, subject to a maximum payment of **$500** per Calendar Year. Electron Beam Tomography (ETB) diagnostic services and self-referred colonoscopy are covered for the Insured Employee ONLY and are subject to the same $500 per Year maximum. After the maximum payment under this Routine Physical Exam benefit has been paid, certain cancer screenings will be covered, according to the terms and conditions of this plan that apply to all other medical conditions, under the provisions described in Breast Cancer, Cervical Cancer Screening and Prostate Cancer Screening.

Note: The Member must always inform the Physician that the purpose of the visit is to receive a routine physical examination. This will insure that the benefits for routine physical examinations are correctly provided.

Skilled Nursing Facility. The following services and supplies, when provided by a Skilled Nursing Facility, for up to **100** days during each Year.

1. Accommodations in a room of two or more beds, or the prevailing charge for two-bed room accommodations in that facility if a private room is used.
2. Special treatment rooms.
3. Laboratory exams.
4. Physical, occupational and speech therapy. Oxygen and other gas therapy.
5. Drugs and medicines approved for general use by the FDA which are used in the facility.
6. Blood transfusions, including blood processing and the cost of unreplaced blood and blood products.

Smoking Cessation Programs. Benefits are provided for Covered Expense incurred up to a maximum of **$100** per lifetime for approved behavior modifying smoking cessation programs. Behavior modification does not consist of hypnosis, shock therapy, acupressure, acupuncture or other similar methods to alter behavior. Benefits are provided when verification of completion of one of the following approved programs is submitted to us:

Class Supported Programs:

1. American Lung Association - "Freedom From Smoking". Call 1-800-586-4872 or your local lung association office or visit the Web site at www.lungusa.org for information.
2. Medical clinic or Hospital-based programs. Consult your Physician or local community Hospital for information.

Self Help Program: The Smokenders program is a 7-week audio cassette self help program that is available only to Members who live beyond 25 miles from approved class-supported program locations or who work shifts that are not compatible with class-supported programs. We have negotiated a significant discount for Smokenders kits, which must be obtained by requesting a special coupon. To determine your eligibility for the Smokenders program and to obtain a Smokenders coupon, call the PORAC- customer service unit. Note: Smokenders programs purchased from any other source will not be reimbursed.

Benefits will be provided subject to the following:

1. The Member must enroll in an approved Smoking Cessation Program and retain the payment receipt.
2. The Member must request a Health Promotion Program Reimbursement Form and a certificate of Completion from the PORAC - customer service unit.
3. The Member must obtain the instructor's signature on the Certificate of Completion, verifying that he or she has completed the program, attended every session and that the Member is smoke free at the time of the program's completion.
4. The Member must mail a copy of the signed Certificate of Completion and Reimbursement Form with the receipt to us for reimbursement.

Transplant Services. Services provided in connection with non-Investigational human organ or tissue transplants, such as skin or cornea transplants, if for:

1. a Member who is the organ or tissue recipient, or
2. a Member who is the organ or tissue donor, or
3. an organ or tissue donor who is not a Member, when the organ or tissue recipient is a Member. Benefits are reduced by any amounts paid or payable by that donor's own health plan.

Covered Expense for a donor, including donor testing and donor search, is limited to expense incurred for Medically Necessary medical services only. Reasonable Charges for services incident to obtaining the transplanted material from a living donor or a human organ transplant bank will be covered. Such charges, including complications from the donor procedure for up to six weeks from the date of procurement, are covered. Services for treatment of a condition that is not directly related to, or a direct result of, the transplant are NOT covered. Payment for unrelated donor searches for covered bone marrow/stem cell transplants will not exceed **$30,000** per transplant.

Covered services are subject to any applicable deductibles, co-payments and medical benefit maximums. Covered Expense does not include charges for services received without first obtaining pre-service review, or which are provided at a facility other than an approved transplant center. See the UTILIZATION REVIEW PROGRAMS section beginning on page 35 for additional information.

Specified Transplants

You must obtain pre-service review for all services including, but not limited to, preoperative tests and postoperative care related to the following specified transplants: heart, liver, lung, combination heart-lung, kidney, pancreas, simultaneous pancreas-kidney, or bone marrow/stem cell and similar procedures. Specified transplants must be performed at Centers of Medical Excellence (CME). **Charges for services provided for or in connection with a specified transplant performed at a facility other than a CME will not be considered Covered Expense.** Call the toll-free telephone number for pre-service review on your identification card if your Physician recommends a specified transplant for your medical care. A case manager transplant coordinator will assist in facilitating your access to a CME. See the UTILIZATION REVIEW PROGRAMS section beginning on page 35 for additional information.

Transplant Travel Expense

Certain travel expenses incurred in connection with an approved, specified transplant (heart, liver, lung, combination heart-lung, kidney, pancreas, simultaneous pancreas-kidney, or bone marrow/stem cell and similar procedures) performed at a designated CME that is 75 miles or more from the recipient's or donor's place of residence are covered, provided pre-service review is obtained. The plan maximum payment will not exceed **$10,000** per transplant for the following travel expenses incurred by the recipient and one companion* or the donor:

- Ground transportation to and from the CME when the designated CME is 75 miles or more from the recipient's or donor's place of residence.
- Coach airfare to and from the CME when the designated CME is 300 miles or more from the recipient's or donor's residence.
- Lodging, limited to one room, double occupancy.
- Other reasonable expenses, such as meals. Tobacco, alcohol, drug expenses, and other non-food items are excluded.

*Note: When the Member recipient is under 18 years of age, this benefit will apply to the recipient and two companions or caregivers.

The Calendar Year deductible will not apply and no co-payments will be required for transplant travel expenses authorized in advance. The plan will provide benefits for meal, lodging and ground transportation, up to the limits set forth in the Internal Revenue Code at the time expenses are incurred.

Expense incurred for the following is not covered: interim visits to a medical care facility while waiting for the actual transplant procedure; travel expenses for a companion and/or caregiver for a transplant donor; return visits for a transplant donor for treatment of a condition found during the evaluation; rental cars, buses, taxis or shuttle services; and mileage within the city in which the medical transplant facility is located.

Details regarding reimbursement can be obtained by calling customer service at 1-800-288-6928. A travel reimbursement form will be provided for submission of legible copies of all applicable receipts in order to obtain reimbursement.

Well-Child Care (for dependent children only). The following services for a dependent child under 19 years of age:

1. A Physician's services for preventive and primary care, including routine physical examinations, newborn well-baby exams (both in and out of a Hospital), measurements, sensory screening, neuropsychiatric evaluation and development screening.
2. Services will also include, as recommended by the Physician, hereditary and metabolic screening at birth, urinalysis, tuberculin tests and appropriate blood tests, including tests to screen for sickle hemoglobinopathy.
3. Immunizations given as standard medical practice for children.
4. Radiology and laboratory services in connection with routine physical examinations.
5. Screening for blood lead levels as prescribed by a Physician.

For children ages 12 through 18, we will pay for up to 3 visits per Calendar Year.

YOUR MEDICAL BENEFITS

MEDICAL CARE THAT IS NOT COVERED

No payment will be made under this plan for expenses incurred for or in connection with any of the items below. (The titles given to these exclusions and limitations are for ease of reference only; they are not meant to be an integral part of the exclusions and limitations and do not modify their meaning.)

The following exclusions, if subject to ambiguity or uncertainty, will be interpreted in a manner most favorable to the Member.

1. **Not Medically Necessary.** Services or supplies that are not Medically Necessary as defined.

2. **Experimental or Investigational**. Experimental or Investigational procedures or medications. But, if you are denied benefits because it is determined that the requested treatment is Experimental or Investigational, you may request an independent medical review as described in CLAIMS REVIEW / GRIEVANCE PROCEDURES.

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

4. **After Coverage Ends.** Services received after the Member's coverage ends, except as specifically stated under TERMINAL BENEFITS**.**

5. **Excess Amounts.** Any amounts in excess of Covered Expense .

6. **Not Specifically Listed.** Services not specifically listed in this Evidence of Coverage as covered services.

7. **Free Services.** Services for which the Member is not legally obligated to pay. Services for which no charge is made to the Member. Services for which no charge is made to the Member in the absence of insurance coverage, except services received at a non-governmental charitable research Hospital. Such a Hospital must meet the following guidelines:

   a. It must be internationally known as being devoted mainly to medical research, and

   b. At least ten percent of its yearly budget must be spent on research not directly related to patient care, and

   c. At least one-third of its gross income must come from donations or grants other than gifts or payments for patient care, and

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

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

8. **Work-Related.** Work-related conditions if benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any Workers' Compensation, employer's liability law or occupational disease law, even if the Member does not claim those benefits.

If there is a dispute or substantial uncertainty as to whether benefits may be recovered for those conditions pursuant to workers' compensation, benefits will be provided subject to our right or recovery and reimbursement under California Labor Code Section 4903, and as described in the THIRD PARTY LIABILITY provision.

9. **Nuclear Energy.** Conditions that result from any release of nuclear energy, whether or not the result of war, when government funds are available for treatment of illness or injury arising from such release of nuclear energy.

10. **Government Treatment.** Any services actually given to you by a local, state or federal government agency, except when payment under this plan is expressly required by federal law or state law. Services provided by VA Hospitals and military treatment facilities will be considered for payment according to current legislation. We will not cover payment for these services if you are not required to pay for them or they are given to you for free.

11. **Relatives.** Professional services received from a person who lives in the Member's home or who is related to the Member by blood or marriage, except as specifically stated in Home Infusion Therapy under MEDICAL CARE THAT IS COVERED**.**

12. **Custodial Care or Rest Cures.** Inpatient room and board charges in connection with a Hospital Stay primarily for environmental change, physical therapy or treatment of chronic pain. Custodial Care or rest cures. 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, except as specifically stated in THE Skilled Nursing Facility provision under MEDICAL CARE THAT IS COVERED.

13. **Diagnostic Hospital Stays.** 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.

14. **Orthopedics.** Orthopedic shoes (other than shoes joined to braces) or non-custom molded and cast shoe inserts, except for therapeutic shoes and inserts for the prevention and treatment of diabetes-related foot complications as specifically stated under the Prosthetic Devices provision of MEDICAL CARE THAT IS COVERED.

15. **Personal Items and Services.** Air purifiers, air conditioners, humidifiers, exercise equipment and supplies for comfort, hygiene or beautification. Educational services, nutritional counseling (except as stated under Diabetes Education Program benefits). This exclusion does not apply to counseling for the treatment of anorexia nervosa or bulimia nervosa. Food or nutritional supplements (other than for the treatment of phenylketonuria). Formulas and food products approved by the FDA and prescribed by a Physician for the treatment of phenylketonuria are covered under this plan.

16. **Orthodontic Care.** Braces, other orthodontic appliances or orthodontic services.

17. **Dental Care.** Dental plates, bridges, crowns, caps or other dental prostheses, dental implants, dental services, extraction of teeth or treatment to the teeth or gums, except as specifically stated in the Dental Care provision under MEDICAL CARE THAT IS COVERED. Cosmetic dental surgery or other services for beautification.

18. **Hearing Aids or Tests.** Hearing aids or routine hearing tests, except as specifically stated under the Hearing Aid Benefits provision of MEDICAL CARE THAT IS COVERED.

19. **Vision Services or Supplies.** Optometric services, eye exercises including orthoptics, routine eye exams and routine eye refractions. Eyeglasses or contact lenses, except as specifically stated in Additional Services and Supplies under MEDICAL CARE THAT IS COVERED.

20. **Refractive Eye Surgery.** Any eye surgery solely for the purpose of correcting refractive defects of the eye such as nearsightedness (myopia) or astigmatism.

21. **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 specifically stated under MEDICAL CARE THAT IS COVERED.

22. **Outpatient Speech Therapy.** Outpatient speech therapy, except following surgery, injury or non-congenital organic disease, or except as specifically stated in Hospice Care under MEDICAL CARE THAT IS COVERED.

23. **Speech Disorders.** Services primarily for correction of speech disorders, including but not limited to stuttering or stammering.

24. **Acupuncture.** Acupuncture treatment except as specifically stated in the "Acupuncture" provision of MEDICAL CARE THAT IS COVERED. 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.

25. **Cosmetic Services.** Cosmetic Surgery or other services performed solely for beautification or to alter or reshape normal (including aged) structures or tissues of the body to improve appearance. This exclusion does not apply to reconstructive surgery (that is, surgery performed to correct deformities caused by congenital or developmental abnormalities, illness, or injury for the purpose of improving bodily function or symptomatology or to create a normal appearance), including surgery performed to restore symmetry following mastectomy. Cosmetic surgery does not become reconstructive surgery because of psychological or psychiatric reasons.

26. **Weight Alteration Programs (Inpatient and Outpatient).** Weight loss or weight gain programs including, but not limited to, dietary evaluations and counseling, exercise programs, behavioral modification programs, surgery, laboratory tests, food and food supplements, vitamins and other nutritional supplements associated with weight loss or weight gain. Dietary evaluations and counseling, and behavioral modification programs are covered for the treatment of anorexia nervosa or bulimia nervosa. Surgical treatment for morbid obesity will be covered only when criteria are met as recommended by our Medical Policy.

27. **Sex Change.** Procedures or treatments to change characteristics of the body to those of the opposite sex.

28. **Sterilization Reversal.** Sterilization reversal.

29. **Infertility Treatment.** Services or supplies furnished in connection with the diagnosis and treatment of infertility, except as specifically stated in the "Infertility Treatment" provision of MEDICAL CARE THAT IS COVERED.

30. **Contraceptive Devices.** Contraceptive devices, except for Prescription oral contraceptives as specifically stated under PRESCRIPTION DRUG BENEFITS or as specifically stated in the Contraceptives provision of MEDICAL CARE THAT IS COVERED.

31. **Nicotine Addiction.** Services for smoking cessation or reduction; nicotine use or addiction, except as specifically stated in the Smoking Cessation Programs and Nicotine Patches provisions of MEDICAL CARE THAT IS COVERED.

32. **Caffeine Addiction.** Caffeine addiction.

33. **Mental or Nervous Disorders.** Services attributable to Mental or Nervous Disorders or substance abuse, except as specifically stated in the "Mental or Nervous Disorders, Severe Mental Disorders or Substance Abuse" provision of MEDICAL CARE THAT IS COVERED.

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

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

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

37. **Clinical Trials.** Services and supplies in connection with clinical trials, except as specifically stated in the Cancer Clinical Trials provision of MEDICAL CARE THAT IS COVERED.

38. **Natural childbirth classes**. Charges incurred for registration and classes that prepare new and expectant parents for a natural birthing experience.

39. **Transportation and Travel Expense.** Expense incurred for transportation, except as specifically stated in the Ambulance and Transplant Travel Expense provisions of MEDICAL CARE THAT IS COVERED. Mileage reimbursement except as specifically stated in the Transplant Travel Expense provision of MEDICAL CARE THAT IS COVERED and approved by Anthem Blue Cross Life and Health. Charges incurred in the purchase or modification of a motor vehicle. Charges incurred for child care, telephone calls, laundry, postage, or entertainment. Frequent flyer miles; coupons, vouchers or travel tickets; prepayments of deposits.

UTILIZATION REVIEW PROGRAMS

Benefits are provided only for Medically Necessary and appropriate services. Utilization Review is designed to work together with you and your provider to ensure you receive appropriate medical care and avoid unexpected out-of-pocket expense.

IMPORTANT: The Utilization Review Program requirements described in this section do not apply when coverage under this plan is secondary to another plan providing benefits for an Insured Employee or Family Member.

The utilization review program evaluates the medical necessity and appropriateness of care and the setting in which care is provided. Members and Physicians are advised if Anthem Blue Cross Life and Health has determined that services can be safely provided in an outpatient setting, or if an inpatient Stay is recommended. Services that are Medically Necessary and appropriate are certified by Anthem Blue Cross Life and Health and monitored so that Members know when it is no longer Medically Necessary and appropriate to continue those services.

It is the Member's responsibility to see that his or her Physician starts the utilization review process before scheduling the Member for any service subject to the Utilization Review Program. If the Member receives any such service and does not follow the procedures set forth in this section, benefits will be reduced as shown under HOW BENEFITS ARE AFFECTED BY UTILIZATION REVIEWS.

Utilization Review Requirements

Utilization reviews are conducted for the following services:

— All inpatient Hospital Stays and Residential Treatment Center admissions.

— Transplant Services.

— Visits for physical therapy, physical medicine and occupational therapy beyond those described under the "Physical Therapy – Physical Medicine" provision of YOUR MEDICAL BENEFITS – MEDICAL CARE THAT IS COVERED.

— Select imaging procedures, including, but not limited to: Magnetic Resonance Imaging (MRI), Computer Axial Tomography (CAT scans), Positron Emission Tomography (PET scan), Magnetic Resonance Spectroscopy (MRS scan), Magnetic Resonance Angiogram (MRA scan) and Nuclear Cardiac Imaging. The Member may call customer service toll-free at 1-800-288-6928 to find out if an imaging procedure requires pre-service review.

Exceptions: Utilization review is not required for inpatient Hospital Stays for the following services:

-- Maternity care of 48 hours or less following a normal delivery or 96 hours or less following a cesarean section; and

-- Mastectomy and lymph node dissection.

The stages of utilization review are:

1. **Pre-service review** determines in advance the medical necessity and appropriateness of certain procedures or admissions and the appropriate length of Stay, if applicable. Pre-service review is required for the following services:

   — Scheduled, non-Emergency inpatient Hospital Stays, and Residential Treatment Center admissions except inpatient Stays for maternity care or mastectomy and lymph node dissection.

