Supplement to Original Medicare Plan with Major Medical Benefits

Combined Evidence of Coverage and Disclosure Form for the Supplement to Original Medicare Plan

Effective January 1, 2017

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)

CalPERS

PORAC SUPPLEMENT TO ORIGINAL MEDICARE PLAN AMENDMENT

This Amendment is attached to and made a part of the Evidence of Coverage and Disclosure Form relating to the medical coverage offered by Anthem Blue Cross to eligible active and retired members of PORAC pursuant to the plan sponsored by the Insurance and Benefits Trust of Peace Officers Research Association of California. All other provisions of the Evidence of Coverage Form which are not inconsistent with this amendment remain in effect. This Amendment has been approved to become effective January 1, 2017.

The following provision is added to the section entitled **ENROLLMENT PROVISIONS**:

For questions or complaints about your eligibility, including if you believe your coverage under the Plan has been or will be improperly terminated you may contact:

Insurance and Benefits Trust of the Peace Officers Research Association of California
4010 Truxel Road
Sacramento, Ca 95834
800-655-6397 (office)
916-999-8892 (fax)

You will be provided a copy of your eligibility and participation policies free of charge.

The following section entitled **BINDING ARBITRATION** is added:

BINDING ARBITRATION

Any dispute or claim, of whatever nature, arising out of, in connection with, or in relation to this Plan or the Agreement, 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 if the amount sought exceeds the jurisdictional limit of the small claims court. Any dispute regarding a claim for damages within the jurisdictional limits of the small claims court will be resolved in such court.

The Federal Arbitration Act shall 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 shall apply.

The Member and Anthem agree to be bound by these arbitration provisions and acknowledge that they are giving up their right to trial by jury for both medical malpractice claims and any other disputes.

California Health & Safety Code section 1363.1 requires that any arbitration agreement include the following notice based on California Code of Civil Procedure 1295(a): **It is understood that any dispute as to medical malpractice, that is, whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings and except for disputes regarding a claim for damages within the jurisdictional limits of the small claims court. Both parties to this contract, by entering into it, acknowledge that they**

are giving up their constitutional right to have any and all disputes, including medical malpractice claims, decided in a court of law before a jury, and instead are accepting the use of arbitration.

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

The arbitration findings will be final and binding except to the extent that state or federal law provides for the judicial review of arbitration proceedings.

The arbitration is initiated by the Member making written demand on Anthem. The arbitration will be conducted by Judicial Arbitration and Mediation Services ("JAMS"), according to its applicable Rules and Procedures. If for any reason JAMS is unavailable to conduct the arbitration, the arbitration will be conducted by another neutral arbitration entity, by agreement of the Member and Anthem, or by order of the court, if the Member and Anthem cannot agree.

The costs of the arbitration will be allocated per the JAMS Policy on Consumer Arbitrations. If the arbitration is not conducted by JAMS, the costs will be shared equally by the parties, except in cases of extreme financial hardship, upon application to the neutral arbitration entity to which the parties have agreed, in which cases, Anthem will assume all or a portion of the costs of the arbitration.

Please send all Binding Arbitration demands in writing to Anthem Blue Cross, P.O. Box 4310, Woodland Hills, CA 91365-4310 marked to the attention of the Member Services Department listed on your identification card.

NOTE: If you wish to appeal a decision made by Medicare and not by us, you must initiate the appeal process by contacting your local Social Security Administration office.

The section entitled **CLAIMS REVIEW / GRIEVANCE PROCEDURES** is deleted in its entirety and replaced by the following:

GRIEVANCE PROCEDURES

We (Anthem Blue Cross) want your experience with us to be as positive as possible. There may be times, however, when you have a complaint, problem, or question about your Plan or a service you have received. If you have a question or complaint about your eligibility, (including if you believe your coverage under this Plan has been or will be improperly terminated), your benefits under this Plan, a Participating provider, concerning a claim, or about us, please call the telephone number listed on your identification card, or you may write to us (please address your correspondence to Anthem Blue Cross, P.O. Box 4310, Woodland Hills, CA 91365-4310 marked to the attention of the Member Services Department listed on your identification card). Our Member Services staff will answer your questions or assist you in resolving your issue.

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NOTE: You should use the following Anthem Blue Cross 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:

Insurance and Benefits Trust of the Peace Officers Research Association of California
4010 Truxel Road
Sacramento, CA, 95834
800-655-6397 (office)
916-999-8892 (fax)

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 Member Services representative. You may complete and return the form to us, or ask the Member Services representative to complete the form for you over the telephone. You may also submit a grievance to us online or print the Plan Grievance Form through the Anthem Blue Cross website at www.anthem.com/ca. You must submit your grievance to us no later than 180 days following the date you receive a denial notice from us or any other incident or action with which you are dissatisfied. Your issue will then become part of our formal grievance process and will be resolved accordingly.

All grievances received by us will be acknowledged in writing, together with a description of how we propose to resolve the grievance. Except for grievances that concern the prescription drug formulary, we will review and respond to your grievance within the following timeframes:

- After we have received your grievance, we will send you a written statement on its resolution within 30 days.
- If your case is urgent and involves an imminent threat to your health, including, but not limited to, severe pain, the potential loss of life, limb, or major bodily function, review of your grievance will be expedited and resolved within three days.

You have the right to review all documents that are part of your grievance file and to present evidence and testimony as part of the grievance process.

If, after our denial, we consider, rely on or generate any new or additional evidence in connection with your claim, we will provide you with that new or additional evidence, free of charge. We will not base our appeal decision on a new or additional rationale without first providing you (free of charge) with, and a reasonable opportunity to respond to, any such new or additional rationale. If we fail to follow the appeal procedures outlined under this section the appeals process may be deemed exhausted. However, the appeals process will not be deemed exhausted due to minor violations that do not cause, and are not likely to cause, prejudice or harm so long as the error was for good cause or due to matters beyond our control.

If you are dissatisfied with the resolution of your grievance, or if your grievance has not been resolved after at least 30 days (or within three days for urgent cases), you may submit your grievance to the California Department of Managed Health Care for review prior to binding arbitration (see DEPARTMENT OF MANAGED HEALTH CARE). If your case is urgent and involves an imminent threat to your health, as described above, you are not required to complete our grievance process or to wait at least 30 days, but may immediately submit your grievance to the Department of Managed Health Care (DMHC) for review. If your grievance concerns the termination of your coverage, you may also immediately submit your grievance to the DMHC if the DMHC determines your grievance requires immediate review.

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If your grievance concerns the termination of your coverage and your coverage is still in effect when you submit a grievance, we will continue to provide coverage to you under the terms of this Plan until a final determination of your request for review has been made, including any review by the Director of the Department of Managed Health Care. (Note: This does not apply if your coverage is cancelled due to non-payment of subscription charges.) If your coverage is maintained in force pending outcome of the review, subscription charges must still be paid to us on your behalf. If your coverage has already ended when you submit the grievance, your coverage will not be maintained. If the Director of the Department of Managed Health Care determines that your coverage should not have been terminated, we will reinstate your coverage back to the date it was terminated. Subscription charges must be paid current to us on your behalf from the date coverage is reinstated.

If at the conclusion of review of your grievance by the Department of Managed Health Care you continue to be dissatisfied with its resolution, or prior to and instead of review of your case by the Department of Managed Health Care, your remedy may be binding arbitration (see BINDING ARBITRATION).

Independent Medical Review of Denials of Experimental or Investigative Treatment

If coverage for a proposed treatment is denied because we determine that the treatment is experimental or investigative, you may ask that the denial be reviewed by an external independent medical review organization contracting with the Department of Managed Health Care ("DMHC"). Your request for this review may be submitted to the DMHC. You pay no application or processing fees of any kind for this review. You have the right to provide information in support of your request for review. A decision not to participate in this review process may cause you to forfeit any statutory right to pursue legal action against us regarding the disputed health care service. We will send you an application form and an addressed envelope for you to use to request this review with any grievance disposition letter denying coverage for this reason. You may also request an application form by calling us at the telephone number listed on your identification card or write to us at Anthem Blue Cross, P.O. Box 4310, Woodland Hills, CA 91365-4310. To qualify for this review, all of the following conditions must be met:

- 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.
- 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.
- The proposed treatment must either be:
    - ♦ Recommended by a Participating provider who certifies in writing that the treatment is likely to be more beneficial than standard treatments, or
    - ♦ Requested by you or by a licensed board certified or board eligible Physician qualified to treat your condition. The treatment requested must be likely to be more beneficial for you than standard treatments based on two documents of scientific and medical evidence from the following sources:

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a) Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized standards;

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

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

d) Either of the following: (i) The American Hospital Formulary Service's Drug Information, or (ii) the American Dental Association Accepted Dental Therapeutics;

e) Any of the following references, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen: (i) the Elsevier Gold Standard's Clinical Pharmacology, (ii) the National Comprehensive Cancer Network Drug and Biologics Compendium, or (iii) the Thomson Micromedex DrugDex;

f) Findings, studies or research conducted by or under the auspices of federal governmental agencies and nationally recognized federal research institutes, including the Federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Centers for Medicare and Medicaid Services, Congressional Office of Technology Assessment, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services; and

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

In all cases, the certification must include a statement of the evidence relied upon.

You must request this review within six months of the date you receive a denial notice from us 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 DMHC for good cause.

Within three business days of receiving notice from the DMHC 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. 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 if your Physician determines that the proposed treatment would be significantly less effective if not provided promptly). This timeframe may be extended by up to three days for any delay in receiving necessary records.

Please note: If you have a terminal illness (an incurable or irreversible condition that has a high probability of causing death within one year or less) and proposed treatment is denied because the treatment is determined to be experimental, you may also meet with our review committee to discuss your case as part of the grievance process (see GRIEVANCE PROCEDURES).

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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 Department of Managed Health Care ("DMHC") 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 and an addressed envelope for you to use to request IMR 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 DMHC will review your application for IMR to confirm that:

1. One or more of the following conditions has been met:
   (a) Your provider has recommended a health care service as Medically Necessary,
   (b) You have received Urgent Care or Emergency Services 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 need not participate in our grievance process for more than three days. The DMHC 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 us 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 DMHC for good cause.

If your case is eligible for IMR, the dispute will be submitted to a medical specialist or specialists 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, we will provide benefits for the health care service.