— Transplant Services.

— Visits for physical therapy, physical medicine and occupational therapy beyond those described under the "Physical Therapy – Physical Medicine" provision of YOUR MEDICAL BENEFITS – MEDICAL CARE THAT IS COVERED.

— Select imaging procedures, including, but not limited to: Magnetic Resonance Imaging (MRI), Computer Axial Tomography (CAT scans), Positron Emission Tomography (PET scan), Magnetic Resonance Spectroscopy (MRS scan), Magnetic Resonance Angiogram (MRA scan) and Nuclear Cardiac Imaging.

2. **Concurrent review** determines whether services are Medically Necessary and appropriate when Anthem Blue Cross Life and Health is notified while service is ongoing, for example, an Emergency admission to the Hospital.

3. **Retrospective review** is performed to review services that have already been provided. This applies in cases when pre-service or concurrent review was not completed, or in order to evaluate and audit medical documentation subsequent to services being provided. Retrospective review may also be performed for services that continued longer than originally certified.

How Benefits Are Affected By Utilization Reviews

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

A. The appropriate utilization reviews must be performed in accordance with this plan. Services that are not reviewed prior to or during service delivery will be reviewed retrospectively when the bill is submitted for benefit payment. If review results in the determination that part or all of the services were not Medically Necessary and appropriate, benefits will not be paid for those services. If the Member proceeds with any services that have been determined to be not Medically Necessary and appropriate at any stage of the utilization review process, benefits will not be provided for those services.

B. When pre-service review is performed and the admission, procedure or service is determined to be Medically Necessary and appropriate , benefits will be provided for the following:

— Transplant Service as follows:

a. For bone, skin or cornea transplants, if the Physicians on the surgical team and the facility in which the transplant is to take place are approved by Anthem Blue Cross Life and Health for the transplant requested.

b. For transplantation of heart, liver, lung, combination heart-lung, kidney, pancreas, simultaneous pancreas-kidney or bone marrow/stem cell and similar procedures if the providers of the related preoperative and postoperative services are approved and the transplant will be performed at a Centers of Medical Excellence (CME) facility.

— A specified number of additional visits for physical therapy, physical medicine and occupational therapy if the Member needs more visits than is provided under the "Physical Therapy – Physical Medicine" provision of YOUR MEDICAL BENEFITS – MEDICAL CARE THAT IS COVERED.

— Select imaging procedures, including, but not limited to: Magnetic Resonance Imaging (MRI), Computer Axial Tomography (CAT scans), Positron Emission Tomography (PET scan), Magnetic Resonance Spectroscopy (MRS scan), Magnetic Resonance Angiogram (MRA scan) and Nuclear Cardiac Imaging.

C. Services that are not reviewed prior to or during service delivery will be reviewed retrospectively when the bill is submitted for benefit payment. If that review results in the determination that part or all of the services were not Medically Necessary and appropriate, benefits will not be paid for those services.

If the Member proceeds with any services that have been determined to be not Medically Necessary and appropriate at any stage of the utilization review process, benefits will not be provided for those services.

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

How To Obtain Utilization Reviews

It is always the Member's responsibility to confirm that the review has been performed. If the review is not performed, benefits will be reduced as shown under HOW BENEFITS ARE AFFECTED BY UTILIZATION REVIEWS.

1. **Pre-service Reviews**

Obtain required pre-service review before receiving scheduled services as follows:

For all scheduled services that are subject to utilization review, the Member or the Member's Physician must initiate the pre-service review at least five (5) working days prior to when the Member is scheduled to receive services.

The Member must tell his or her Physician that this plan requires pre-service review. The Member or the Member's Physician may initiate a pre-service review by calling toll-free 1-800-274-7767.

If the Member does not receive the certified service within 60 days of the certification, or if the nature of the service changes, a new pre-service review must be obtained.

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

2. **Concurrent Reviews**

If pre-service review was not performed, the Member, the Member's Physician, or the provider of service must contact Anthem Blue Cross Life and Health for concurrent review. For an Emergency Hospital admission or procedure, Anthem Blue Cross Life and Health must be notified within one working day of the admission or procedure. The toll-free telephone number is 800-274-7767.

When a Participating Provider has been informed of the Member's need for utilization review, they may initiate the review on the Member's behalf. The Member may ask other providers to call the toll free number, or the Member may call Anthem Blue Cross Life and Health directly.

When Anthem Blue Cross Life and Health determines that the service is Medically Necessary and appropriate, Anthem Blue Cross Life and Health will, depending upon the type of treatment or procedure, specify the period of time for which the service is medically appropriate. Also, Anthem Blue Cross Life and Health will determine the medically appropriate setting.

If Anthem Blue Cross Life and Health determines that the service is not Medically Necessary and appropriate, the Member's Physician will be notified by telephone no later than 24 hours following Anthem Blue Cross Life and Health's decision. Written notice will be sent to the Member and the Member's Physician within two (2) business days following Anthem Blue Cross Life and Health's decision. However, care will not be discontinued until the Member's Physician has been notified and a plan of care that is appropriate for the Member's needs has been agreed upon.

3. **Retrospective Reviews**

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

Such services which have been retrospectively determined to not be Medically Necessary and appropriate will be retrospectively denied certification.

THE MEDICAL NECESSITY REVIEW PROCESS

Anthem Blue Cross Life and Health works with Members and Members' health care providers to cover Medically Necessary and appropriate care and services. While the types of services requiring review and the timing of the reviews may vary, Anthem Blue Cross Life and Health is committed to ensuring that reviews are performed in a timely and professional manner. The following information explains Anthem Blue Cross Life and Health's review process.

1. A decision on the medical necessity of a pre-service request will be made no later than five (5) business days from receipt of the information reasonably necessary to make the decision, and based on the nature of the Member's medical condition.

2. A decision on the medical necessity of a concurrent request will be made no later than one (1) business day from receipt of the information reasonably necessary to make the decision, and based on the nature of the Member's medical condition. However, care will not be discontinued until the Member's Physician has been notified and a plan of care that is appropriate for the Member's needs has been agreed upon.

3. A decision on the medical necessity of a retrospective review will be made and communicated in writing to the Member and the Member's Physician no later than thirty (30) days from receipt of the information necessary to make the decision.

4. If Anthem Blue Cross Life and Health does not have the information it needs, it will make every attempt to obtain that information from the Member or the Member's Physician. If Anthem Blue Cross Life and Health is unsuccessful and a delay is anticipated, it will notify the Member or the Member's Physician of the delay and what is needed to make a decision. Anthem Blue Cross Life and Health will also inform the Member of when a decision can be expected following receipt of the needed information.

5. All pre-service, concurrent and retrospective reviews for medical necessity are screened by clinically experienced, licensed personnel (called "Review Coordinators") using pre-established criteria and Anthem Blue Cross Life and Health's medical policy. These criteria and policies are developed and approved by practicing providers not employed by us, and are evaluated at least annually and updated as standards of practice or technology changes. Requests satisfying these criteria are certified as Medically Necessary. Review Coordinators are able to approve most requests.

6. A written confirmation including the specific service determined to be Medically Necessary will be sent to the Member and Member's provider no later than two (2) business days after the decision, and the Member's provider will be initially notified by telephone within 24 hours of the decision for pre-service and concurrent reviews.

7. If the request fails to satisfy these criteria or medical policy, the request is referred to a Peer Clinical Reviewer. Peer Clinical Reviewers are health professionals clinically competent to evaluate the specific clinical aspects of the request and render an opinion specific to the medical condition, procedure and/or treatment under review. Peer Clinical Reviewers are licensed in California with the same license category as the requesting provider. When the Peer Clinical Reviewer is unable to certify the service, the requesting Physician is contacted by telephone for a discussion of the case. In many cases, services can be certified after this discussion. If the Peer Clinical Reviewer is still unable to certify the service, the Member's provider will be given the option of having the request reviewed by a different Peer Clinical Reviewer.

8. Only the Peer Clinical Reviewer may determine that the proposed services are not Medically Necessary and appropriate. The Member's Physician will be notified by telephone within 24 hours of a decision not to certify and will be informed at that time of how to request reconsideration. Written notice will be sent to the Member and the requesting provider within two (2) business days of the decision. This written notice will include:

   - an explanation of the reason for the decision,
   - reference of the criteria used in the decision to modify or not certify the request,
   - the name and phone number of the Peer Clinical Reviewer making the decision to modify or not certify the request,
   - how to request reconsideration if the Member or the Member's provider disagree with the decision.

9. Reviewers may be plan employees or an independent third party Anthem Blue Cross Life and Health chooses at its sole and absolute discretion.

10. The Member or the Member's Physician may request copies of specific criteria and/or medical policy by writing to the address shown on the Member's identification card. Anthem Blue Cross Life and Health discloses its medical necessity review procedures to health care providers through provider manuals and newsletters.

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

- The information submitted with the claim differs from that given by phone;

- The service is excluded from coverage; or
- The Member is not eligible for coverage when the service is actually provided.

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

- The Member's coverage under this plan ends;
- The Agreement with the PORAC and Anthem Blue Cross Life and Health terminates;
- You reach a benefit maximum that applies to the services in question; or
- Your benefits under the plan change so that the services in question are no longer covered or are covered in a different way.

QUESTIONS ABOUT OR DISAGREEMENTS WITH UTILIZATION REVIEW DETERMINATIONS

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

B. If the Member, the Member's representative or the Member's Physician acting on the Member's behalf find the reconsidered decision still unsatisfactory, a request for an appeal of the reconsidered decision may be submitted in writing to Anthem Blue Cross Life and Health.

C. In the event that the appeal decision still is unsatisfactory, the Member's remedy may be binding arbitration as stated elsewhere in this Evidence of Coverage.

QUALITY ASSURANCE

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

CASE MANAGEMENT

The personal case management program enables Anthem Blue Cross Life and Health to authorize the Member to obtain medically appropriate care in a more economical, cost effective and coordinated manner during prolonged periods of intensive medical care. Anthem Blue Cross Life and Health has the right, through a case manager, to recommend an alternative plan of treatment which may include services not covered under this plan. It is not the Member's right to receive personal case management, nor does Anthem Blue Cross Life and Health have an obligation to provide it; Anthem Blue Cross Life and Health provides these services at its sole and absolute discretion.

How Case Management Works

Members may be identified for possible personal case management through the plan's utilization review procedures described under UTILIZATION REVIEW PROGRAMS, by the attending Physician, Hospital staff, or Anthem Blue Cross Life and Health claims reports. The Member or the Member's family may also call Anthem Blue Cross Life and Health.

Benefits for personal case management will be considered only when the following criteria are met:

1. The Member requires extensive long-term treatment;
2. Anthem Blue Cross Life and Health anticipates that such treatment utilizing services or supplies covered under this plan will result in considerable cost;
3. A cost-benefit analysis by Anthem Blue Cross Life and Health determines that the benefits payable under this plan for the alternative plan of treatment can be provided at a lower overall cost than the benefits the Member would otherwise receive under this plan while maintaining the same standards of care; and
4. The Member (or the Member's legal guardian) and the Member's Physician agree, in a letter of agreement, with Anthem Blue Cross Life and Health's recommended substitution of benefits and with the specific terms and conditions under which the alternative benefits are to be provided.

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

Anthem Blue Cross Life and Health makes treatment recommendations only; any decisions regarding treatment belong to the Member and the Member's Physician. The plan will in no way compromise the Member's freedom to make such decisions.

How Benefits Are Affected By Case Management

1. Any alternative benefits are accumulated toward any lifetime maximums.
2. Benefits are provided for an alternative treatment plan on a case-by-case basis only. Anthem Blue Cross Life and Health has absolute discretion in deciding whether or not to authorize services in lieu of benefits for any Member, which alternatives may be offered and the terms of the offer.

3. Anthem Blue Cross Life and Health's authorization of services in lieu of benefits in a particular case in no way commits Anthem Blue Cross Life and Health to do so in another case or for another Member.

4. The personal case management program does not prevent Anthem Blue Cross Life and Health from strictly applying the expressed benefits, exclusions and limitations of this plan at any other time or for any other Member.

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

PRESCRIPTION DRUG BENEFITS

Benefits for Prescription Drugs are determined by the type of pharmaceutical provider the Member chooses and the type of Drug provided. A Member can choose to have his or her Prescriptions filled by Participating Pharmacies, Non-Participating Pharmacies, or through the mail service program. The Member can also choose between Generic Drugs, Brand Name Drugs on the Prescription Drug Formulary list, or non-Formulary Brand Name Drugs. However, the amount the Member will pay for his or her Prescription is affected by these choices.

PARTICIPATING PHARMACIES

When the Member presents his or her plastic Identification Card to a Participating Pharmacy to have a Prescription filled, the Member will only pay the applicable copayment amount for each covered Prescription and each refill. The Member may call **1-800-700-2541** (or TTY/TTD 1-800-905-9821) for assistance in locating a Participating Pharmacy.

Generic Drugs will be dispensed by Participating Pharmacies when the Prescription indicates a Generic Drug. When a Brand Name Drug is specified, but a Generic Drug equivalent exists, the Generic Drug will be substituted. Brand Name Drugs will be dispensed by Participating Pharmacies when the Prescription specifies a Brand Name Drug and states “dispense as written” or no Generic Drug equivalent exists.

Please note that presentation of a Prescription to a Pharmacy or pharmacist does not constitute a claim for benefit coverage. If you present a Prescription to a Participating Pharmacy, and the Participating Pharmacy indicates your Prescription cannot be filled or requires an additional copayment, this is not considered an adverse claim decision. If you want the Prescription filled, you will have to pay either the full cost or the additional copayment for the Prescription Drug. If you believe you are entitled to some plan benefits in connection with the Prescription Drug, submit a claim for reimbursement to us at the address shown below:

Prescription Drug Program
P.O. Box 4165
Woodland Hills, CA 91365-4165

Participating Pharmacies usually have claims forms, but, if the Participating Pharmacy does not have claim forms, claim forms and customer service are available by calling 1-800-700-2541 (or TTY/TTD 1-800-905-9821). Mail your claim, with the appropriate portion completed by the pharmacist, to us within 90 days of the date of purchase. If it is not reasonably possible to submit the claim within that time frame, an extension of up to 12 months will be allowed.

NON-PARTICIPATING PHARMACIES

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

Prescription Drug Program
P.O. Box 4165
Woodland Hills, CA 91365-4165

Non-Participating Pharmacies do not have our Prescription Drug claim forms. The Member must bring a claim form to the Non-Participating Pharmacy and have the pharmacist complete the pharmacy portion of the form and sign it.

Claim forms and customer service are available by calling **1-800-700-2541** (or TTY/TTD 1-800-905-9821). The Member must mail the claim form with the appropriate portion completed by the pharmacist to us within 90 days of the date of purchase. If it is not reasonably possible to submit the claim within that timeframe, an extension of up to 12 months will be allowed. The Member will be reimbursed according to the procedures described under the REIMBURSEMENT provision of this section.

PRESCRIPTION DRUG BENEFITS

MAIL SERVICE PROGRAM

You can order your Prescription through the mail service Prescription Drug program, however, not all medications are available through the mail service pharmacy. For any available Prescription Drugs ordered through the mail service program, the Member will only pay the applicable copayment amount. Prescriptions can be filled through the mail service program for up to a 90-day supply or 100 units, whichever is greater.

The Prescription must state the Drug name, dosage, directions for use, quantity, Physician's name and phone number, patient's name and address, and be signed by a Physician. The Member must submit the Prescription with the appropriate payment for the amount of copayment (**$20**, **$40** or **$75**) and a properly completed order form. (If you are not sure what your copayment amount is, you may call the toll-free phone number listed below for assistance.) Additional cost, if any, resulting from the purchase of a Brand Name Drug will be billed to the Member.

The Member's first mail service program Prescription must also include a completed patient profile questionnaire. The patient profile questionnaire can be obtained by calling the toll-free number below. The Member need only enclose the Prescription or refill notice and the appropriate payment for any subsequent mail service program Prescriptions, or call the toll-free number. Copayments can be paid by check, money order or credit card.

To obtain order forms or verify whether the Drug is available through the mail service program, contact Prescription Drug Program- Mail Service at the following address or telephone number:

Prescription Drug Program - Mail Service
P.O. Box 746000
Cincinnati, OH 45274-6000
1-866-274-6825

Generic Drugs will be dispensed through the mail service program when the Prescription indicates a Generic Drug. When a Brand Name Drug is specified, but a Generic Drug equivalent exists, the Generic Drug will be substituted. Brand Name Drugs will be dispensed through the mail service program when the Prescription specifies a Brand Name and states "dispense as written" or when no Generic Drug equivalent exists.

SPECIALTY PHARMACY PROGRAM

Members can only order Prescriptions for Specialty Pharmacy Drugs through the specialty pharmacy program unless they are given an exception from the specialty drug program (see PRESCRIPTION DRUG CONDITIONS OF SERVICE on page 47 of this section). Anthem Blue Cross Life and Health – Specialty Pharmacy Program only fills Prescriptions for Specialty Pharmacy Drugs and will ship such medication to the Member by mail or common carrier (You cannot pick up your medication at Anthem Blue Cross Life and Health).

The Prescription for the Specialty Pharmacy Drug must state the Drug name, dosage, directions for use, quantity, Physician's name and phone number, patient's name and address, and be signed by a Physician.

The Member or Member's Physician may order the Member's Specialty Pharmacy Drug by calling 1-877-241-3489. When the Member calls Anthem Blue Cross Life and Health – Specialty Pharmacy Program, a dedicated care coordinator will guide the Member through the process up to and including actual delivery of the Member's Specialty Pharmacy Drug to the Member. (If you order your Specialty Pharmacy Drug by telephone, you will need to use a credit card or debit card to pay for it.) The Member may also submit a Prescription for a Specialty Pharmacy Drug with the appropriate payment for the amount of the purchase (You can pay by check, money order, credit card or debit card), and a properly completed order form to Anthem Blue Cross Life and Health – Specialty Pharmacy Program at the address shown below. The Member will only have to pay the cost of the applicable copayment (**$10**, **$25** or **$45**).

PRESCRIPTION DRUG BENEFITS

The first time the Member gets a Prescription for a Specialty Pharmacy Drug the Member must also include a completed intake referral form. The intake referral form is to be completed by calling the toll-free number below. The Member need only enclose the Prescription or refill notice and the appropriate payment for any subsequent Specialty Pharmacy Drug Prescriptions, or call the toll-free number. Copayments can be made by check, money order, credit card or debit card.

The Member or Member's Physician may obtain a list of Specialty Pharmacy Drugs available through the specialty pharmacy program or order forms by either calling the toll-free number shown below or accessing the Web site at www.anthem.com/ca.

Anthem Blue Cross Life and Health Insurance Company
– Specialty Pharmacy Program
2825 W. Perimeter Road
Indianapolis, IN 46241
Phone 1-877-241-3489
Fax 1-800-824-2642

If the Member does not get Specialty Pharmacy Drugs through the specialty pharmacy program, the Member will not receive any benefits under this plan for such Drugs.

COPAYMENTS AT A RETAIL PHARMACY

A. The Member is responsible for a **$25.00** copayment for each Brand Name Prescription Drug or refill listed on the Prescription Drug Formulary, plus the difference in Prescription Drug Covered Expense between the cost of the Brand Name Drug and its Generic Drug equivalent, unless a Generic Drug equivalent is not available or a Brand Name Drug is Medically Necessary. When no Generic Drug equivalent is available, or when a Physician prescribes a Brand Name Drug and indicates that it is Medically Necessary on the Prescription form, the Member will only be responsible for the $25.00 copayment.

B. The Member is responsible for a **$45.00** copayment for each Brand Name Prescription Drug or refill **not** listed on the Prescription Drug Formulary, plus the difference in Prescription Drug Covered Expense between the cost of the Brand Name Drug and its Generic Drug equivalent, unless a Generic Drug equivalent is not available or a Brand Name Drug is Medically Necessary. When no Generic Drug equivalent is available, or when a Physician prescribes a Brand Name Drug and indicates that it is Medically Necessary on the Prescription form, the Member will only be responsible for the $45.00 copayment.

C. The Member is responsible for a **$45.00** copayment for each Compound Medication dispensed by a Participating Pharmacy. (You are responsible for the full cost of Compound Medications filled by Non-Participating Pharmacies.)

D. The Member is responsible for a **$10.00** copayment for each Generic Prescription Drug or refill.

E. The copayments specified in A., B., C. and D. above will apply to each 34-day or 100 unit supply. See page 48 for more information.

PRESCRIPTION DRUG BENEFITS

COPAYMENTS THROUGH THE MAIL SERVICE PROGRAM

A. The Member is responsible for a **$40.00** copayment for each Brand Name Prescription Drug or refill listed on the Prescription Drug Formulary, plus the difference in Prescription Drug Covered Expense between the cost of the Brand Name Drug and its Generic Drug equivalent, unless a Generic Drug equivalent is not available or a Brand Name Drug is Medically Necessary. When no Generic Drug equivalent is available, or when a Physician prescribes a Brand Name Drug and indicates that it is Medically Necessary on the Prescription form, the Member will only be responsible for the $40.00 copayment.

B. The Member is responsible for a **$75.00** copayment for each Brand Name Prescription Drug or refill **not** listed on the Prescription Drug Formulary, plus the difference in Prescription Drug Covered Expense between the cost of the Brand Name Drug and its Generic Drug equivalent, unless a Generic Drug equivalent is not available or a Brand Name Drug is Medically Necessary. When no Generic Drug equivalent is available, or when a Physician prescribes a Brand Name Drug and indicates that it is Medically Necessary on the Prescription form, the Member will only be responsible for the $75.00 copayment.

C. The Member is responsible for a **$20.00** copayment for each Generic Prescription Drug or refill.

D. The copayments specified in A., B. and C. above will apply to each 90-day or 100 unit supply. See page 48 for more information.

COPAYMENTS THROUGH THE SPECIALTY PHARMACY PROGRAM

A. The Member is responsible for a **$25.00** copayment for each Brand Name Prescription Drug or refill listed on the Prescription Drug Formulary, plus the difference in Prescription Drug Covered Expense between the cost of the Brand Name Drug and its Generic Drug equivalent, unless a Generic Drug equivalent is not available or a Brand Name Drug is Medically Necessary. When no Generic Drug equivalent is available, or when a Physician prescribes a Brand Name Drug and indicates that it is Medically Necessary on the Prescription form, the Member will only be responsible for the $25.00 copayment.

B. The Member is responsible for a **$45.00** copayment for each Brand Name Prescription Drug or refill **not** listed on the Prescription Drug Formulary, plus the difference in Prescription Drug Covered Expense between the cost of the Brand Name Drug and its Generic Drug equivalent, unless a Generic Drug equivalent is not available or a Brand Name Drug is Medically Necessary. When no Generic Drug equivalent is available, or when a Physician prescribes a Brand Name Drug and indicates that it is Medically Necessary on the Prescription form, the Member will only be responsible for the $45.00 copayment.

C. The Member is responsible for a **$10.00** copayment for each Generic Prescription Drug or refill.

D. The copayments specified in A., B. and C. above will apply to each 30-day supply. See page 48 for more information.

REIMBURSEMENT

A. When the Member has a Prescription filled at a Participating Pharmacy or through the specialty pharmacy program, the Member pays only the applicable copayment amount.

B. When the Member has a Prescription filled at a Non-Participating Pharmacy, the Member will be reimbursed for covered expense incurred according to the following:

   1. We determine the amount of covered expense using the Drug Limited Fee Schedule; then,

2. We then subtract the Member's applicable copayment from covered expense.

The result is the amount for which the Member will be reimbursed. The Member is responsible for any copayment, plus any amount exceeding covered expense as well as the cost of any non-covered items.

DETERMINATION OF COVERED EXPENSE

Covered expense for Prescription Drugs is determined as follows. Expense is incurred on the date the Member receives the Drug for which the charge is made.

A. For Prescription Drugs dispensed by a Participating Pharmacy and the mail service program, the amount we consider covered expense is the Prescription Drug Negotiated Rate.

B. For Prescription Drugs dispensed by a Non-Participating Pharmacy, the amount we consider covered expense is derived from the Drug Limited Fee Schedule. The Member is responsible for any amount exceeding the schedule.

PRESCRIPTION DRUG CONDITIONS OF SERVICE

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

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

B. It must be approved for general use by the federal Food and Drug Administration (FDA).

C. It must be for the direct care and treatment of the Member's illness, injury or condition. Dietary supplements, health aids or Drugs for cosmetic purposes are not included. However formulas prescribed by a Physician for the treatment of phenylketonuria are covered.

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

E. **An approved Compound Medication must be dispensed by a Participating Pharmacy.** Call 1-800-700-2541 (or TTY/TTD 1-800-905-9821) to find out where to take the Member's Prescription for an approved Compound Medication to be filled. (You can also find a listing of Participating Pharmacies online at www.anthem.com/ca.) **Some Compound Medications must be approved before the Member can get them** (See PRESCRIPTION DRUG FORMULARY on pages 52 to 54 of this section). **The Member will have to pay the full cost of any Compound Medication the Member gets from a Non-Participating Pharmacy.**

F. **A Specialty Pharmacy Drug must be obtained by using the specialty pharmacy program.** See SPECIALTY PHARMACY PROGRAM on pages 44 & 45 of this section for information on how to get the Member's Drugs by using the specialty pharmacy program. **The Member will have to pay the full cost of any Specialty Pharmacy Drug the Member gets from a retail Pharmacy that should have been obtained from the specialty pharmacy program.**

Exceptions to specialty pharmacy program. This requirement does not apply to:

a. The first two month's supply of a Specialty Pharmacy Drug which is available through a retail Participating Pharmacy; or

b. Drugs which, due to medical necessity, must be obtained immediately; or

c. A Member who is unable to pay for delivery of their medication (i.e., no credit card).

How to obtain an exception to the specialty pharmacy program. If you believe that you should not be required to get your medication through the specialty pharmacy program, for any of the reasons listed above, you must complete an Exception to Specialty Drug Program form to request an exception and send this form to us by either facsimile or mail (See page 45 for facsimile number and address for specialty pharmacy program). If you need a copy of the form, you may call us at 1-800-700-2541 (or TTY/TTD 1-800-905-9821) to request one. You can also get the form on-line at www.anthem.com/ca. If we have given you an exception, it will be in writing and will be good for 12-months from the time it is given. After this 12-month period, if you believe that you should still not be required to get your medication through the specialty pharmacy program, you must again request an exception. If we deny your request for an exception, it will be in writing and will tell you why we did not approve the exception.

Urgent or emergency need of a Specialty Pharmacy Drug subject to the specialty pharmacy program. If you are out of a Specialty Pharmacy Drug which must be obtained through the specialty pharmacy program, we will authorize an override of the specialty pharmacy program requirement for 72 hours, or until the next business day following a holiday or weekend, to allow you to get an emergency supply of medication if your Physician decides that it is appropriate and Medically Necessary. You may have to pay the applicable copayment, shown in SUMMARY OF BENEFITS: PRESCRIPTION DRUG BENEFITS on page 12 and under COPAYMENTS THROUGH THE SPECIALTY PHARMACY PROGRAM of this section on page 46, for the 72-hour supply of your Drug.

If you order your Specialty Pharmacy Drug through the specialty pharmacy program and it does not arrive, if your Physician decides that it is Medically Necessary for you to have the Drug immediately, we will authorize an override of the specialty pharmacy program requirement for a 30-day supply or less, to allow you to get an emergency supply of medication from a Participating Pharmacy near you. A dedicated care coordinator from the specialty pharmacy program will coordinate the exception, and you will not be required to make an additional copayment.

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

H. For a retail Pharmacy, the Prescription must not exceed the greater of a 34-day supply or 100 units.

Drugs federally-classified as Schedule II which are FDA-approved for treatment of attention deficit disorder and that require a triplicate prescription form must not exceed a 60-day supply or 100 units. If the Physician prescribes a 60-day supply for Drugs classified as Schedule II for the treatment of attention deficit disorders, the Member has to pay double the amount of copayment for retail Pharmacies. If the Drugs are obtained through the mail service program, the copayment will remain the same as for any other Prescription Drug.

I. For specialty pharmacy program, the Prescription must not exceed a 30-day supply.

J. For the mail service program, the Prescription must not exceed the greater of a 90-day supply or 100 units.

K. Drugs for the treatment of impotence and/or sexual dysfunction are limited to six tablets/units for a 30-day period and are available at retail Pharmacies only. Documented evidence of contributing medical condition must be submitted to us for review.

L. Certain Drugs have specific quantity supply limits based on our analysis of Prescription dispensing trends and the FDA dosing recommendations.

M. The drug will be covered under PRESCRIPTION DRUG BENEFITS only if it is not covered under another benefit of your plan.

PRESCRIPTION DRUG SERVICES AND SUPPLIES THAT ARE COVERED

A. Outpatient Drugs and medications which the law restricts to sale by Prescription. Formulas prescribed by a Physician for the treatment of phenylketonuria. These formulas are subject to the copayment for Brand Name Drugs.

B. Insulin and diabetic supplies (i.e. test strips and lancets); niacin for lowering cholesterol.

C. Syringes and/or needles when dispensed for use with insulin, antibiotics and other self-injectable Drugs or medications.

D. Injectable Drugs which are self-administered by the subcutaneous route (under the skin) by the patient or family member (except immunizing agents). Drugs with FDA labeling for self-administration.

E. Prescription oral contraceptives; contraceptive diaphragms. Contraceptive diaphragms are limited to one per Year and are subject to the copayment for Brand Name Drugs.

F. Prescription Drugs prescribed for the treatment of male or female Infertility including, but not limited to, Clomid, Pergonal and Metrodin. Drugs used primarily for the purpose of treating Infertility that are Medically Necessary for treatment of another covered condition.

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

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

I. Inhaler spacers and peak flow meters for the treatment of pediatric asthma. These items are subject to the copayment for Brand Name Drugs.

PRESCRIPTION DRUG SERVICES AND SUPPLIES THAT ARE NOT COVERED

In addition to the items listed in this Evidence of Coverage under MEDICAL CARE THAT IS NOT COVERED, Prescription Drug benefits are not provided for or in connection with the following:

A. Immunizing agents, biological sera, blood, blood products or blood plasma. While not covered under PRESCRIPTION DRUG BENEFITS, these items are covered under the Additional Services and Supplies and Well-Child Care provisions of MEDICAL CARE THAT IS COVERED, subject to all terms of this plan that apply to those benefits.

B. Hypodermic syringes and/or needles, except when dispensed for use with insulin, antibiotics or other self-injectable Drugs or medications. While not covered under PRESCRIPTION DRUG BENEFITS, these items are covered under the Home Health Care, Home Infusion Therapy and Hospice Care provisions of MEDICAL CARE THAT IS COVERED, subject to all terms of this plan that apply to those benefits.

C. Drugs and medications used to induce spontaneous and non-spontaneous abortions. While not covered under PRESCRIPTION DRUG BENEFITS, FDA approved medications that may only be dispensed by or under direct supervision of a Physician, such as Drugs and medications used to induce non-spontaneous abortions, are covered as specifically stated in the Pregnancy, Maternity Care and Family Planning provision of MEDICAL CARE THAT IS COVERED, subject to all terms of this plan that apply to the benefit.

D. Drugs and medications dispensed or administered in an outpatient setting, including, but not limited to, outpatient Hospital facilities and Physicians' offices. While not covered under PRESCRIPTION DRUG BENEFITS, these items are covered as specified under the Home Health Care, Home Infusion Therapy, Hospice Care and Hospital - Outpatient provisions of MEDICAL CARE THAT IS COVERED, subject to all terms of this plan that apply to those benefits.

E. Professional charges in connection with administering, injecting or dispensing of Drugs. While not covered under PRESCRIPTION DRUG BENEFITS, these items are covered as specified under the Home Infusion Therapy and Professional Services provisions of MEDICAL CARE THAT IS COVERED, subject to all terms of this plan that apply to those benefits.

F. A non-Prescription patent or proprietary medicine. Drugs or medication which may be obtained without a Physician's written Prescription, except insulin or niacin, for lowering cholesterol.

G. Drugs and medications dispensed by or while the Member is confined in a Hospital, Skilled Nursing Facility, rest home, sanatorium, convalescent hospital or similar facility. While not covered under PRESCRIPTION DRUG BENEFITS, these items are covered as specified under the Hospice Care, Hospital – Inpatient, and Skilled Nursing Facility provisions of MEDICAL CARE THAT IS COVERED, subject to all terms of this plan that apply to those benefits. While the Member is confined in a rest home, sanatorium, convalescent hospital or similar facility, Drugs and medications supplied and administered by the Member's Physician are covered as specified under the Professional Services provision of MEDICAL CARE THAT IS COVERED, subject to all terms of this plan that apply to the benefit. Other Drugs that may be prescribed by the Member's Physician while the Member is confined in a rest home, sanatorium, convalescent hospital or similar facility, may be purchased at a Pharmacy by the Member, or a friend, relative or care giver on the Member's behalf, and are covered under these PRESCRIPTION DRUG BENEFITS.

H. Durable medical equipment, devices, appliances and supplies, even if prescribed by a Physician, except Prescription contraceptive diaphragms as specified under PRESCRIPTION DRUG SERVICES AND SUPPLIES THAT ARE COVERED. While not covered under PRESCRIPTION DRUG BENEFITS, these items are covered as specified under the Additional Services and Supplies and Hearing Aid Benefits provisions of MEDICAL CARE THAT IS COVERED, subject to all terms of this plan that apply to those benefits.

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

J. Oxygen. While not covered under PRESCRIPTION DRUG BENEFITS, this item is covered as specified under the Home Health Care, Hospice Care, Hospital and Skilled Nursing Facility provisions of MEDICAL CARE THAT IS COVERED, subject to all terms of this plan that apply to those benefits.

K. Cosmetics and health or beauty aids. However, health aids that are Medically Necessary and meet the requirements for durable medical equipment as specified under the Additional Services and Supplies provision of MEDICAL CARE THAT IS COVERED are covered, subject to all terms of this plan that apply to that benefit.

L. Any Drug labeled "Caution, Limited By Federal Law to Investigational Use" or non-FDA approved Investigational Drugs. Any Drug or medication prescribed for Experimental indications. If you are denied a Drug because we determine that the Drug is Experimental or Investigational, you may ask that the denial be reviewed by an external independent medical review organization. See the CLAIMS REVIEW / GRIEVANCE PROCEDURES section for information on how to ask for a review of your Drug denial.

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

N. Any Drug which has not been approved for general use by the FDA. This does not apply to Drugs that are Medically Necessary for a covered condition.

O. Over-the-counter smoking cessation Drugs. This exclusion does not apply to Medically Necessary Drugs that you can only get with a Prescription under state and federal law. While not covered under PRESCRIPTION DRUG BENEFITS, nicotine patches are covered under the Nicotine Patches provision under MEDICAL CARE THAT IS COVERED, subject to all terms of this plan that apply to that benefit.