For non-urgent cases, the IMR organization designated by the DMHC 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 3 days.

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For more information regarding the IMR process, or to request an application form, please call us at the Member Services telephone number listed on your ID card.

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

Coverage grievances: A coverage grievance concerns 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. It does not include a plan or contracting provider decision regarding a disputed health care service.

If you have followed the grievance procedures on the previous pages and are still dissatisfied, you may request a review by the Department of Managed Health Care. If your coverage dispute is within the jurisdictional limits of Small Claims Court, you may proceed through that court.

Disputed Health Care Service grievances: A disputed health care service grievance concerns any heath 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.

If you are still dissatisfied after you have followed the grievance procedures and received a response regarding the grievance filed with the Department of Managed Health Care (see: Independent Medical Review of Grievances Involving a Disputed Health Care Service), you may proceed to Binding Arbitration. If your coverage dispute is within the jurisdictional limits of Small Claims Court, you may proceed through that court.

Eligibility grievances: These issues should always be referred directly to CalPERS at the following address:

Insurance and Benefits Trust of the Peace Officers Research Association of California
4010 Truxel Road
Sacramento, CA, 95834

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

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

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Department of Managed Health Care

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at the **telephone number listed on your identification card** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (**1-888-HMO-2219**) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The department's Internet Web site (**http://www.hmohelp.ca.gov**) has complaint forms, IMR applications forms and instructions online.

ANTHEM BLUE CROSS SUPPLEMENT TO ORIGINAL MEDICARE PLAN

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

This Supplement to Original Medicare Plan is specially designed for retired members of PORAC and their eligible Family Members who are enrolled in **both Part A (Hospital Insurance Program) and Part B (Medical Insurance Program) of Original Medicare**. An eligible Family Member who is currently enrolled in the PORAC Prudent Buyer Classic Plan may enroll in the PORAC Supplement to Original Medicare Plan when he or she attains eligibility by enrolling in Original Medicare Parts A and B.

For answers to questions regarding Medicare, contact your local Social Security Administration Office.

This Supplement to Original Medicare Plan is provided by Anthem Blue Cross (Anthem). Anthem Blue Cross has a Group Benefit Agreement (the Agreement) with the Insurance and Benefits Trust of the Peace Officers Research Association of California (PORAC). The benefits of this Evidence of Coverage booklet are provided while Medically Necessary for the Subscriber and enrolled Family Members for a covered illness, injury or condition, subject to all terms and conditions of the Agreement.

The Group Benefit Agreement 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.

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.

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

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

1-800-288-6928

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ADMINISTRATIVE AND BENEFIT CHANGES

Effective January 1, 2017, the following changes have been made to your plan.

Administrative Changes

No administrative changes have been made to your plan.

Benefit Changes

No benefit changes have been made to your plan.

Please see the back cover for the plan's phone number and address.

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**.

SUMMARY OF PLAN BENEFITS

The following chart is only a brief outline of your benefits under the plan. Please refer to pages 15 through 17 for a detailed description of Supplemental Services and Benefits. Payments applicable to Benefits For Services Not Covered By Original Medicare are described on pages 18 through 22. Major Medical Benefits are described on pages 23 through 28. Please review the entire Evidence of Coverage for more complete information on benefits, limitations and exclusions and to determine the exact terms and conditions of your coverage. Benefits are subject to all provisions of this Evidence of Coverage and the Agreement, which may limit benefits or result in benefits not being payable.

Type of Service	Member Pays
Hospital - Inpatient and Outpatient	No charge, if Medicare approved *
Emergency Services	No charge, if Medicare approved
Ambulance	No charge, if Medicare approved *
Physician Services	No charge, if Medicare approved *
Diagnostic X-Ray and Lab	No charge, if Medicare approved
Durable Medical Equipment	No charge, if Medicare approved *
Mental Disorders	No charge, if Medicare approved *
Chemical Dependency	No charge, if Medicare approved
Home Health Agency	No charge, if Medicare approved
Skilled Nursing Facility	No charge, if Medicare approved *
Speech Therapy	No charge, if Medicare approved *
Physical and Occupational Therapies	No charge, if Medicare approved *
Hospice Care Program	No charge, if Medicare approved
Blood	No charge, if Medicare approved *
Diabetes - education program, equipment and supplies	No charge, if Medicare approved *
Hearing Aid Services	20%, plus charges in excess of benefit maximums +
Vision Care	20%, plus charges in excess of benefit maximums +

* When services or supplies are not covered by Original Medicare, expense may be covered as stated under BENEFITS FOR SERVICES NOT COVERED BY ORIGINAL MEDICARE, starting on page 18, and MAJOR MEDICAL BENEFITS, starting on page 23.

\+ These are services and supplies not covered by Original Medicare. See BENEFITS FOR SERVICES NOT COVERED BY ORIGINAL MEDICARE on pages 18 through 22 for information regarding Member copayments, plan payments and benefit maximums.

DEFINITIONS

When any of the following terms are capitalized in this Evidence of Coverage booklet, 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).

The **Agreement** is the Group Benefit Agreement entered into by Anthem Blue Cross and the Insurance and Benefits Trust of the Peace Officers Research Association of California (PORAC). The Agreement 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.