P. Drugs used primarily for cosmetic purposes (e.g., Retin-A for wrinkles). However, this exclusion will not apply to the use of this type of Drug for Medically Necessary treatment of a medical condition other than one that is cosmetic.

Q. Anorexiants and Drugs used for weight loss except when used to treat morbid obesity (i.e., diet pills and appetite suppressants).

R. Drugs obtained outside the United States, unless such drugs are furnished in connection with urgent care or an Emergency.

S. Allergy desensitization products or allergy serum. While not covered under PRESCRIPTION DRUG BENEFITS, such Drugs are covered as specified under the Hospital, Skilled Nursing Facility, and Professional Services provisions of MEDICAL CARE THAT IS COVERED, subject to all terms of this plan that apply to those benefits.

T. Infusion Drugs, except Drugs that are self-administered subcutaneously. While not covered under PRESCRIPTION DRUG BENEFITS, these Drugs are covered as specified under the Home Infusion Therapy and Professional Services provisions of MEDICAL CARE THAT IS COVERED, subject to all terms of this plan that apply to those benefits.

U. Herbal, nutritional and dietary supplements. However, formulas prescribed by a Physician for the treatment of phenylketonuria that are obtained from a Pharmacy are covered as specified under PRESCRIPTION DRUG SERVICES AND SUPPLIES THAT ARE COVERED. Special food products that are not available from a Pharmacy are covered as specified under the Nonprescription Medical Formulas provision of MEDICAL CARE THAT IS COVERED, subject to all terms of this plan that apply to that benefit.

V. Prescription Drugs with a non-Prescription (over-the-counter) chemical and dose equivalent except insulin. This exclusion does not apply if an over-the-counter equivalent was tried and was ineffective.

W. Compound Medication obtained from other than a Participating Pharmacy. **The Member will have to pay the full cost of the Compound Medications the Member gets from a Non-Participating Pharmacy**.

X. 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. **The Member will have to pay the full cost of the Specialty Pharmacy Drugs the Member gets from a retail Pharmacy that the Member should have gotten through the specialty pharmacy program**.

PRESCRIPTION DRUG BENEFITS

PRESCRIPTION DRUG PROGRAM UTILIZATION REVIEW

These Prescription Drug benefits include utilization review of Prescription Drug usage for the Member's health and safety. If there are patterns of over-utilization or misuse of Drugs, our medical consultant will notify the Member's personal Physician and pharmacist. We reserve the right to limit benefits as a result of over-utilization of Drugs.

PRESCRIPTION DRUG FORMULARY

We use a Prescription Drug Formulary to help your Physician make prescribing decisions. The presence of a Drug on the plan's Prescription Drug Formulary list does not guarantee that you will be prescribed that Drug by your Physician. These medications, which include both generic and Brand Name Drugs, are listed in the Prescription Drug Formulary. The Formulary is updated quarterly to ensure that the list includes Drugs that are safe and effective. Note: The Formulary Drugs may change from time to time.

Some Drugs may require prior authorization. If you have a question regarding whether a particular Drug is on our Formulary Drug list or requires prior authorization, please call us at 1-800-700-2541 (or TTY/TTD 1-800-905-9821).

Certain Drugs require written prior authorization of benefits in order for Members to receive plan benefits. Prior authorization criteria will be based on medical policy and the pharmacy and therapeutics established guidelines. The Member may need to try a Drug other than the one originally prescribed if it is determined through prior authorization that it should be clinically effective for the Member. However, if it is determined through prior authorization that the Drug originally prescribed is Medically Necessary, the Member will be provided the Drug originally requested at the applicable co-payment. (If, when you first become a Member, you are already being treated for a medical condition by a Drug that has been appropriately prescribed and is considered safe and effective for your medical condition, we will not require you to try a Drug other than the one you are currently taking.) If approved, Drugs requiring prior authorization for benefits will be provided to the Member after the Member makes the required co-payment.

In order for the Member to get a Drug that requires prior authorization, the Member's Physician must make a written request to us for the Member to get it using an Outpatient Prescription Drug Prior Authorization of Benefits form. The form can be sent by facsimile or mailed to us. The Physician may call us toll-free at 1-800-700-2541 (or TTY/TTD 1-800-905-9821) to request a copy of the form. This form is also available on-line at www.anthem.com/ca.

If the request is for urgently needed Drugs, after we receive the Outpatient Prescription Drug Prior Authorization of Benefits form:

- We will, within 72 hours, review the form and decide if benefits are approved. (As soon as we can, based on your medical condition, as Medically Necessary, we may take less than 72 hours to decide if benefits will be approved.) We will notify the Member and Member's Physician in writing of the decision - by facsimile to the Physician and by mail to the Member.
- If more information is needed to make a decision or we, for any reason, cannot make a decision, we will tell the Member's Physician, within 24 hours after we get the form, what information is missing and why we cannot make a decision. If, for reasons beyond our control, we cannot tell the Member's Physician within 24 hours what information is missing, we will tell the Physician that there is a problem as soon as we know that we cannot respond within 24 hours. In either event, we will tell the Member and Member's Physician that there is a problem – always in writing by facsimile and, when appropriate, by telephone call to the Member's Physician and in writing by mail to the Member.

- As soon as we can, based on the Member's medical condition, as Medically Necessary, but not more than 48 hours after it has all the information it needs to decide if benefits will be approved, we will notify the Member and Member's Physician in writing of the decision - by facsimile to the Physician and by mail to the Member.

If the request is not for urgently needed Drugs, after we get the Outpatient Prescription Drug Prior Authorization of Benefits form:

- Based on the Member's medical condition, as Medically Necessary, we will, within 5 business days, review the form and decide if benefits will be approved. We will tell the Member and Member's Physician in writing what was decided - by facsimile to the Physician and by mail to the Member.
- If more information is needed to make a decision, we will tell the Member's Physician, in writing within 5 business days after we get the request, what information is missing and why we cannot make a decision. If, for reasons beyond our control, we cannot tell the Member's Physician within 5 business days what information is missing, we will tell the Physician that there is a problem as soon as we know that we cannot respond within 5 business days. In any event, we will tell the Member and Member's Physician that there is a problem – in writing by facsimile and, when appropriate, by telephone call to the Physician, and in writing by mail to the Member.
- As soon as we can, based on the Member's medical condition, as Medically Necessary, within 5 business days after we have all the information it needs to decide if benefits will be approved, we will tell the Member and Member's physician in writing what was decided - by facsimile to the Physician and by mail to the Member.

While we are reviewing the Outpatient Prescription Drug Prior Authorization of Benefits form, a 72-hour Emergency supply of medication may be dispensed to the Member if the Member's Physician or pharmacist determines that it is appropriate and Medically Necessary. The Member may have to pay the applicable copayment, shown in SUMMARY OF BENEFITS section on page 12 and under COPAYMENTS AT A RETAIL PHARMACY on page 45 of this section, for the 72-hour supply of the Drug. If the request for the Specialty Pharmacy Drug is approved after the Member has received a 72-hour supply, the Member will receive the remainder of the 30-day supply of the Drug with no additional copayment.

If you have any questions regarding whether a Drug is on the Prescription Drug Formulary or requires prior authorization, please call 1-800-700-2541 (or TTY/TTD 1-800-905-9821).

If we deny a request for prior authorization of a Drug that is not part of our Formulary Drug list, you or your prescribing Physician may appeal our decision by calling us at 1-800-700-2541 (or TTY/TTD 1-800-905-9821). If you are not satisfied with the resolution of your inquiry, you may file a grievance with us by following the procedures described in the section entitled CLAIMS REVIEW / GRIEVANCE PROCEDURES.

Revoking or modifying a prior authorization. A prior authorization of benefits for Prescription Drugs may be revoked or modified prior to your receiving the Drugs for reasons including but not limited to the following:

- The Member's coverage under this plan ends;
- The Agreement with the PORAC and Anthem Blue Cross Life and Health terminates;
- The Member reaches a benefit maximum that applies to Prescription Drugs, if the plan includes such a maximum;
- Prescription Drug benefits under the plan change so that Prescription Drugs are no longer covered or are covered in a different way.

PRESCRIPTION DRUG BENEFITS

A revocation or modification of a prior authorization of benefits for Prescription Drugs applies only to unfilled portions or remaining refills of the Prescription, if any, and not to Drugs you have already received.

The outpatient Prescription Drugs included on the list of Formulary Drugs covered by the plan is decided by our Pharmacy and Therapeutics Committee which is comprised of independent Physicians and pharmacists. The Pharmacy and Therapeutics Committee meets quarterly and decides on changes to make in the Formulary Drug list based on recommendations from us and a review of relevant information, including current medical literature.

SERVICES COVERED BY OTHER BENEFITS

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

DEFINITIONS

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

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

Compound Medication. Compound Medication is a mixture of Prescription Drugs and other ingredients, of which at least one of the components is commercially available as a Prescription product. Compound Medications do not include:

1. Duplicates of existing products and supplies that are mass-produced by a manufacturer for consumers; or
2. Products lacking an NDC number.

All claims for reimbursement for Compound Medications must be submitted electronically by the Pharmacy and will be paid at the Prescription Drug Negotiated Rate. Compound Medications may be limited to distribution at designated Pharmacies.

Drug. Drug means a Drug approved by the federal Food and Drug Administration (FDA) for general use by the public which requires a prescription before it can be obtained. For the purpose of this plan, insulin and niacin for lowering cholesterol will be considered a Prescription Drug.

Drug Limited Fee Schedule. The Drug Limited Fee Schedule represents the maximum amounts we will allow as covered expense for Prescriptions filled at Non-Participating Pharmacies. These amounts are the lesser of billed charges or the Average Wholesale Price.

Formulary Drug. Formulary Drug is a Drug listed on the Prescription Drug Formulary.

Generic Prescription Drug (Generic Drug). A Generic Prescription Drug is a pharmaceutical equivalent of one or more Brand Name Drugs and must be approved by the FDA as meeting the same standards of safety, purity, strength, and effectiveness as the Brand Name Drug.

Non-Participating Pharmacy. A Non-Participating Pharmacy is a Pharmacy which does not have a Participating Pharmacy Agreement in effect with us at the time services are rendered. In most instances, the Member will be responsible for a larger portion of the pharmaceutical bill when using a Non-Participating Pharmacy.

PRESCRIPTION DRUG BENEFITS

Participating Pharmacy. A Participating Pharmacy is a Pharmacy which has a Participating Pharmacy Agreement in effect with us at the time services are rendered. Call your local Pharmacy to determine whether it is a Participating Pharmacy or call the toll-free customer service telephone number.

Pharmacy. A Pharmacy is a licensed retail pharmacy.

Prescription. A Prescription is a written order or refill notice issued by a licensed prescriber.

Prescription Drug Covered Expense. Prescription Drug Covered Expense is the expense the Member incurs for a covered Prescription Drug, but not more than the maximum amounts described in items 1 and 2 in the paragraph below. Expense is incurred on the date the Member receives the service or supply.

Prescription Drug Covered Expense does not include any expense in excess of: (1) the Drug Limited Fee Schedule for Drugs dispensed by Non-Participating Pharmacies; or (2) the Prescription Drug Negotiated Rate, for Drugs dispensed by Participating Pharmacies or by the mail service program.

Prescription Drug Formulary (Formulary). The Prescription Drug Formulary is a list which we developed of outpatient Prescription Drugs which may be cost-effective, therapeutic choices. Any Participating Pharmacy can assist you in purchasing Drugs listed on the Formulary. The Member may also get information about covered formulary drugs by calling 1-800-700-2541 (or TTY/TTD 1-800-905-9821) or going to our internet website anthem.com/ca.

Prescription Drug Negotiated Rate is the rate that we have negotiated with Participating Pharmacies under a Participating Pharmacy Agreement for Prescription Drug Covered Expense. Participating Pharmacies have agreed to charge Members no more than the Prescription Drug Negotiated Rate. It is also the rate which Prescription Drug Program - Mail Service has agreed to accept as payment in full for Prescription Drugs filled through the mail service program.

Specialty pharmacy drug. Specialty pharmacy drugs are high-cost, injectable, infused, oral or inhaled medications that generally require close supervision and monitoring of their effect on the patient by a medical professional. These Drugs often require special handling, such as temperature controlled packaging and overnight delivery, and are often unavailable at retail Pharmacies.

COORDINATION OF BENEFITS

Benefits payable hereunder are subject to reduction, as set forth in the Policy, if the Member has other group coverage providing hospital, surgical or medical benefits. Such reduction will preclude the Member's receiving an aggregate of more than 100 percent of Covered Expenses from all group coverages.

THIRD PARTY LIABILITY

Under some circumstances a Member may need services under the benefits of this Evidence of Coverage for which a third party may be liable or legally responsible by reason of negligence, an intentional act or breach of any legal obligation. In that event, Anthem Blue Cross Life and Health will advance the benefits of this Evidence of Coverage to the Member subject to the following:

A. Anthem Blue Cross Life and Health will automatically have a lien, to the extent of benefits provided, upon any recovery, whether by settlement, judgment or otherwise, that the Member receives from the third party, the third party's insurer, or the third party's guarantor. The lien will be in the amount of benefits paid by Anthem Blue Cross Life and Health under the Policy for the treatment of the illness, disease, injury or condition for which the third party is liable.

- If Anthem Blue Cross Life and Health paid the provider other than on a capitated basis, its lien will not be more than amount Anthem Blue Cross Life and Health paid for those services.
- If Anthem Blue Cross Life and Health paid the provider on a capitated basis, its lien will not be more than 80% of the usual and customary charges for those services in the geographic area in which they were given.
- If you hired an attorney to gain your recovery from the third party, Anthem Blue Cross Life and Health's lien will not be for more than one-third of the money due you under any final judgment, compromise, or settlement agreement.
- If you did not hire an attorney, Anthem Blue Cross Life and Health's lien will not be for more than one-half of the money due you under any final judgment, compromise or settlement agreement.
- If a final judgment includes a special finding by a judge, jury, or arbitrator that you were partially at fault, Anthem Blue Cross Life and Health's lien will be reduced by the same comparative fault percentage by which your recovery was reduced.
- Anthem Blue Cross Life and Health's lien is subject to a pro rata reduction equal to your reasonable attorney's fees and costs in line with the common fund doctrine.

B. The Member agrees to advise Anthem Blue Cross Life and Health, in writing, within 60 days of filing his or her claim against the third party and to take such action, furnish such information and assistance, and execute such papers as Anthem Blue Cross Life and Health may require to facilitate enforcement of its rights. The Member also agrees to take no action which may prejudice the rights or interests of Anthem Blue Cross Life and Health under the Policy. Failure of the Member to give such notice to Anthem Blue Cross Life and Health or cooperate with Anthem Blue Cross Life and Health, or actions of the Member that prejudice the rights or interests of Anthem Blue Cross Life and Health, will be a material breach of the Policy and will result in the Member being personally responsible for reimbursing Anthem Blue Cross Life and Health.

C. Anthem Blue Cross Life and Health will be entitled to collect on its lien even if the amount the Member or anyone recovered for the Member (or the Member's estate, parent or legal guardian) from or for the account of such third party as compensation for the injury, illness or condition is less than the actual loss the Member suffered.

WORKERS' COMPENSATION INSURANCE

If, pursuant to any Workers' Compensation or Employer's Liability Law or other legislation of similar purpose or import, a third party is responsible for all or part of the cost of health services provided by Anthem Blue Cross Life and Health, and such third party disputes that responsibility, then we shall provide the benefits of the Policy and we shall automatically acquire thereby, by operation of law, a lien to the extent of benefits paid by Anthem Blue Cross Life and Health. The Member agrees to take no action that may prejudice our rights under such lien. The lien may be filed with the responsible third party, his or her agent, or the court, and we may exercise all rights available to it as a lien holder.

For purposes of this subsection, reasonable value shall be determined to be the usual, Customary or Reasonable Charge for services in the geographic area where the services are rendered.

BENEFITS FOR MEDICARE ELIGIBLE MEMBERS

If a Member is eligible for Medicare Parts A and B, the Member shall **not** be enrolled in a basic health benefits plan (including the PORAC BC PPO [non-California resident] Plan) in accordance with Section 22844 of the Act. CalPERS will provide the Member with information regarding his or her eligibility for a supplement to original Medicare plan.

Exception: For treatment of end-stage renal disease after the first 30 months, a Member who is enrolled in Medicare will remain enrolled in the Basic Plan, but the benefits of this plan will be reduced. When the Member incurs covered expense under this plan, we will determine payment according to the section entitled COORDINATION OF BENEFITS and the provision "Coordinating Benefits with Medicare" below.

When Medicare is the primary payer for a Member, covered expense for covered services is determined as stated under Exception in the section YOUR MEDICAL BENEFITS - HOW COVERED EXPENSE IS DETERMINED.

If you have questions about your eligibility for a Basic or Supplement Plan, please contact the CalPERS Customer Service and Education Division (CSED) at **888 CalPERS** (or **888**-225-7377).

COORDINATING BENEFITS WITH MEDICARE

We will not provide benefits under this plan that duplicate any benefits to which a Member would be entitled under Medicare. This exclusion applies to all parts of Medicare in which the Member can enroll without paying additional premium. If the Member is required to pay additional premium for any part of Medicare, this exclusion will apply to that part of Medicare only if the Member is enrolled in that part.

If a Member is entitled to Medicare, his or her Medicare coverage will not affect the services covered under this plan except as follows:

1. Medicare must provide benefits first to any services covered both by Medicare and this plan.

2. For services the Member receives that are covered both by Medicare Part A or B and this plan, coverage under this plan will apply only to Medicare Part A or B deductibles, coinsurance, and other charges for covered services over and above what Medicare pays.