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.

Anthem Blue Cross (Anthem) is a health care service plan, regulated by the California Department of Managed Health Care.

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

BlueCard Program is a Blue Cross Blue Shield Association program that links participating health care providers and the independent Blue Cross and Blue Shield Plans across the country with a single electronic process for claims processing and reimbursement.

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

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

A **Contracting Hospital** is a Hospital which has a standard Contracting Hospital Agreement in effect with Anthem Blue Cross to provide care to all Anthem Blue Cross Members. A list of Contracting Hospitals will be sent on request.

DEFINITIONS

Cosmetic Surgery is performed to reshape normal structures of the body and is intended solely to improve the appearance of the individual.

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

A **Customary and Reasonable (C & R) Charge**, as determined annually by Anthem Blue Cross, is a charge 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 any plan deductible and co-payment amounts, amounts over stated benefit maximums, and any other non-covered expense.

A **Dependent** is an Employee's Spouse, domestic partner, as defined in California Government Code section 22770, or child, as defined in Title 2, California Code of Regulations, Section 599.500.

Disability means a bodily injury, or an illness ("illness" includes any Mental Disorder). However,

— all bodily injuries sustained in any one accident shall be considered one Disability, and
— all illnesses existing simultaneously which are due to the same or related causes shall be considered one Disability, and
— if any illness is due to causes which are the same as or related to the causes of any prior illness, the succeeding illness shall be considered a continuation of the previous Disability and not a separate Disability.

Durable Medical Equipment and medical devices when the equipment meets the following criteria:

— is meant for repeated use and is not disposable;
— is used for a medical purpose and is of no further use when medical needs ends;
— is meant for use outside a medical facility;
— is only for the use of the patient;
— is made to serve a medical; and
— is ordered by a provider.

Drug means a drug approved by the State of California Department of Health or the Food and Drug Administration for general use by the public which requires a prescription before it can be obtained.

The **Effective Date** is the date the Member's coverage under the Agreement begins.

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

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

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

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 Care Agency.

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. A list of approved Hospices will be sent on request.

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

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

For the limited purpose of Inpatient care for the acute phase of a Mental Disorder, or substance abuse, "hospital" also includes Psychiatric Health Facilities.

Inpatient is a Member who is treated as a registered bed patient in a Hospital and for whom a room and board charge is made.

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 proven and effective procedures within the organized medical community.

DEFINITIONS

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:

— In accordance with generally accepted standards of medical practice;

— Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and

— 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.

NOTE: In some cases Anthem Blue Cross will accept Medicare's determination of medical necessity.

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

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

Mental Disorders. Mental Disorders, including substance abuse, for the purposes of this plan, are conditions that are listed in the most current edition of the Diagnostic and Statistical Manual (DSM) of Mental Disorders. Mental Disorders include Severe Mental Disorders as defined in this plan (see definition of "severe mental disorders").

A **Non-Contracting Hospital** is a Hospital which does not have a standard Contracting Hospital Agreement in effect with Anthem Blue Cross at the time services are rendered.

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

Participating Hospital means an institution, other than a Skilled Nursing Facility, which is participating in Medicare under an agreement with the Secretary of Health and Human Services of the United States or an institution with which any corporation approved or licensed by the American Hospital Association as an Anthem Blue Cross Plan has, at the time a Member is admitted to a Hospital, an agreement to render hospital service to Members of such Anthem Blue Cross Plan.

A **Physician** means:

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

2. One of the following providers, but only when the provider is licensed to practice where the care is provided, is rendering a service within the scope of that license and such license is required to render that service, and is providing a service for which benefits are specified in the Evidence of Coverage:

    — A dentist (D.D.S. or D.M.D.)
    — An optometrist (O.D.)

- A dispensing optician
- A podiatrist or chiropodist (D.P.M., D.S.P. or D.S.C.)
- A licensed clinical psychologist
- A chiropractor (D.C.)
- An acupuncturist (A.C.) (but only for acupuncture and for no other services)
- A certified registered nurse anesthetist (C.R.N.A.)
- A licensed clinical social worker (C.S.W. or L.C.S.W.)
- A marriage and family therapist (M.F.T.)
- A physical therapist (P.T. or R.P.T.)*
- A speech pathologist*
- An audiologist*
- An occupational therapist (O.T.R.)*
- A respiratory care practitioner (R.C.P.)*
- A nurse midwife
- A nurse practitioner
- A physician assistant
- A psychiatric-mental health nurse (a registered nurse having a masters degree in psychiatric-mental health nursing who meets the qualifications for registration and is in fact registered as a psychiatric-mental health nurse with the California Board of Registered Nurses)*
- Any agency licensed by the state to provide services for the treatment of Mental Disorders or substance abuse, when Anthem Blue Cross is required by law to cover those services
- A registered dietitian (R.D.)* or another nutritional professional* with a master's or higher degree in a field covering clinical nutrition sciences, from a college or university accredited by a regional accreditation agency, who is deemed qualified to provide these services by the referring M.D. or D.O. A registered dietitian or other nutritional professional as described here are covered for the provision of diabetic medical nutrition therapy and nutritional counseling for the treatment of eating disorders such as anorexia nervosa and bulimia nervosa only.