3. If the Member elects to enroll in Medicare voluntary outpatient Prescription Drug benefits (Part D), the Member will **not** receive any benefits under the PRESCRIPTION DRUG BENEFITS section of this plan.

4. For any given claim, the combination of benefits provided by Medicare and the benefits provided under this plan will not exceed covered expense for the covered services.

Any charges paid by Medicare Part A or B benefits for services covered under this plan will be applied toward this plan's deductible, if any.

ENROLLMENT PROVISIONS

ELIGIBILITY FOR ENROLLMENT

A. All Members whose usual residence is not in the State of California are eligible in accordance with the Act and may enroll hereunder. Enrollment is restricted to members of the Peace Officers Research Association of California (PORAC) and their eligible Family Members.

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

B. An Employee, Annuitant or a Family Member shall not be eligible for enrollment with Anthem Blue Cross Life and Health while enrolled under any of the Board's alternative medical and hospital benefit programs.

CONDITIONS OF ENROLLMENT

A. Each Employee eligible to become an Insured Employee according to the provisions stated under ENROLLMENT PROVISIONS, and who files an application for membership for himself or herself and his or her eligible Family Members on forms provided by the Employer with the Employer during an Open Enrollment Period or period of initial eligibility, as specified in the Act, shall have fulfilled the Conditions of Enrollment.

B. If an Employee fails to enroll himself or herself or his or her eligible Family Members during an Open Enrollment Period or the period of initial eligibility as specified in the Act, the Employee may apply for enrollment for himself or herself and any eligible Family Members in accordance with the Act. Contact your Employer or CalPERS Customer Service and Education Division (CSED) by calling **888 CalPERS** (or **888**-225-7377) for further information.

Important Note: It is the Insured Employee's responsibility to request additions, deletions or changes in enrollment in a timely manner and to stay informed about the eligibility requirements stated in the Act and Regulations. The Insured Employee may be held liable retroactively for any services provided to ineligible dependents.

COMMENCEMENT OF COVERAGE

After fulfilling the Conditions of Enrollment as stated in ENROLLMENT PROVISIONS, coverage shall commence for an Insured Employee and his or her Family Members at 12:01 a.m. on the date set forth in the Act.

TERMINATION AND RELATED PROVISIONS

TERMINATION OF THE POLICY

This plan may be terminated by the Board, the Insurance and Benefits Trust of PORAC, or Anthem Blue Cross Life and Health according to the provisions set forth in the Policy.

TERMINATION OF COVERAGE

Coverage may be terminated for individual Members by any of the following conditions, subject, however, to the provisions for extensions of coverage required by Section 599.508 (a) (5) of the Regulations, the continuation benefits provided under CONTINUATION OF GROUP COVERAGE, HIPAA COVERAGE AND INDIVIDUAL CONVERSION and TERMINAL BENEFITS:

1. By the Board's termination of the Memorandum of Agreement.

2. By Anthem Blue Cross Life and Health's termination of the Policy.

3. By voluntary cancellation by the Insured Employee or Family Member in accordance with Section 599.505 of the Act. In the event of such voluntary cancellation, the Member shall cease to be covered hereunder without notice from the Employer or Anthem Blue Cross Life and Health at midnight of the day on which such cancellation becomes effective in accordance with Section 599.505 of the Regulations.

4. If an Insured Employee or Family Member ceases to be eligible for coverage in accordance with Section 599.506 of the Act.

IMPORTANT NOTE: The Insured Employee may be held liable retroactively for any services provided to ineligible dependents. It is the Insured Employee's responsibility to report any changes in a Family Member's status to his or her Employer in a timely manner. Insured Employee or Family Members who lose eligibility according to the above criteria may be entitled to continue coverage under the terms of the CONTINUATION OF GROUP COVERAGE section which follows.

OPEN ENROLLMENT

Members who have voluntarily cancelled enrollment with Anthem Blue Cross Life and Health may apply for reenrollment during the Open Enrollment Period.

UNFAIR TERMINATION OF COVERAGE

A Member's coverage may not be terminated because of his or her health status or requirements for health care services. If the Member believes that his or her coverage has been terminated for either of these reasons, the Member may request a review of the matter by the Commissioner of Corporations.

CONTINUATION OF GROUP COVERAGE

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

A. Eligibility for Continuation - Qualifying Events

Under the Act and Regulations, all CalPERS Employers are subject to the Consolidated Omnibus Reconciliation Budget Act of 1985 (COBRA). Under COBRA, Insured Employees or Family Members may choose to continue coverage under the Policy if it would otherwise end for any of the reasons shown below. These are called qualifying events, and they are:

For Insured Employee and Family Members . . .

1. The Insured Employee's termination of employment, for any reason other than gross misconduct;
2. A reduction in the Insured Employee's work hours;
3. For Members who may be covered as retirees, cancellation of that retiree coverage due to the Employer's filing for protection under the bankruptcy law (Chapter 11), provided the Member was covered prior to the filing of bankruptcy.

For Family Members . . .

4. The death of the Insured Employee;
5. The spouse's divorce or legal separation from the Insured Employee, or if the spouse vacates the residence shared with the Insured Employee;
6. The end of a child's status as a Family Member, in accordance with the Act and Regulations.
7. The Insured Employee's entitlement to Medicare.

B. Requirements for Continuation

1. Notice

For qualifying events 1, 2 or 3 above, the Insured Employee's Employer will notify the Insured Employee of the right to continue coverage. For qualifying events 4 and 7, a Family Member will be notified of the continuation right. Anyone choosing to continue coverage must so notify the Board within 60 days of the date they receive notice of their continuation right.

In the event of an annuitant's death, it is the Family Member's responsibility to notify the Board within 30 days of the date of such qualifying event.

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

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

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

Once the continuation of coverage under the Policy is elected, written notice of his/her rights to continuation of coverage shall be sent to each covered Insured Employee. In addition to the notice, an Evidence of Coverage booklet shall be sent to each enrolled Insured Employee at the address on enrollment document(s) and shall be deemed notice to such Insured Employee and his/her spouse.

2. Family Members Acquired During Continuation

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

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

3. Cost of Coverage

The benefits of continuation coverage are identical to the benefits in this Evidence of Coverage. The cost for this continuation coverage, called the "premium", must be paid each month during the COBRA continuation period to keep the continuation in force. The premium for continuation coverage may not exceed 102 percent of the prepayment fees specified for coverage under the Policy or any amendment, renewal or replacement of this plan. An eligible Insured Employee or his/her eligible Family Member(s) electing continuation coverage shall pay to Anthem Blue Cross Life and Health the premium for continuation coverage not later than the following dates:

a. If such election is made before the qualifying event, the premium may be paid with the written election, in the amount required for the first month of continuation coverage.

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

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

For an Insured Employee who is eligible for an extension of continuation coverage due to having been determined by the Social Security Administration to be totally and permanently disabled, we shall charge 150 percent of the Insured Employee's premium prior to the disability. We must receive timely payment of the premium charge each month in order to maintain the coverage in force.

If a second Qualifying Event (as shown below) occurs during this extended continuation, the total COBRA continuation may continue up to 36 months from the date of the first Qualifying Event. The premium charge shall then be 150 percent of the applicable rate for the 19th through 36th month.

For purposes of determining premium charges payable for continued coverage, a person originally covered as a spouse will be treated as the Insured Employee if coverage is continued for him/herself alone. If such spouse and his or her child(ren) enroll, the premium charge payable will depend upon the number of persons covered. Each child continuing coverage other than as a dependent of an Insured Employee will pay the premium rate applicable to an Insured Employee (if more than one child is so enrolled, the premium will be the two-party or three-party rate depending upon the number of children enrolled).

4. Subsequent Qualifying Events

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

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

5. When Continuation Coverage Begins

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

C. When The Continuation Ends

This continuation will end on the earliest of:

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

   Exceptions: A qualified beneficiary whose coverage is continued may extend that continuation coverage, provided that:

   a. the Member whose COBRA continuation under this plan began on or after January 1, 2003, and ends in accordance with item 1, elects to continue coverage for medical benefits only under CalCOBRA for the balance of 36 months (COBRA and CalCOBRA combined). All COBRA eligibility must be exhausted before the Member is eligible to further continue coverage under CalCOBRA. See CALCOBRA CONTINUATION OF COVERAGE beginning on the next page for more information.

   b. the disabled Member has been determined by the Social Security Administration to be totally and permanently disabled according to the statutory requirements of either Title II or Title XVI of the Social Security Act. The extension applies to all covered Members as well as the disabled Member. The disabled Member must furnish proof of the Social Security Administration's determination to his/her Employer during the first 18 months of COBRA continuation, but no later than 60 days after the later of the following events:

      i. the date of the Social Security Administration's determination of the Member's disability;
      ii. the date on which the original Qualifying Event occurs;
      iii. the date on which the qualified beneficiary loses coverage; or
      iv. the date on which the qualified beneficiary is informed of the obligation to provide the disability notice.

      The period of continuation will in no event continue beyond (1) the period of disability, or (2) a maximum of 29 months after the date the Insured Employee's coverage terminated due to the loss of employment, whichever occurs first. A Member whose COBRA continuation under this plan began on or after January 1, 2003, and ends in accordance with item 1, may elect to continue coverage for medical benefits only under CalCOBRA for the balance of 36 months (COBRA and CalCOBRA combined). All COBRA eligibility must be exhausted before the Member is eligible to further continue coverage under CalCOBRA. See CALCOBRA CONTINUATION OF COVERAGE beginning on the next page for more information.

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

3. The end of 36 months from the date the Insured Employee became entitled to Medicare, if the qualifying event was the Insured Employee's entitlement to Medicare.
4. The date the Policy terminates.
5. The end of the last period for which the final premium charge was paid.
6. The date after the date of election of COBRA, the Member first becomes eligible for Medicare.
7. The date after the date of election of COBRA, the Member first becomes covered under any other group health plan, except that if the Member's coverage under a group health plan contains any exclusion or limitation relating to a pre-existing condition, the Member's coverage will remain effective until the exclusions or limitations of the group health plan for pre-existing conditions no longer apply to the Member.

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

Subject to the Policy remaining in effect, a retired Insured Employee whose coverage began due to a Chapter 11 bankruptcy may continue coverage for the remainder of his life; that Insured Employee's covered Family Members may continue coverage for 36 months after their coverage terminates due to the Insured Employee's death. However, coverage could terminate prior to such time for either the Insured Employee or Family Member in accordance with items 4, 5, 6, or 7 above.

If a Member's continuation under this plan ends in accordance with items 1 or 3 that Member is eligible for Individual Conversion coverage. If a Member's continuation under this plan ends in accordance with items 1, 2, 3 or 4, the Member may be eligible for HIPAA coverage. The Employer will provide notice of these options within 180 days prior to the Member's COBRA termination date.

CALCOBRA CONTINUATION OF COVERAGE

If your continuation coverage under federal COBRA began on or after January 1, 2003, you have the option to further continue coverage under CalCOBRA for medical benefits only if your federal COBRA ended following:

1. 18 months after the qualifying event, if the qualifying event was termination of employment or reduction in work hours; or
2. 29 months after the qualifying event, if you qualified for the extension of COBRA continuation during total disability.

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

CONTINUATION OF GROUP COVERAGE

TERMS OF CALCOBRA CONTINUATION

Notice. Within 180 days prior to the date federal COBRA ends, we will notify you of your right to further elect coverage under CalCOBRA. If you choose to elect CalCOBRA coverage, you must notify us in writing within 60 days of the date your coverage under federal COBRA ends or when you are notified of your right to continue coverage under CalCOBRA, whichever is later. If you do not give Anthem Blue Cross Life and Health written notification within this time period, you will not be able to continue your coverage.

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

Additional Family Members. A dependent acquired during the CalCOBRA continuation period is eligible to be enrolled as a Family Member. The standard enrollment provisions of the Policy apply to enrollees during the CalCOBRA continuation period.

Cost of Coverage. You will be required to pay the entire cost of your CalCOBRA continuation coverage (this is the "premium"). This cost will be:

1. 110% of the applicable group rate if your coverage under federal COBRA ended after 18 months; or
2. 150% of the applicable group rate if your coverage under federal COBRA ended after 29 months.

You must make payment to us within the timeframes specified below. We must receive payment of your premium each month to maintain your coverage in force.

Payment Dates. The first payment is due along with your enrollment form within 45 days after you elect continuation coverage. You must make this payment by first-class mail or other reliable means of delivery, in an amount sufficient to pay any required premium and premium due. Failure to submit the correct amount within this 45-day period will disqualify you from receiving continuation coverage under CalCOBRA. Succeeding premium payments are due on the first day of each following month.

If premium is not received when due, your coverage will be cancelled. Anthem Blue Cross Life and Health will cancel your coverage only upon sending you written notice of cancellation at least 15 days prior to cancelling your coverage. If you make payment in full within 15 days after Anthem Blue Cross Life and Health issues this notice of cancellation, your coverage will not be cancelled. If you do not make the required payment in full within this 15 day period, your coverage will be cancelled as of 12:00 midnight on the fifteenth day after the date on which the notice of cancellation is sent and will not be reinstated. Any payment Anthem Blue Cross Life and Health receives more than 15 days after it issues the notice of cancellation will be refunded to you within 20 business days.

Change of Premium. The amounts of the premium may be changed by us as of any premium due date. We will provide you with written notice at least 30 days prior to the date any premium increase goes into effect.

Accuracy of Information. You are responsible for supplying up-to-date eligibility information. We shall rely upon the latest information received as correct without verification but maintain the right to verify any eligibility information you provide.

CONTINUATION OF GROUP COVERAGE

CalCOBRA Continuation Coverage Under the Prior Plan. If you were covered through CalCOBRA continuation under the prior plan, your coverage may continue under this plan for the balance of the continuation period. However your coverage shall terminate if you do not comply with the enrollment requirements and premium payment requirements of this plan within 30 days of receiving notice that your continuation coverage under the prior plan will end.

When CalCOBRA Continuation Coverage Begins. When you elect CalCOBRA continuation coverage and pay the premium, coverage is reinstated back to the date federal COBRA ended, so that no break in coverage occurs.

For Family Members properly enrolled during the CalCOBRA continuation, coverage begins according to the enrollment provisions of the Policy.

When the CalCOBRA Continuation Ends. This CalCOBRA continuation will end on the earliest of:

1. The date that is 36 months after the date of your qualifying event under federal COBRA*;
2. The date the Policy terminates;
3. The end of the period for which premium is last paid (your coverage will be cancelled upon written notification, as explained under "Payment Dates" above);
4. The date you become covered under any other health plan, unless the other health plan contains an exclusion or limitation relating to a pre-existing condition that you have. In this case, this continuation will end at the end of the period for which the pre-existing condition exclusion or limitation applied;
5. The date you become entitled to Medicare; or
6. The date you become covered under a federal COBRA continuation.

CalCOBRA continuation will also end if you move out of our service area or if you commit fraud.

*If your CalCOBRA continuation coverage began under a prior plan, this term will be dated from the time of the qualifying event under that prior plan.

If your CalCOBRA continuation under this plan ends in accordance with items 1, 2 or 3, you may be eligible for HIPAA coverage or Individual Conversion coverage. You will receive notice of these options within 180 days prior to your CalCOBRA termination date. See the HIPAA COVERAGE AND INDIVIDUAL CONVERSION section on pages 71 & 72 for more information.

POST-COBRA CONTINUATION FOR QUALIFYING MEMBERS

This section does not apply to any individual who is not eligible for this continuation prior to January 1, 2005. Subject to payment of premium as stated in the Policy, coverage under this plan may be continued for the Insured Employee, the Insured Employee's spouse, and the Insured Employee's former spouse (if any) under Section 1373.621 of the Health and Safety Code and Section 2800.2 of the Labor Code, in accordance with the following provisions. This continuation may be elected following the CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA) (the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), or Title X of P.L. 99-272) and the CALCOBRA CONTINUATION OF COVERAGE shown above.

CONTINUATION OF GROUP COVERAGE

For the purposes of this section, "former spouse" means: (a) an individual who is divorced from the Insured Employee; or (b) an individual who was married to the Insured Employee at the time of the Insured Employee's death.

Requirements. The Insured Employee and spouse may continue coverage under this plan if:

1. The Insured Employee, or the Insured Employee on behalf of himself or herself and the spouse, was entitled to, and had elected to continue coverage under, COBRA or CalCOBRA, as described in the preceding sections;
2. The Insured Employee or spouse has not elected to continue coverage under any other available continuation;
3. The Insured Employee has worked for the Employer for at least the prior five years; and
4. The Insured Employee is at least 60 years old on the date employment with the Employer ended.

The former spouse may continue coverage under this plan in accordance with this section if he or she was covered as a qualified beneficiary under COBRA or CalCOBRA, as described in the preceding sections.

Notice and Election. The Employer will notify the Insured Employee or spouse and the former spouse of the right to continue coverage at least 180 days prior to the date continuation of coverage under COBRA or CalCOBRA is scheduled to end.

For the Insured Employee and spouse, this continuation may be chosen for both, for the Insured Employee only, or for the spouse only. The former spouse may elect this continuation for himself or herself only.

To elect this continuation, you must notify the Board in writing within 30 days prior to the date continuation coverage under COBRA or CalCOBRA is scheduled to end. If you fail to elect this continuation when first eligible, you may not elect this continuation at a later date. Notice of continued coverage, along with the initial premium amount, must be delivered to us within 45 days after you elect this continuation.

Cost of Coverage. This continuation is subject to payment of premium charges to us at the time premium charges are due. The Employer may require that you pay the entire cost of your continuation coverage. The Employer is responsible to us for the timely payment of premium charges due for the continuation of your coverage under this Policy. The rate for continuation coverage under this section shall be 213 percent of the applicable prepayment fees. For the purpose of determining premium charges payable, the spouse or former spouse continuing coverage alone will be considered to be an Insured Employee.

When Continuation Ends. This continuation will end on the earliest of:

1. The end of the period for which premiums are last paid;
2. The date the Policy terminates;
3. The date after the date of election, the Insured Employee, spouse, or former spouse first becomes covered under any group health plan not maintained by the Employer;
4. The date after the date of election, the Insured Employee, spouse, or former spouse first becomes entitled to Medicare;
5. The date the Insured Employee, spouse, or former spouse reaches age 65; or

6. For the spouse or former spouse, five years from the date the spouse's or former spouse's COBRA or CalCOBRA continuation coverage ended.

If your continuation under this plan ends in accordance with item 6, you are eligible for Individual Conversion coverage. If your continuation under this plan ends in accordance with items 2 or 6, you may be eligible for HIPAA coverage. See the HIPAA COVERAGE AND INDIVIDUAL CONVERSION section on pages 71 & 72 for more information.

STATE CONTINUATION FOR QUALIFYING MEMBERS

Subject to payment of premium as stated in the Policy, coverage under this plan may be continued for you in accordance with the following provisions. You may elect this continuation instead of, or following, the CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA) described previously (The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), or Title X of P. L. 99-272). However, this continuation may not be elected if the CALCOBRA CONTINUATION OF COVERAGE described previously was elected, or for the Insured Employee and eligible spouse, this continuation may not be elected if the POST-COBRA CONTINUATION FOR QUALIFYING MEMBERS described in the preceding section (under Section 2807.5 of the Labor Code) was elected.

Qualifying Events for Continuation Coverage. You may continue your coverage if any of the following circumstances would otherwise terminate your coverage under this plan:

1. **For Insured Employees and Family Members:** the Insured Employee's termination of employment.

2. **For Family Members:** (a) the death of the Insured Employee; or (b) the spouse's divorce or legal separation from the Insured Employee.

Notice and Election. We will notify the Insured Employee or Family Member of the right to continue coverage within ten days after the Member becomes ineligible to continue coverage under this plan.

To elect this continuation, the Member (or guardian for a child under age 18) must properly file an application within 31 days from the qualifying event. An application is considered properly filed only if all requested information is supplied and the application is personally signed, dated, and given to the Board within 31 days of the qualifying event. We must receive this application from the Board within 90 days.

This continuation coverage may be chosen for all eligible Members, or only for selected Members. But if you fail to elect the continuation when first eligible, you may not elect it at a later date.

Cost of Coverage. You will be required to pay the entire cost of your continuation coverage. You are responsible to us for the timely payment of the premiums due for the continuation of any Member's coverage under this Policy. For purposes of determining premiums payable, the surviving spouse, divorced or legally separated spouse will be considered to be an Insured Employee.

If termination of employment is due to the Employer's cessation or reduction of business, such Employer must pay that part of the premium, if any, normally paid by the Employer, for the first three months of continuation. Thereafter, you may be required to pay the entire cost of your continuation coverage.

With respect to a surviving spouse, divorced or legally separated spouse, who is age 55 or over on the date coverage under this plan terminates, the cost of coverage after the first three years of continuation will be 102 percent of the Insured Employee's premium rates.

CONTINUATION OF GROUP COVERAGE

When Continuation Ends. This continuation will end on the earliest of:

1. The end of the period for which premiums were last paid;
2. The date the Policy terminates;
3. The end of 39 weeks from the date of termination of employment for an Insured Employee;
4. The end of 39 weeks from the date the continuation coverage began for the surviving or divorced spouse;
5. The date the surviving or divorced spouse remarries; or
6. The date the Member becomes eligible for coverage under an employer group health plan.

Exceptions:

1. Continuation coverage for a surviving spouse, divorced or legally separated spouse, who is age 55 years or over, will not end at the end of 39 weeks, but will end on the earlier of:
   a. The date the surviving spouse, divorced or legally separated spouse remarries;
   b. The date the surviving spouse, divorced or legally separated spouse becomes eligible for Medicare; or
   c. The date the surviving spouse, divorced or legally separated spouse becomes eligible for coverage under another employer group health plan.
2. Continuation coverage for a spouse due to divorce or legal separation, except as specified in 1 above, will end on the later of: (a) any of the dates listed above; or (b) such time as is provided by the divorce or legal separation judgment.

If your continuation under this plan ends in accordance with items 3 or 4 above, you are eligible for Individual Conversion. If your continuation under this plan ends in accordance with items 3, 4, or 5 above, you may be eligible for HIPAA coverage. See HIPAA COVERAGE AND INDIVIDUAL CONVERSION beginning on the next page for more information.

HIPAA COVERAGE AND INDIVIDUAL CONVERSION

If coverage for medical benefits under this plan ends, the Member may be eligible to enroll for coverage with any carrier or health plan that offers individual medical coverage. HIPAA coverage and Individual Conversion are available upon request if the Member meets the requirements stated below. Both HIPAA coverage and Individual Conversion are available for medical benefits only. Please note that the benefits and cost of these plans will differ from the Employer's plan.

HIPAA COVERAGE

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law that provides an option for individual coverage when coverage under the Employer's group plan ends. To be eligible for HIPAA coverage, the Member must meet all of the following requirements:

1. The Member must have a minimum of 18 months of continuous health coverage, most recently under an employer-sponsored health plan, and have had coverage within the last 63 days.
2. The Member's most recent coverage was not terminated due to nonpayment of premium charges or fraud.
3. If continuation of coverage under the Employer plan was available under COBRA, CalCOBRA, or a similar state program including Post-COBRA, such coverage must have been elected and exhausted.
4. The Member must not be eligible for Medicare, Medi-Cal, or any group medical coverage and cannot have other medical coverage.

The Member must apply for HIPAA coverage within 63 days of the date their coverage under the Employer's plan ends. If a Member decides to enroll in HIPAA coverage, he or she will no longer qualify for Individual Conversion.

INDIVIDUAL CONVERSION

A. An Insured Employee whose coverage under the Employer's plan is terminated, other than by voluntary cancellation, termination of the Memorandum of Agreement by the Board, termination of the Policy by Anthem Blue Cross Life and Health, withdrawal of his or her Employer from participation in the Act, or failure to continue enrollment or to make contributions during continuation of enrollment in a non-pay status according to the Act, may apply on behalf of himself or herself and all enrolled Family Members for an Individual Membership Policy that may be in effect at the time of application for individual coverage.

B. A Family Member whose coverage under the Employer's plan terminates because of termination of enrollment of an Insured Employee, or because of loss of Family Member status, may apply for an Individual Membership Policy that may be in effect at the time of application for individual coverage.

C. A Member, eligible for an individual conversion plan as specified in A. and B. above, must submit a written application and make the first premium payment to Anthem Blue Cross Life and Health within 63 days following the date coverage under the Employer's plan ends. In such event, individual coverage shall become effective at 12:01 a.m. on the day following termination of coverage through the Employer.

If you decide to enroll in an Individual Conversion plan, you will no longer qualify for HIPAA coverage.

HIPAA COVERAGE AND INDIVIDUAL CONVERSION

The intention of conversion coverage is not to replace the coverage a Member has under this plan, but to make available a specified amount of coverage for medical benefits until the Member can find a replacement. The conversion plan provides lesser benefits than this plan and the provisions and rates differ.

When coverage under the Employer's group plan ends, the Member will receive more information about how to apply for Individual Conversion or HIPAA coverage, including a postcard for requesting an application and a telephone number to call if the Member has any questions. Any carrier or health plan that offers individual medical coverage must make HIPAA coverage available to qualified persons without regard to health status.

TERMINAL BENEFITS

In the event the Policy is terminated by Anthem Blue Cross Life and Health, we shall provide extension of benefits for a Member who is totally disabled at the time of such termination, subject to the following provisions:

A. If a Member is totally disabled when coverage ends and is under the treatment of a Physician, the benefits of the Policy shall continue to be provided under this section for services treating the totally disabling illness or injury, and for no other condition related to the condition causing the total disability, illness or injury or arising out of such totally disabling illness or injury. This extension of benefits is not available if the Member becomes covered under another group health plan that provides coverage without limitation for the disabling condition.

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

C. A Member not confined as an inpatient who wishes to apply for total disability benefits must submit written certification by the Physician of the total disability. We must receive this certification within 30 days of the date coverage ends under the Policy. At least once every 60 days while benefits are extended, We must receive proof that the Member's total disability is continuing.

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

   1. The Member is no longer Totally Disabled, or

   2. The maximum benefits of the Policy are paid, or

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

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

   Exception: If you are pregnant on the date of discontinuance of the Policy, your pregnancy and maternity care benefits under this plan will be continued subject to the following:

   1. Your pregnancy began while the Policy was in effect.

   2. You do not have to be totally disabled.

   3. Your extension of benefits will end when any one of the following circumstances occurs:

      a. You are no longer pregnant.

      b. The maximum benefits available to you under this plan are paid.

MONTHLY RATES

Type of Enrollment	Enrollment Code	Gross Rate
Self Only	2071	$484.00
Self and One Dependent	2072	$906.00
Self and Two or More Dependents	2073	$1,151.00

State Employees and Annuitants

The gross rate shown above will be reduced by the amount the State of California contributes toward the cost of your health benefits plan. These contribution amounts are subject to change by legislative action. Any such change resulting in a change in the amount of your contribution will be accomplished automatically by the State Controller or affected Retirement System without action on your part. For current contribution information, contact your Agency or Retirement System Health Benefits Officer.

Public Agency Employees and Annuitants

The gross rate amount shown above will be reduced by the amount your Public Agency contributes toward your health benefits plan premium. This amount varies among Public Agencies. Therefore, for assistance in calculating your net rate cost, contact your Agency or Retirement System Health Benefits Officer.

Rate Change

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

GENERAL PROVISIONS

Evidence of Coverage

Anthem Blue Cross Life and Health shall issue to the Insured Employee an Evidence of Coverage booklet. This Evidence of Coverage booklet is not the Policy. It does not change coverage under the Policy in any way. This Evidence of Coverage booklet, which is evidence of coverage under the Policy, is subject to all of the terms and conditions of that Policy.

Identification Cards

Anthem Blue Cross Life and Health shall issue to the Insured Employee an identification card to which the Insured Employee and Family Members are entitled. Possession of an identification card confers no right to services or other benefits of the Policy. To be entitled to services or benefits, the holder of the card must, in fact, be a Member on whose behalf applicable prepayment fees under the Policy have actually been paid. Any person receiving services or other benefits to which he or she is not then entitled pursuant to the provisions of the Policy is chargeable therefor at prevailing rates.

Medical Necessity

The benefits of this Evidence of Coverage are provided only for services that are Medically Necessary. The services must be ordered by the attending Physician for the direct care and treatment of a covered illness, injury or condition, except for routine care, dental care and lenses following surgery as specifically stated. They must be standard medical practice where received for the illness, injury or condition being treated and must be legal in the United States. When an inpatient Hospital Stay is necessary, services are limited to those which could not have been performed before admission. The process used to authorize or deny health care services under this plan is available to you upon request.

Expense in Excess of Benefits

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

Blue Cross and/or Blue Shield Providers

When you obtain covered health care services, the amount you pay, if it is not a flat dollar amount, is usually calculated on the lower of the:

- billed charges for your covered services, or
- negotiated price that the on-site Blue Cross and/or Blue Shield Licensee (Host Blue) passes on to us.

Often this negotiated price referred to above will consist of a simple discount which reflects the actual price paid by the Host Blue. But sometimes it is an estimated price that factors in expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect **average** expected savings with your health care provider or with a specified group of providers. If the negotiated price reflects average expected savings, it may result in greater variation (more or less) from the actual price paid than will the estimated price. The estimated or average price may be adjusted in the future to correct for overestimation or underestimation of past prices. Regardless of how the negotiated price is determined, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating Member liability for covered services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state statutes mandate Member liability calculation methods that differ from the usual BlueCard Program method noted above in the second paragraph of this section or require a surcharge, we would then calculate your liability for any covered health care services in accordance with the applicable state statute in effect at the time you received your care.

Providers available to you through the BlueCard Program have not entered into contracts with Anthem Blue Cross Life and Health. If you have any questions or complaints about the BlueCard Program, please call us at the customer service telephone number listed on your ID card.

Payment to Providers

The benefits of this plan will be paid directly to Participating Providers, Centers of Medical Excellence and medical transportation providers. Also, we will pay other providers of service directly when you assign benefits in writing. If another party pays for your medical care and you assign benefits in writing, we will pay the benefits of this plan to that party. These payments will fulfill our obligation to you for those covered services.

Exception: Under certain circumstances we will pay the benefits of this plan directly to a provider or third party even without your assignment of benefits in writing. To receive direct payment, the provider or third party must provide us the following:

1. Proof of payment of medical services and the provider's itemized bill for such services;
2. If the Insured Employee does not reside with the patient, either a copy of the judicial order requiring the Insured Employee to provide coverage for the patient or a state approved form verifying the existence of such judicial order which would be filed with us on an annual basis;
3. If the Insured Employee does not reside with the patient, and if the provider is seeking direct reimbursement, an itemized bill with the signature of the custodian or guardian certifying that the services have been provided and supplying on an annual basis, either a copy of the judicial order requiring the Insured Employee to provide coverage for the patient or a state approved form verifying the existence of such judicial order;
4. The name and address of the person to be reimbursed, the name and policy number of the Insured Employee, the name of the patient, and other necessary information related to the coverage.

Claims Procedures

Properly completed claim forms itemizing the services received and clearly and accurately describing the services or supplies received and the charges must be sent to us by the Member or the provider of service. These claim forms must be received by us within 90 days of the date services are received. If it is not reasonably possible to submit the claim within that timeframe, an extension of up to 12 months will be allowed. We are not liable for the benefits of the Policy if claims are not filed within this time period. Claim forms must be used; cancelled checks or receipts are not acceptable.

GENERAL PROVISIONS

Members using Non-Participating Providers must submit bills attached to a claim form to:

Anthem Blue Cross Life and Health Insurance Company
Attn: BC PPO (non-California resident) Plan
State of California (PORAC)
P.O. Box 60007
Los Angeles, CA 90060-0007

If you have any questions regarding your claim, please call the statewide service telephone number:

1-800-288-6928.

Right of Recovery

When the amount paid by Anthem Blue Cross Life and Health exceeds the amount for which we are liable under this Evidence of Coverage, we have the right to recover the excess amount. This amount may be recovered from the Member, the person to whom payment was made or any other plan.

Free Choice of Hospital and Physician

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

Workers' Compensation Insurance

This Evidence of Coverage is not in lieu of and does not affect any requirement of coverage by Workers' Compensation Insurance.

Non-Regulation of Providers

Benefits provided under this Evidence of Coverage do not regulate the amounts charged by providers of medical care.

Area of Service

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

Benefits Non-Transferable

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

Independent Contractors

All providers are independent contractors. Anthem Blue Cross Life and Health is not liable for any claim or demand of damages connected with any injury resulting from any treatment.

GENERAL PROVISIONS

Clerical Error

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

Grievance Procedure

Anthem Blue Cross Life and Health has established and will maintain a grievance procedure comprised of at least two levels.

Right to Receive and Release Information

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

Member Cooperation

By virtue of the agreement with CalPERS, Members agree to: (a) take action, furnish help and information, and execute instruments required to enforce our rights as set forth in the Policy; (b) take no action to harm our rights or interests; and (c) tell us of circumstances that may give rise to our rights.

Protection of Coverage

Anthem Blue Cross Life and Health does not have the right to cancel the coverage of any Member under the Policy while:

A. The Policy is still in effect, and

B. The Member is still eligible, and

C. The Member's premium charges are paid according to the terms of the Policy.

Providing of Care

Anthem Blue Cross Life and Health is not responsible for providing any type of hospital, medical or similar care.

Terms of Coverage

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

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

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

Entire Contract

This Evidence of Coverage, including any amendments and endorsements to it, is a summary of your benefits. It replaces any older Evidence of Coverages issued to you for the coverages described in the Summary of Benefits. All benefits are subject in every way to the entire Policy which includes this Evidence of Coverage. The terms of the Policy may be changed only by a written endorsement signed by one of our authorized officers. No agent or employee has any authority to change any of the terms, or waive the provisions of, the Policy.

Liability For Statements

No statements made by you, unless they appear on a written form signed by you or are fraudulent, will be used to deny a claim under the Policy. Statements made by you will not be deemed warranties. With regard to each statement, no statement will be used by us in defense to a claim unless it appears in a written form signed by you and then only if a copy has been furnished to you. After two years following the filing of such claim, if the coverage under which such claim is filed has been in force during that time, no such statement will be used to deny such a claim, unless the statement is fraudulent.

Conformity with Laws

Any provision of the Policy which, on its effective date, is in conflict with the laws of the governing jurisdiction, is hereby amended to conform to the minimum requirements of such laws.

Continuity of Care after Termination of Provider

Subject to the terms and conditions set forth below, we will provide benefits to a Member at the Participating Provider level for covered services (subject to applicable co-payments, coinsurance, deductibles and other terms) received from a provider at the time the provider's contract is terminated by a Blue Cross or Blue Shield Plan (unless the provider's contract is terminated for reasons of medical disciplinary cause or reason, fraud, or other criminal activity). This does not apply to a provider who voluntarily terminates his or her contract.