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

Psychiatric Emergency Medical Condition is a mental disorder that manifests itself by acute symptoms of sufficient severity that the patient is either (1) an immediate danger to himself or herself or to others, or (2) immediately unable to provide for or utilize food, shelter, or clothing due to the Mental Disorder.

Reasonable Charge. A Reasonable Charge is one which Anthem Blue Cross considers not to be excessive, based on the circumstances of the care provided. Such circumstances include: level of skill, experience involved, the prevailing or common cost of similar services or supplies and any other factors which determine value. The Member is responsible for paying billed amounts over the Reasonable Charge, in addition to any plan 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 Administrative Code of the State of California.

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

DEFINITIONS

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).

Service Area means the designated geographical area, approved by the CalPERS Pension and Health Benefits Committee, within which a Member must reside to be eligible for enrollment.

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 of Health Care Organizations and which is recognized as a Skilled Nursing Facility by the Secretary of Health and Human Services of the United States government pursuant to the Medicare Act.

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

A **Spouse** is the Subscriber's spouse under a legally valid marriage between persons of the opposite sex.

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

Subscriber means the person enrolled here under who is responsible for payment to Anthem Blue Cross, and whose employment or other status, except family dependency, is the basis for eligibility for enrollment under the Agreement.

A **Totally Disabled 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.

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

A **Year** or **Calendar Year** is a twelve month period starting each January 1 at 12:01 a.m. Pacific Standard Time and ending on January 1 of the next following year.

DEFINITIONS

You (your) refers to the Subscribers and Family Members who are enrolled for benefits under this plan.

ENROLLMENT PROVISIONS

ELIGIBILITY FOR ENROLLMENT

— All Employees, Annuitants and Family Members who are eligible in accordance with the Act and Regulations and who are enrolled under Medicare Parts A and B may enroll here under. Enrollment is restricted to members of the Peace Officers Research Association of California (PORAC) and their eligible Family Members.

Family Member means the spouse or Domestic Partner 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. Such children include: (1) the Employee's or Annuitant's adopted, step or recognized natural child up to age 26, and (2) any other child up to age 26 for whom the Employee or Annuitant has intentionally assumed a parent-child relationship or assumed parental duties, except for a foster child, as certified by the Employee or Annuitant at the time of the child's enrollment, and annually thereafter.

A child who meets either of the preceding requirements may be eligible for coverage beyond age 26 if the child at the time of attaining age 26, is already enrolled in the plan and is incapable of self-support because of a physical or mental disability which existed continuously from a date prior to the child's attainment of age 26. Such a child will be eligible for continued coverage beyond age 26 until the termination of his or her incapacity, subject to all other termination provisions or other limits of the plan. Satisfactory evidence of the child's disability must be filed with the plan during the period 60 days before the child's 26th birthday or the 60-day period after the child's 26th birthday.

A Domestic Partner must meet the criteria provided in Section 22770 of the Act to be eligible for coverage. Generally, this means that the individual must be either an Employee's or Annuitant's domestic partner pursuant to: (1) a registered domestic partnership as provided in California Family Code Section 297; or (2) a union of two persons of the same sex, other than a marriage, that was validly formed in another jurisdiction, and that is substantially equivalent to a domestic partnership as defined in California Family Code Section 297, regardless of whether it bears the name "domestic partnership" (see California Family Code Section 299.2).

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.

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

ENROLLMENT PROVISIONS

CONDITIONS OF ENROLLMENT

— Each Employee or Annuitant eligible to become a Subscriber according to the requirements stated under **ELIGIBILITY FOR ENROLLMENT**, and who files an application for membership with the Employer for himself or herself and his or her eligible Family Members on forms provided by the Employer during an Open Enrollment Period or period of initial eligibility, as specified in the Act and the Regulations, shall have fulfilled the conditions of enrollment.

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

Important Note: It is the Employee or Annuitant'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 Employee or Annuitant may be held liable retroactively for any services provided to ineligible Dependents.

COMMENCEMENT OF COVERAGE

After fulfilling the Condition of Enrollment as stated under **CONDITIONS OF ENROLLMENT**, coverage shall commence for an Employee, Annuitant and his or her Family Members at 12:01 a.m. on the date set forth in the Regulations.

TERMINATION AND RELATED PROVISIONS

TERMINATION OF AGREEMENT

This plan may be terminated by the Board, the Insurance and Benefits Trust of PORAC or Anthem Blue Cross according to the provisions set forth in the Memorandum of Agreement and the Group Benefit Agreement.

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 and the continuation benefits provided under **TERMINAL BENEFITS** in this section of the Evidence of Coverage:

— By the Board's termination of the Memorandum of Agreement;

— By Anthem Blue Cross' termination of the Agreement;

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

— If an Employee, Annuitant or Family Member ceases to be eligible for coverage in accordance with Section 599.506 of the Regulations.

IMPORTANT NOTE: The Employee or Annuitant may be held liable retroactively for any services provided to ineligible Dependents. It is the Employee or Annuitant's responsibility to report any changes in a Family Member's status to CalPERS in a timely manner.

REENROLLMENT

Members who have voluntarily cancelled enrollment with Anthem Blue Cross 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.