The Member must be under the care of the Participating Provider at the time the provider's contract terminates. The terminated provider must agree in writing to provide services to the Member in accordance with the terms and conditions of his or her agreement with the Blue Cross or Blue Shield plan prior to termination. The provider must also agree in writing to accept the terms and reimbursement rates under his or her agreement with the Blue Cross or Blue Shield plan prior to termination. . If the provider does not agree with these contractual terms and conditions, we are not required to continue the provider's services beyond the contract termination date.

We will provide such benefits for the completion of covered services by a terminated provider only for the following conditions:

1. An acute condition. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the acute condition.

2. A serious chronic condition . A serious chronic condition is a medical condition caused by a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by us in consultation with you and the terminated provider and consistent with good professional practice. Completion of covered services shall not exceed twelve (12) months from the time you enroll in this plan.

3. A pregnancy. A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of covered services shall be provided for the duration of the pregnancy.

4. A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one (1) year or less. Completion of covered services shall be provided for the duration of the terminal illness.

5. The care of a newborn child between birth and age thirty-six (36) months. Completion of covered services shall not exceed twelve (12) months from the time the child enrolls in this plan.

6. Performance of a surgery or other procedure that we have authorized as part of a documented course of treatment and that has been recommended and documented by the provider to occur within 180 days of the time you enroll in this plan.

Please contact customer service at the telephone number listed on your ID card to request continuity of care or to obtain a copy of the written policy. Eligibility is based on the Member's clinical condition and is not determined by diagnostic classifications. Continuity of care does not provide coverage for services not otherwise covered under the plan.

We will notify you by telephone, and the provider by telephone and facsimile, as to whether or not your request for continuity of care is approved. If approved, you will be financially responsible only for applicable deductibles, coinsurance, and co-payments under the plan. Financial arrangements with terminated providers are negotiated on a case-by-case basis. We will request that the terminated provider agree to accept reimbursement and contractual requirements that apply to Participating Providers, including payment terms. If the terminated provider does not agree to accept the same reimbursement and contractual requirements, we are not required to continue that provider's services. If you disagree with our determination regarding continuity of care, you may file a complaint with us as described in the COMPLAINT NOTICE.

Financial Arrangements with Providers

Anthem Blue Cross Life and Health or an affiliate has contracts with certain health care providers and suppliers (hereafter referred to together as "Providers") for the provision of and payment for health care services rendered to its Insured Employees and Members entitled to health care benefits under individual certificates and group policies or contracts to which Anthem Blue Cross Life and Health or an affiliate is a party, including all persons covered under the Policy.

GENERAL PROVISIONS

Under the above-referenced contracts between Providers and Anthem Blue Cross Life and Health or an affiliate, the negotiated rates paid for certain medical services provided to persons covered under the Policy may differ from the rates paid for persons covered by other types of products or programs offered by Anthem Blue Cross Life and Health or an affiliate for the same medical services. In negotiating the terms of the Policy, PORAC was aware that Anthem Blue Cross Life and Health or its affiliates offer several types of products and programs. The Insured Employees, Family Members and PORAC are entitled to receive the benefits of only those discounts, payments, settlements, incentives, adjustments and/or allowances specifically set forth in the Policy.

Also, under arrangements with some Providers certain discounts, payments, rebates, settlements, incentives, adjustments and/or allowances, including, but not limited to, pharmacy rebates, may be based on aggregate payments made by Anthem Blue Cross Life and Health or an affiliate in respect to all health care services rendered to all persons who have coverage through a program provided or administered by Anthem Blue Cross Life and Health or an affiliate. They are not attributed to specific claims or plans and do not inure to the benefit of any covered individual or group, but may be considered by Anthem Blue Cross Life and Health or an affiliate in determining its fees or subscription charges or premiums.

Certificate of Creditable Coverage

Certificates of creditable coverage are issued automatically when a Member's coverage under this plan ends. Anthem Blue Cross Life and Health will also provide a certificate of creditable coverage in response to a Member's request, or to a request made on a Member's behalf, at any time while the Member is covered under this plan and up to 24 months after the Member's coverage under this plan ends. The certificate of creditable coverage documents the Member's coverage under this plan. To request a certificate of creditable coverage, please call customer service toll-free at 1-800-288-6928.

GENERAL INFORMATION

Information pertaining to eligibility, enrollment, cancellation or termination of insurance, Individual Continuation of Benefits, etc., is found in the informational pamphlet entitled *CalPERS Health Program Handbook*. This pamphlet is prepared by CalPERS in Sacramento, California. To receive a copy of this pamphlet, contact your employing office, or you may request a copy online by visiting the CalPERS Web site at www.calpers.ca.gov or by calling CalPERS Customer Service and Education Division (CSED) at **888 CalPERS** (or **888**-225-7377).

Remember, it is your responsibility to stay informed about your health plan coverage. If you have any questions, consult your Health Benefits Officer in your agency or the retirement system from which you receive your allowance, or write to CalPERS Office of Employer and Member Health Services at P.O. Box 942714, Sacramento, CA 94229-2714, or telephone the appropriate number shown below:

CalPERS Office of Employer and Member Health Services

Toll free number ---	**888 CalPERS** (or **888**-225-7377)
Fax number ---	(916) 795-1277
TTY ---	(800) 735-2929; (916) 795-3240

Direct Payment of Dues

If you arrange for direct payment of dues, send your payment, together with Form HBD 21 to Anthem Blue Cross Life and Health Insurance Company, Attn: CalPERS BC PPO (non-California resident) Membership & Billing, P.O. Box 629, Woodland Hills, CA 91365. Be sure to include your identification number with your payment. For further details, see the CalPERS Health Program Handbook.

CLAIMS REVIEW / GRIEVANCE PROCEDURES

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

Action on your claim, including any denial, will be given in writing, including the reason for any denial.

NOTE: You should use the following Anthem Blue Cross Life and Health grievance procedures for disputes over coverage and/or benefits, or if you are dissatisfied with the quality of care or your access to care. For matters of eligibility, you should contact CalPERS Office of Employer and Member Health Services at P.O. Box 942714, Sacramento, CA 94229-2714.

The following procedures shall be used to resolve a dispute:

1. Objection to Claims Processing or Denial

If you do not agree with the action Anthem Blue Cross Life and Health has taken on your claim, either you or your attending physician, acting as your authorized representative, may request reconsideration. To request reconsideration you may telephone Anthem Blue Cross Life and Health at 800-288-6928 or send a written request to Anthem Blue Cross Life and Health Insurance Company at P.O. Box 60007, Los Angeles, CA 90060-0007, Attn: PORAC Unit. Anthem Blue Cross Life and Health's customer service staff will answer your questions or assist you in resolving your issue.

If you are not satisfied with the resolution based on your initial inquiry, you may request a copy of the Plan Grievance Form from the customer service representative. You may complete and return the form to Anthem Blue Cross Life and Health, or ask the customer service representative to complete the form for you over the telephone. You may also submit a grievance online or print the Plan Grievance Form by accessing the Web site at **www.anthem.com/ca**. You must submit your grievance to Anthem Blue Cross Life and Health no later than 180 days following the date you receive a denial notice from Anthem Blue Cross Life and Health or any other incident or action with which you are dissatisfied. Your issue will then become part of Anthem Blue Cross Life and Health's formal grievance process and will be resolved accordingly.

All grievances received by Anthem Blue Cross Life and Health will be acknowledged in writing, together with a description of how Anthem Blue Cross Life and Health proposes to resolve the grievance. After Anthem Blue Cross Life and Health has reviewed your grievance, you will be sent a written statement on its resolution within 30 days. If your case involves an imminent threat to your health, including, but not limited to, the potential loss of life, limb, or major bodily function, review of your grievance will be expedited and resolved within three days.

If you have questions or concerns about your outpatient Prescription Drug coverage, you may call the Pharmacy Customer Service number listed on your ID card. If you are dissatisfied with the resolution of your inquiry and want to file a grievance, you may write to us at the address listed above and follow the formal grievance process.

2. Special Independent Medical Reviews

A. Objection to Denial of Experimental or Investigational Treatment. If coverage for a proposed treatment is denied because Anthem Blue Cross Life and Health determines that the treatment is Experimental or Investigational, you may ask that the denial be reviewed by an external independent medical review organization contracting with the Department of Managed Health Care. To request this review, please call or write to us at the location shown above under item 1. To qualify for this review, all of the following conditions must be met:

1. You have a life-threatening or seriously debilitating condition, described as follows:

   --A life-threatening condition is a condition or disease where the likelihood of death is high unless the course of the disease is interrupted or a condition or disease with a potentially fatal outcome where the end point of clinical intervention is the patient's survival.

   --A seriously debilitating condition is a disease or condition that causes major, irreversible morbidity.

2. Your physician must certify that either (a) standard treatment has not been effective in improving your condition, (b) standard treatment is not medically appropriate, or (c) there is no more beneficial standard treatment covered by this plan than the proposed treatment.

3. The proposed treatment must be recommended by either (a) a Participating Provider or (b) a board certified or board eligible Physician qualified to treat you who certifies in writing that the proposed treatment is more likely to be beneficial than standard treatment. This certification must include a statement of the evidence relied upon.

4. If this review is requested either by you or by a qualified Non-Participating Provider (as described above), the requestor must supply two items of acceptable medical and scientific evidence. This evidence consists of the following sources:

   a) Peer-reviewed scientific studies published in medical journals with nationally recognized standards;

   b) Medical literature meeting the criteria of the National Institute of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus, Medline, and MEDLARS database Health Services Technology Assessment Research;

   c) Medical journals recognized by the Secretary of Health and Human Services, under Section 1861(t)(2) of the Social Security Act;

   d) The American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluation, the American Dental Association Accepted Dental Therapeutics, and the United States Pharmacopoeia-Drug Information;

   e) Findings, studies or research conducted by or under the auspices of federal governmental agencies and nationally recognized federal research institutes; and

   f) Peer reviewed abstracts accepted for presentation at major medical association meetings.

You must request this review within six months of the date you receive a denial notice from Anthem Blue Cross in response to your grievance, or from the end of the 30 day or three day grievance period if your case involves an imminent threat to your health, whichever applies. This application deadline may be extended by the CDI for good cause.

Within three business days of receiving notice of your request for review we will send the reviewing panel all relevant medical records and documents in our possession, as well as any additional information submitted by you or your Physician. Information we receive subsequently will be sent to the review panel within three business days. Any newly developed or discovered relevant medical records identified by us or by a Participating Provider after the initial documents are sent will be immediately forwarded to the reviewing panel. The external independent review organization will complete its review and render its opinion within 30 days of its receipt of request for review (or within seven days in the case of an expedited review). This timeframe may be extended by up to three days for any delay in receiving necessary records.

B. Independent Medical Review of Grievances Involving a Disputed Health Care Service

You may request an independent medical review (IMR) of disputed health care services from the California Department of Insurance (CDI) if you believe that we have improperly denied, modified, or delayed health care services. A "disputed health care service" is any health care service eligible for coverage and payment under your plan that has been denied, modified, or delayed by us, in whole or in part because the service is not Medically Necessary.

The IMR process is in addition to any other procedures or remedies that may be available to you. You pay no application or processing fees of any kind for IMR. You have the right to provide information in support of the request for IMR. We must provide you with an IMR application form with any grievance disposition letter that denies, modifies, or delays health care services. A decision not to participate in the IMR process may cause you to forfeit any statutory right to pursue legal action against us regarding the disputed health care service.

Eligibility: The CDI will review your application for IMR to confirm that:

1. (a) Your provider has recommended a health care service as Medically Necessary, or

   (b) You have received urgent care or Emergency Care that a provider determined was Medically Necessary, or

   (c) You have been seen by a Participating Provider for the diagnosis or treatment of the medical condition for which you seek independent review;

2. The disputed health care service has been denied, modified, or delayed by us, based in whole or in part on a decision that the health care service is not Medically Necessary; and

3. You have filed a grievance with us and the disputed decision is upheld or the grievance remains unresolved after 30 days. If your grievance requires expedited review, you may bring it immediately to the CDI's attention. The CDI may waive the requirement that you follow our grievance process in extraordinary and compelling cases.

You must apply for IMR within six months of the date you receive a denial notice from Anthem Blue Cross in response to your grievance or from the end of the 30 day or three day grievance period, whichever applies. This application deadline may be extended by the CDI for good cause.

If your case is eligible for IMR, the dispute will be submitted to a medical specialist who will make an independent determination of whether or not the care is Medically Necessary. You will receive a copy of the assessment made in your case. If the IMR determines the service is Medically Necessary, Anthem Blue Cross Life and Health will provide benefits for the health care service.

For non-urgent cases, the IMR organization designated by the CDI must provide its determination within 30 days of receipt of your application and supporting documents. For urgent cases involving an imminent and serious threat to your health, including, but not limited to, serious pain, the potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of your health, the IMR organization must provide its determination within three business days.

For more information regarding the IMR process or to request an application form, please call us at 800-288-6928.

3. Time Limits for Filling an Objection

The reconsideration request must be made within 60 days of the denial of your claim and must give the reasons you believe the claim should be paid.

4. Time Limit for Anthem Blue Cross Life and Health Review of Objection

Anthem Blue Cross Life and Health will acknowledge receipt of a complaint by written notice to the complainant within 20 days. Anthem Blue Cross Life and Health will then either affirm or resolve the denial within 30 days. If your case involves an imminent threat to your health**,** including, but not limited to, the potential loss of life, limb, or major bodily function, review of your grievance will be expedited.

If Anthem Blue Cross Life and Health affirms the denial or fails to respond within 30 days after receiving your request for review and you still disagree, you may proceed to either item 6 or item 7 below.

5. Instructions for Grievances Regarding Coverage, Disputed Health Care Services, Eligibility, Malpractice and Bad Faith:

Coverage grievances: If you have followed the grievance procedures on the previous pages and are still dissatisfied you may proceed to item 6: Administrative Appeal Process or item 7: Binding Arbitration in the alternative. If your coverage dispute is within the jurisdictional limits of Small Claims Court, you may proceed through that court.

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

Disputed Health Care Service grievances: A disputed health care service grievance concerns any health care service eligible for coverage and payment under this Evidence of Coverage booklet that has been denied, modified, or delayed in whole or in part due to a finding that the service is not Medically Necessary. A decision regarding a disputed health care service relates to the practice of medicine and is not a coverage grievance, and includes decisions as to whether a particular service is experimental or investigational.

CLAIMS REVIEW / GRIEVANCE PROCEDURES

If you are still dissatisfied after you have followed the grievance procedures on pages 83 through 86 and received a response regarding the grievance filed with the California Department of Insurance (See Independent Medical Review of Grievances Involving a Disputed Health Care Service on page 85), you may proceed to item 6. CalPERS Administrative Appeal Process, or item 7. Binding Arbitration is the alternative. If your coverage dispute is within the jurisdictional limits of Small Claims Court, you may proceed through that court.

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

Eligibility grievances: These issues should always be referred directly to CalPERS at the address noted on page 87.

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

Bad faith grievances: You must proceed to item 7: Binding Arbitration for claims for benefits involving charges of bad faith.

6. CalPERS Administrative Appeal Process

Only eligibility grievances and coverage grievances which concern the denial or approval of health care services substantially based on a finding that the provision of a particular service is included or excluded as a covered benefit under the Evidence of Coverage booklet may be appealed directly to CalPERS. CalPERS staff will conduct an administrative review upon your appeal of Anthem Blue Cross Life and Health's denial of coverage grievance. **Note: Anthem Blue Cross Life and Health reserves the right to dispute or challenge CalPERS jurisdiction in particular matters.** Your written appeal must be submitted to CalPERS within 30 days of the postmark date of Anthem Blue Cross Life and Health's letter of denial following your grievance.

If the dispute remains unresolved during the administrative review process, the matter may then proceed to an Administrative Hearing. During the Administrative Hearing, evidence and testimony will be presented to an Administrative Law Judge. As an alternative to this hearing, you may have recourse to Binding Arbitration. **Note: You must choose between the Administrative Hearing and Binding Arbitration. You may not take the same grievance through both procedures.** You may withdraw your appeal to CalPERS at any time, and proceed to item 7: Binding Arbitration.

To file for an Administrative Hearing, please contact CalPERS Office of Employer and Member Health Services, P.O. Box 942714, Sacramento, CA, 94229-2714 or call the CalPERS Customer Service and Education Division (CSED) at **888 CalPERS** (or **888**-225-7377) for information.

7. Binding Arbitration (Small Claims Court)

If you do not use item 6, or if it does not apply, binding arbitration is the final step in resolving your grievance. Any dispute or claim, of whatever nature, arising out of, in connection with, or in relation to this plan or the Policy or breach or rescission thereof, or in relation to care or delivery of care (including any claim based on contract, tort or statute) must be resolved by arbitration, except any dispute or claim within the jurisdictional limits of the small claims court must be resolved in such court. **Note: A small claims court judgement cannot be appealed.**

CLAIMS REVIEW / GRIEVANCE PROCEDURES

The Federal Arbitration Act will govern the interpretation and enforcement of all proceedings under this Binding Arbitration provision. To the extent that the Federal Arbitration Act is inapplicable, or is held not to require arbitration of a particular claim, state law governing agreements to arbitrate will apply.

By enrolling in this plan, the Member is agreeing to have certain disputes (coverage grievance and bad faith grievance as described above) decided by neutral binding arbitration. Both Anthem Blue Cross Life and Health and the plan Member waive their right to a jury or court trial for these disputes.