TERMINATIONS AND RELATED PROVISIONS

TERMINAL BENEFITS

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

- If a Member is Totally Disabled when coverage ends and is under the treatment of a Physician, the benefits of the Agreement 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.
- 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.
- 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. Anthem Blue Cross must receive this certification within 30 days of the date coverage ends under the Agreement. At least once every 60 days while benefits are extended, Anthem Blue Cross must receive proof that the Member's total disability is continuing.
- Benefits are provided until one of the following occurs:
    1. The Member is no longer Totally Disabled, or
    2. The maximum benefits of the Agreement are paid, or
    3. The Member becomes covered under another group health plan that provides coverage without limitation for the disabling illness or injury.
    4. A period of 12 consecutive months has passed since the date coverage ended.

MONTHLY RATES

Type of Enrollment	Enrollment Code	Supplement to Original Medicare Rate	Medicare Prescription Drug Rate	Gross Rate *
Self Only	2081	$196.10	$267.90	$464.00
Self and One Dependent	2082	$388.20	$535.80	$924.00
Self and Two or More Dependents	2083	$663.30	$803.70	$1,467.00

* The gross rates shown above include the monthly rates for the Medicare Prescription Drug coverage provided under Anthem Blue Cross MedicareRx Evidence of Coverage and Disclosure Form. The portion of the gross rate shown allocable to the Supplement to Original Medicare coverage for each type of enrollment combined with the respective portion allocable to the Medicare Prescription Drug program equals the gross rate.

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, 2018, following at least sixty (60) days' written notice to the Board prior to such change.

SUPPLEMENTAL SERVICES AND BENEFITS

Some providers do not participate in Medicare. If you choose to get care from a provider who has decided not to participate in, or has been excluded from, the Medicare program, Medicare and this plan will not pay for services provided by that provider. You will have to pay whatever the provider charges you for his or her services.

The following benefits are provided for care received inside the United States and its territories.

BENEFITS TO SUPPLEMENT ORIGINAL MEDICARE PLAN PART A (HOSPITAL)

The services and benefits in this section are intended to supplement Medicare-approved services and benefits. Supplemental services and benefits are provided only for those services deemed allowable and Medically Necessary by Medicare. The services and benefits listed are subject to all provisions of the Agreement, which may limit benefits or result in benefits not being payable.

Inpatient Hospital Benefits

— Anthem Blue Cross pays the Medicare Part A Deductible for the first 60 days of Inpatient Hospital services each Benefit Period. *

— Anthem Blue Cross pays the Medicare Part A Co-payment for the 61st through the 90th day of Inpatient Hospital services each Benefit Period. *

— Anthem Blue Cross pays the Medicare Part A Co-payment when the Member elects to use the lifetime reserve of 60 additional Inpatient Hospital days. *

— Anthem Blue Cross pays up to the Reasonable Charge for the first three units of unreplaced whole blood, packaged red blood cells or any other blood derivative received during a covered Stay.

* Inpatient Hospital benefits for Mental Disorders are limited to a combined total of 190 days in each Member's lifetime.

Skilled Nursing Facility Benefits

Anthem Blue Cross pays the Medicare Part A Co-payment for the 21st through the 100th day of Skilled Nursing Facility care each Benefit Period.

Hospice Benefit

Anthem Blue Cross pays for five percent (5%) of the cost of Inpatient Respite Care, up to the Medicare Part A Co-payment amount, during a period that begins when a Hospice plan is first chosen and ends 14 days after such care is cancelled.

SUPPLEMENTAL SERVICES AND BENEFITS

BENEFITS TO SUPPLEMENT ORIGINAL MEDICARE PLAN PART B (MEDICAL)

The services and benefits in this section are intended to supplement Medicare-approved services and benefits. Supplemental services and benefits are provided only for those services deemed allowable and Medically Necessary by Medicare. The services and benefits listed are subject to all provisions of the Agreement, which may limit benefits or result in benefits not being payable.

Anthem Blue Cross pays the Medicare Part B Deductible incurred for the services listed below under Professional and Other Medical Services and Outpatient Hospital Services. In order to receive this payment, the Member must provide Anthem Blue Cross with written proof by submitting a copy of an Explanation of Medicare Benefits (EOMB) which shows that Medicare has applied these amounts to the Member's Medicare Part B Deductible.

Professional and Other Medical Services

After the Medicare Part B Deductible is met for the Year, Anthem Blue Cross pays the amount of covered expense remaining after subtracting Medicare's payment. If the provider accepts Medicare assignment, covered expense is the approved amount as determined by Medicare. The Member is not responsible to pay any billed amount in excess of covered expense when a Physician or other health care provider accepts Medicare assignment. If the provider does not accept Medicare assignment, in no event shall covered expense exceed Customary and Reasonable Charges for services of a Physician or Reasonable Charges for services of a health care provider other than a Physician. The Member is responsible to pay any billed charge which exceeds the Customary and Reasonable Charge or Reasonable Charge, whichever is applicable when a Physician or other health care provider does not accept Medicare assignment.

Covered services are:

— Services of a Physician, including, but not limited to, chiropractic services and occupational therapist services when such services supplement benefits provided by Medicare.

— Services of an anesthesiologist or anesthetist (M.D. or C.R.N.A.).

— Services of a Physician during a covered Hospice Care Program.

— Services of a Home Health Agency while the Member is confined at home.

— Professional services of a licensed physical therapist.

— Outpatient diagnostic x-ray and laboratory services, including allergy testing.

— Radiation therapy, including use of x-ray, radium, cobalt and other radioactive substances.

— Medical supplies, rental or purchase of appliances and Durable Medical Equipment required for treatment of an illness or injury.

— Ambulance services of a licensed ambulance company for transportation to or from the nearest Participating Hospital or Skilled Nursing Facility.

— Outpatient blood and blood plasma beginning with the fourth unit during any one Year.

— Diabetes instruction programs.

SUPPLEMENTAL SERVICES AND BENEFITS

Outpatient Hospital Services

After the Medicare Part B Deductible is met for the Year, Anthem Blue Cross will pay the amount of covered expense remaining after subtracting Medicare's payment. In no event shall payment exceed the approved amount as determined by Medicare. The Member is not responsible to pay any billed amount in excess of Medicare's approved amount.

Covered services are:

— Hospital services for outpatient medical care.

— Hospital or Ambulatory Surgical Center services for outpatient surgical treatment.

— Radiation therapy, chemotherapy and hemodialysis treatment.

BENEFITS FOR SERVICES NOT COVERED BY ORIGINAL MEDICARE

The benefits described in this section are provided for Medically Necessary services and supplies received for treatment of a covered illness, injury or condition when a Member's benefits under Original Medicare are exhausted or when charges exceed amounts covered by Original Medicare. These benefits are subject to all limitations and exclusions of this Evidence of Coverage, which may limit benefits or result in benefits not being payable.

INPATIENT HOSPITAL BENEFITS BEYOND ORIGINAL MEDICARE

When Medicare Inpatient Hospital benefits, including all lifetime reserve days, are exhausted, Anthem Blue Cross will provide the following Hospital Benefits. Services must not be provided for treatment of Mental Disorders.

Co-Payment

There is no co-payment for covered expense incurred by the Member. Any billed amount in excess of Reasonable Charges will be the Member's responsibility to pay.

Maximum Benefit

Anthem Blue Cross pays 100% of Reasonable Charges up to **365 additional days** during a Benefit Period for Medically Necessary Inpatient services listed under Covered Services below when provided by a Hospital. Any billed amounts in excess of the maximum benefit will be the Member's responsibility to pay.

Covered Services

— 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. However, if the Member's Physician certifies that a private room is needed because of the Member's medical condition, private room accommodations are covered.

— Services in Special Care Units.

— Operating and special treatment rooms.

— 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 Anthem Blue Cross to be Medically Necessary.

— Physical therapy, radiation therapy, chemotherapy and hemodialysis treatment.

— Drugs and medicines approved for general use by the federal Food and Drug Administration which are supplied by the Hospital for use during the Member's Stay.

— Blood transfusions, including the first three units of unreplaced blood, blood products or blood processing.

Conditions of Service

— Services must be those which are regularly provided and billed by a Hospital.

— Services are provided only for the number of days required to treat the Member's illness, injury or condition.

— If a Member is hospitalized in California, payment for covered expense as stated above is provided only if care is received in a Contracting Hospital. If care is received in a Non-Contracting Hospital, Anthem Blue Cross first deducts a penalty of twenty-five percent (25%) from the amount of the Hospital's charges Anthem Blue Cross would otherwise consider to be covered expense. The Member is responsible for paying this penalty amount in addition to any amount in excess of covered expense. An exception to this penalty will be made for an Emergency. Call the PORAC Anthem Blue Cross customer service toll-free number to locate a Contracting Hospital.

— If a Member is hospitalized outside California, the Contracting Hospital benefits described above are provided. The out-of-California Hospital can bill the local Blue Cross and/or Blue Shield Plan for claims processing and reimbursement through the BlueCard Program.

— Treatment of Mental Disorders is not covered.

SKILLED NURSING FACILITY BENEFITS BEYOND ORIGINAL MEDICARE

When Medicare benefits for Skilled Nursing Facility care are exhausted and the Member requires additional care and treatment, Anthem Blue Cross will provide the following Skilled Nursing Facility benefits.

Co-Payment

There is no co-payment for covered expense incurred by the Member. Any billed amount in excess of Reasonable Charges will be the Member's responsibility to pay.

Maximum Benefit

Anthem Blue Cross pays 100% of Reasonable Charges up to **265 additional days** during a Benefit Period for Medically Necessary Inpatient services listed under Covered Services below when provided by a Skilled Nursing Facility. Any billed amounts in excess of the maximum benefit will be the Member's responsibility to pay.

Covered Services

— 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.

— Special treatment rooms.

— Laboratory exams.

— Physical, occupational, respiratory and speech therapy. Oxygen and other gas therapy.

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

— Blood transfusions, including the first three units of unreplaced blood.

BENEFITS FOR SERVICES NOT COVERED BY ORIGINAL MEDICARE

Conditions of Service

— The Member must be referred to the Skilled Nursing Facility by a Physician.

— Services must be those which are regularly provided and billed by a Skilled Nursing Facility.