The steps for binding arbitration are as follows:

A. Binding arbitration is begun by the Member making written demand on Anthem Blue Cross Life and Health.

B. The Member and Anthem Blue Cross Life and Health agree to give up the right to participate in class arbitration against each other. Even if applicable law permits class arbitration, the Member waives any right to pursue, on a class basis, any such controversy or claim against Anthem Blue Cross Life and Health and Anthem Blue Cross Life and Health waives any right to pursue on a class basis any such controversy or claim against the Member.

C. The arbitration will be conducted by Judicial Arbitration and Mediation Services (JAMS). If, for any reason, JAMS is unavailable to conduct the arbitration, the arbitration will be conducted by another neutral arbitration entity, by mutual agreement of the Member and Anthem Blue Cross Life and Health, or by order of the court, if the Member and Anthem Blue Cross Life and Health cannot agree. Copies of such arbitration rules are available from Anthem Blue Cross Life and Health.

D. Anthem Blue Cross Life and Health and the Member will each be responsible for paying their own shares of the fees and expenses of the arbitration; however Anthem Blue Cross Life and Health may pay the Member's share of these fees in cases of extreme hardship, as determined by JAMS. An application to claim extreme hardship under this section may be obtained from JAMS.

E. **THE ARBITRATION FINDINGS ARE FINAL AND BINDING,** except to the extent that state or Federal law provides for the judicial review of arbitration proceedings.

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

GENERAL DEFINITIONS

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

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

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

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

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

Anniversary Date is the first day of each contract term.

Annuitant is defined in accordance with the definition currently in effect in the Act and Regulations.

Board means the Board of Administration of the Public Employees' Retirement System, State of California.

Centers of Medical Excellence (CME) are health care providers designated by Anthem Blue Cross Life and Health as a selected facility for specified medical services. A provider participating in a CME network has an agreement in effect with Anthem Blue Cross Life and Health at the time services are rendered or is available through Anthem Blue Cross Life and Health's affiliate companies or Anthem Blue Cross Life and Health's relationship with the Blue Cross and Blue Shield Association. CME agree to accept Negotiated Rate as payment in full for covered services. A Participating Provider in the Blue Cross and/or Blue Shield Plan is not necessarily a CME.

Cosmetic Surgery is performed solely for beautification or to alter or reshape normal structures or tissues of the body to improve the appearance of the individual.

Covered Expense is the expense you incur for a covered service or supply, but not more than the maximum amounts described in YOUR MEDICAL BENEFITS: HOW COVERED EXPENSE IS DETERMINED. Expense is incurred on the date you receive the service or supply.

Custodial Care means care that is provided primarily for the maintenance of the patient or that is designed essentially to assist the patient in meeting his or her activities of daily living and which is not primarily provided for its therapeutic value in the treatment of sickness or accidental bodily injury. Custodial Care includes, but is not limited to, help in walking, bathing, dressing, feeding, preparation of special diets, and supervision over self-administration of medication not requiring the constant attention of trained medical personnel.

GENERAL DEFINITIONS

A **Customary and Reasonable (C & R) Charge,** as determined annually by us, is a charge that falls within the common range of fees billed by a majority of Physicians for a procedure in a given geographic region. If it exceeds that range, the expense must be justified based on the complexity of treatment or severity of the condition in a specific case. Some providers charge much more than the C & R amount, and the Member is responsible for paying all of that excess expense, in addition to deductible and coinsurance amounts, amounts over stated benefit maximums, and any other non-Covered Expense.

Day Treatment Center is an outpatient psychiatric facility which is part of or affiliated with a Hospital. It must be licensed according to state and local laws to provide outpatient care and treatment of Mental or Nervous Disorders, Severe Mental Disorders or substance abuse under the supervision of Physicians.

The term **Effective Date** means the date of the Policy or the date on which the Member's coverage starts, whichever occurs last.

Emergency means a sudden, serious and unexpected acute illness, injury or condition (including without limitation sudden and unexpected severe pain) which the Member reasonably perceives, could permanently endanger health if medical treatment is not received immediately. Final determination as to whether services were rendered in connection with an Emergency will rest solely with Anthem Blue Cross Life and Health.

Emergency Care is the initial treatment of a medical or psychiatric Emergency.

Employee is defined in accordance with the definition currently in effect in the Act and Regulations.

Employer means the state, and any contracting agency or other entity which has elected to join the Public Employees' Medical and Hospital Care Act.

An **Experimental** procedure is any treatment, therapy, procedure, drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supply which is mainly limited to laboratory and/or animal research.

Family Member means the spouse and children of an Employee or Annuitant who qualify under Articles 1 and 5 of the Act and Sections 599.500, 599.501 and 599.502 of the Regulations. In addition, a Family Member shall include a Domestic Partner as defined in Section 22770 of the Act.

Home Health Care is Physician-directed professional, technical and related medical and personal care service provided in the Member's home, on a visiting or part-time basis, by a Home Health Agency.

Home Health Agencies (Home Health Agencies) are Home Health Care providers which are licensed according to state and local laws to provide skilled nursing and other services on a visiting basis in the Member's home. They must be recognized as Home Health Care providers under Medicare.

Home Infusion Therapy Provider is a provider licensed according to state and local laws as a pharmacy, and must be either certified as a home health care provider by Medicare, or accredited as a home pharmacy by the Joint Commission on Accreditation of Health Care Organizations.

Hospice means a public agency or private organization that provides a specialized form of interdisciplinary health care that provides palliative care (pain control and symptom relief) and alleviates the physical, emotional, social and spiritual discomforts of a terminally ill person, as well as providing supportive care to the primary caregiver and the patient’s family. Care may be provided on a home-based or inpatient basis, or both. The Hospice administering the Hospice Care Program must be approved by Anthem Blue Cross Life and Health. A list of approved Hospices will be sent on request.

GENERAL DEFINITIONS

A **Hospice Care Program** is a program administered by a Hospice for symptom management and supportive services to terminally ill people and their families.

A **Hospital** is a facility which provides diagnosis, treatment and care of persons who need acute inpatient Hospital care under the supervision of Physicians. It must be licensed as a general acute care Hospital according to state and local laws. It must also be registered as a general Hospital by the American Hospital Association and meet accreditation standards of the Joint Commission on Accreditation of Health Care Organizations.

With respect to treatment of Mental or Nervous Disorders, Severe Mental Disorder or substance abuse, "Hospital" also includes Psychiatric Health Facilities and Residential Treatment Centers which are licensed or certified under state law.

Infertility is (1) the presence of a condition recognized by a Physician as the cause of infertility, or (2) the inability to conceive a pregnancy or carry a pregnancy to a live birth after a year or more of regular sexual relations without contraception.

Insured employee means the person enrolled hereunder who is responsible for payment to Anthem Blue Cross Life and Health, and whose employment or other status, except family dependency, is the basis for eligibility for enrollment under the Policy. Insured Employees must be members of the Peace Officers Research Association of California (PORAC).

An **Investigational** procedure is a treatment, therapy, procedure, drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage or supply which may have progressed to limited use on humans, but which is not widely accepted as a proven and effective procedure within the organized medical community.

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

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

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

Medicare refers to the programs of medical care coverage set forth in Title XVIII of the Social Security Act as amended by Public Law 89-97 or as thereafter amended.

Member means any Employee, Annuitant or Family Member enrolled under the Policy.

GENERAL DEFINITIONS

Mental or Nervous Disorders are conditions that affect thinking and the ability to figure things out, perception, mood and behavior. A mental or nervous disorder is recognized primarily by symptoms or signs that appear as distortions of normal thinking, distortions of the way things are perceived (for example, seeing or hearing things that are not there), moodiness, sudden and/or extreme changes in mood, depression, and/or unusual behavior such as depressed behavior or highly agitated or manic behavior.

Some mental or nervous disorders are: schizophrenia, manic-depressive and other conditions usually classified in the medical community as psychosis; drug, alcohol and other substance addiction or abuse; depressive, phobic, manic and anxiety conditions (including panic disorders); bipolar affective disorders including mania and depression; obsessive compulsive disorders; hypochondria; personality disorders (including paranoid, schizoid, dependent, anti-social and borderline); dementia and delirious states; post traumatic stress disorder; adjustment reactions; reactions to stress; hyperkinetic syndromes; attention deficit disorders; learning disabilities; conduct disorder; oppositional disorder; mental retardation; autistic disease of childhood; anorexia nervosa and bulimia.

Any condition meeting this definition is a mental or nervous disorder no matter what the cause of the condition may be. One or more of these conditions may be specifically excluded in this plan.

Negotiated Rate is the amount participating providers agree to accept as payment in full for covered services. It is usually lower than their normal charge. Negotiated rates are determined by Participating Provider Agreements.

Non-Participating Provider is one of the following providers which is NOT participating in a Blue Cross and/or Blue Shield Plan at the time services are rendered:

1. A Hospital;
2. A Physician;
3. An Ambulatory Surgical Center;
4. A Home Health Agency;
5. A facility which provides diagnostic imaging services;
6. A durable medical equipment outlet;
7. A Skilled Nursing Facility;
8. A clinical laboratory; or
9. A Home Infusion Therapy Provider.

They are not Participating Providers. Remember that only a portion of the amount which a non-participating provider charges for services may be treated as Covered Expense under this plan. See YOUR MEDICAL BENEFITS: HOW COVERED EXPENSE IS DETERMINED on page 13.

Open Enrollment Period means a period of time established by the Board during which eligible Employees and Annuitants may enroll in a health benefit plan, add Family Members, or change their enrollment from one health benefit plan to another.

Other health care provider is one of the following providers:

1. A certified registered nurse anesthetist;
2. A blood bank;
3. A licensed ambulance company; or

4. A Hospice.

The provider must be licensed according to state and local laws to provide covered medical services.

Out-of-Pocket Expense is the difference between Covered Expense and Anthem Blue Cross Life and Health's payment. You are responsible to pay Out-of-Pocket Expense until your total out-of-pocket payments in a Year equal the Out-of-Pocket Expense Amount shown in the SUMMARY OF BENEFITS section. Out-of-Pocket Expense Amount does **not** include any expense applied to deductibles, amounts exceeding the Customary and Reasonable Charges or Reasonable Charges for Non-Participating Providers and Other Health Care Providers, and any other charges which are not considered covered expense. In addition, any co-payments made for non-Emergency services received in a Hospital emergency room, Nicotine Patches, office visits to Physicians who are Participating Providers, diabetes education program services provided by Physicians who are Participating Providers and outpatient prescription drug copayments do **not** accrue towards the Out-of-Pocket Expense Amount, and you will continue to be required to pay such co-payments after the Out-of-Pocket Expense Amount is reached.

Participating provider is one of the following providers which is participating in a Blue Cross and/or Blue Shield Plan at the time services are rendered:

1. A Hospital;
2. A Physician;
3. An Ambulatory Surgical Center;
4. A Home Health Agency;
5. A facility which provides diagnostic imaging services;
6. A durable medical equipment outlet;
7. A Skilled Nursing Facility;
8. A clinical laboratory; or
9. A Home Infusion Therapy Provider.

Participating Providers agree to accept the Negotiated Rate as payment for covered services. A directory of Participating Providers is available upon request.

Physician means:

1. A doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is licensed to practice medicine or osteopathy where the care is provided; or

2. One of the following providers, but only when the provider is licensed to practice where the care is provided, is rendering a service within the scope of that license, is providing a service for which benefits are specified in this booklet, and when benefits would be payable if the services were provided by a physician as defined above:

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

g. An acupuncturist (A.C.)
h. A licensed midwife
i. A clinical social worker (L.C.S.W.)
j. A marriage and family therapist (M.F.T.)
k. A physical therapist (P.T. or R.P.T.)*
l. A speech pathologist*
m. An audiologist*
n. An occupational therapist (O.T.R.)*
o. A respiratory care practitioner (R.C.P.)*
p. A Psychiatric Mental Health Nurse (R.N.)*
q. A registered dietitian (R.D.)* for the provision of diabetic medical nutrition therapy only

***Note**: The providers indicated by asterisks (*) are covered only by referral of a physician as defined in 1 above.

The **Policy** is the Group Policy entered into by Anthem Blue Cross Life and Health and the Insurance and Benefits Trust of the Peace Officers Research Association of California (PORAC). The Policy is an attachment to the Memorandum of Agreement between PORAC and the Board of Administration of the California Public Employees' Retirement System (CalPERS). The Memorandum of Agreement is on file and available for review in the office of the Insurance and Benefits Trust of PORAC, 4010 Truxel Road, Sacramento, CA 95834, or you may request a copy by writing to PORAC. PORAC will provide a copy of the Memorandum of Agreement for a reasonable duplication charge.

Prosthetic Devices are appliances which replace all or part of a function of a permanently inoperative, absent or malfunctioning body part. The term "Prosthetic Devices" includes orthotic devices, rigid or semi-supportive devices which restrict or eliminate motion of a weak or diseased part of the body.

Psychiatric Health Facility is an acute 24-hour facility operating within the scope of a state license, or in accordance with a license waiver issued by the State. It must be:

1. Qualified to provide short-term inpatient treatment according to state law;
2. Accredited by the Joint Commission on Accreditation of Health Care Organizations; and
3. Staffed by an organized medical or professional staff which includes a Physician as medical director.

Psychiatric Mental Health Nurse is a registered nurse (R.N.) who has a master's degree in psychiatric mental health nursing, and is registered as a psychiatric mental health nurse with the state board of registered nurses.

A **Reasonable Charge** is one which Anthem Blue Cross Life and Health considers not to be excessive, based on the circumstances of the care provided. Such circumstances include: level of skill, experience involved, the prevailing or common cost of similar services or supplies and any other factors which determine value. The Member is responsible for paying amounts over the Reasonable Charge, in addition to the deductible and co-payment amounts, amounts over stated benefit maximums, and any non-Covered Expense.

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

GENERAL DEFINITIONS

A **Residential Treatment Center** is an inpatient treatment facility where the Member resides in a modified community environment and follows a comprehensive medical treatment regimen for treatment and rehabilitation as the result of a Mental or Nervous Disorder, Severe Mental Disorder or substance abuse. The facility must be licensed to provide psychiatric treatment of Mental or Nervous Disorders, Severe Mental Disorders or rehabilitative treatment of substance abuse according to state and local laws.

Severe Mental Disorders include the following psychiatric diagnoses specified in California Health and Safety Code Section 1374.72: schizophrenia, schizoaffective disorder, bipolar disorder, major depression, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia, and bulimia.

Severe mental disorders also includes serious emotional disturbances of a child as indicated by the presence of one or more mental disorders as identified in the Diagnostic and Statistical Manual (DSM) of Mental Disorders, other than primary substance abuse or developmental disorder, resulting in behavior inappropriate to the child's age according to expected developmental norms. The child must also meet one or more of the following criteria:

1. As a result of the mental disorder, the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community and is at risk of being removed from the home or has already been removed from the home or the mental disorder has been present for more than six months or is likely to continue for more than one year without treatment.
2. The child is psychotic, suicidal, or potentially violent.
3. The child meets special education eligibility requirements under California law (Government Code Section 7570).

A **Skilled Nursing Facility** is a facility which is licensed to operate in accordance with state and local laws pertaining to institutions identified as such and which is listed as such by the American Hospital Association and accredited by the Joint Commission on Accreditation of Health Care Organizations and related facilities, or which is recognized as a Skilled Nursing Facility by the Secretary of Health and Human Services of the United States government pursuant to the Medicare Act.

Special Care Units are special areas of a Hospital which have highly skilled personnel and special equipment for acute conditions that require constant treatment and observation.

A **Stay** is an inpatient confinement of a Member which begins when the Member is admitted to the facility and ends when the Member is discharged from the facility.

A **Totally Disabled Insured Employee** is one who, because of illness or injury, is unable to work for income in any job for which he or she is qualified or for which he or she becomes qualified by training or experience, and who is in fact unemployed. A **Totally Disabled Annuitant or Family Member** is one who is unable to perform all activities usual for a person of that age.

A **Year** or **Calendar Year** is a twelve month period starting each January 1 at 12:01 a.m. Pacific Standard Time.

FOR YOUR INFORMATION

WEB SITE

Information specific to your benefits and claims history are available by calling the 800 number on your identification card. Anthem Blue Cross Life and Health is an affiliate of Anthem Blue Cross. You may use Anthem Blue Cross' Web site to access benefit information, claims payment status, benefit maximum status, participating providers or to order an ID card. Simply log on to **www.anthem.com/ca**, select "Member", and click the "Register" button on your first visit to establish a User ID and Password to access the personalized and secure MemberAccess Web site. Once registered, simply click the "Login" button and enter your User ID and Password to access the MemberAccess Web site. Anthem Blue Cross Life and Health's privacy statement can also be viewed on the Web site.

SPECIAL NOTICE REGARDING REPRODUCTIVE HEALTH CARE SERVICES

Some hospitals and other providers do not provide one or more of the following services that may be covered under your health plan and that you or your family member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor or delivery; infertility treatments, or abortion. You should obtain more information before you select your coverage. Call your respective health care provider, or call us at 800-288-6928 to ensure that you can obtain the health care services that you need.

For claims and customer service, contact:

Anthem Blue Cross Life and Health Insurance Company
P.O. Box 60007
Los Angeles, CA 90060-0007
Attention: PORAC Unit

1-800-288-6928

www.anthem.com/ca

Sponsored by:
Insurance and Benefits Trust of PORAC
4010 Truxel Road
Sacramento, CA 95834-3725

1-800-937-6722

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