— The services must be consistent with the illness, injury, degree of disability and medical needs of the Member. Benefits are provided only for the number of days required to treat the Member's illness or injury.

— The Member must remain under the active medical supervision of a Physician. The Physician must be treating the illness or injury for which the Member is confined in the Skilled Nursing Facility.

— In order to receive these Skilled Nursing Facility benefits, the Member must be admitted within fourteen (14) days following the date the Member was discharged from a Hospital Stay of three (3) or more days and be confined for the same illness, injury or condition. If the Member is readmitted to a Skilled Nursing Facility within fourteen (14) days of discharge from a previous Stay and care is required for the same illness, injury or condition for which the Member was previously confined, it is considered the same Benefit Period. These Skilled Nursing Facility benefits renew with each new Benefit Period.

SPECIAL DUTY NURSING SERVICES BENEFITS

Deductible and Co-Payment

Each Member must meet a $50.00 plan deductible for covered expense incurred during any Year. Any billed amount in excess of Customary and Reasonable Charges is not applied toward the plan deductible. After the plan deductible is met, the Member's co-payment is twenty percent (20%) of covered expense that Member incurs for Inpatient services of a private duty nurse. In addition to the plan deductible, billed amounts in excess of covered expense will be the Member's responsibility to pay.

Maximum Benefit

Anthem Blue Cross will pay 80% of covered expense, up to a maximum payment of **$800.00** for covered expense incurred by the Member during a Year. Any billed amounts in excess of the maximum benefit will be the Member's responsibility to pay.

Conditions of Service

— Services must be provided by a registered nurse (R.N.) or a licensed vocational nurse (L.V.N.).

— Services must be provided while the Member is hospitalized as a registered bed patient in a Participating Hospital or Contracting Hospital.

— Special duty nursing services must be ordered by the Member's attending Physician (M.D. or D.O.).

BENEFITS FOR SERVICES NOT COVERED BY ORIGINAL MEDICARE

VISION CARE BENEFITS

Co-Payment

The Member's co-payment is twenty percent (20%) of covered expense the Member incurs for vision care services and supplies. In addition to the co-payment, the Member is responsible to pay any billed amounts in excess of Customary and Reasonable Charges for services of a Physician or licensed optometrist.

Maximum Benefits

Anthem Blue Cross will pay 80% of covered expense for:

— one eye examination each Year;

— the initial set of frames and lenses up to a maximum payment of **$40.00**; thereafter

— one set of lenses each Year up to a maximum payment of **$20.00**, and one set of replacement frames up to a maximum payment of **$20.00** when the correction is such that a new set of frames is required; or

— contact lenses, if provided at the Member's option, up to the combined total allowance for frames and lenses as specified above.

Anthem Blue Cross will pay 100% of covered expense for contact lenses after cataract surgery or when the visual acuity of the Member is not correctable to 20/70 in the better eye by use of conventional type lenses, but can be improved to 20/70 or better by the use of contact lenses.

Any billed amounts in excess of the maximum benefits will be the Member's responsibility to pay.

Covered Services and Supplies

— Normal eye examination for refractive error including refraction, examination of the inner eye, measurement of eye tension, routine testing for visual field and muscle balance. If a normal examination reveals the need, a complete visual field examination, including pupil dilation or muscle balance, will be allowed. A follow up visit for muscle balance will also be covered if Medically Necessary.

— When an eye examination indicates the need for a correction to insure proper visual health and welfare, frames and lenses or contact lenses.

BENEFITS FOR SERVICES NOT COVERED BY ORIGINAL MEDICARE

HEARING AID BENEFITS

Co-Payment

The Member's co-payment is twenty percent (20%) of covered expense the Member incurs for hearing aid and hearing evaluation services. Any billed amounts in excess of covered expense will be the Member's responsibility to pay.

Maximum Benefits

Anthem Blue Cross will pay 80% of covered expense for:

— one hearing aid per ear during any **36** month period. Benefits are further limited to a maximum payment of **$450** for each hearing aid.

— examinations in conjunction with the purchase of a hearing aid, up to a maximum Anthem Blue Cross payment of **$50** for each visit.

Covered Services and Supplies

— 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.

— Audiological evaluations and audio-metric examinations to measure the extent of hearing loss and determine the most appropriate make and model of hearing aid.

MAJOR MEDICAL BENEFITS

The benefits described in this section are provided for covered expense incurred for Medically Necessary services and supplies received for the treatment of a covered illness, injury or condition. Covered expense under **MAJOR MEDICAL BENEFITS** does **not** include any expense incurred for a service or supply covered under the **SUPPLEMENTAL SERVICES AND BENEFITS** and/or **BENEFITS FOR SERVICES NOT COVERED BY ORIGINAL MEDICARE** sections of the plan. Expense is incurred on the date the Member receives the service or supply for which the charge is made. These benefits are subject to all provisions of the Agreement, which may limit benefits or result in benefits not being payable.

MAJOR MEDICAL BENEFITS DEDUCTIBLE

— Each Member must initially meet a Major Medical Benefits deductible amount of **$100.00** for covered expense incurred during any Year. Any billed amount exceeding a Customary and Reasonable Charge or Reasonable Charge is not applied toward the Major Medical Benefits deductible. Enrolled Members of a family must meet a total of $200.00 in Major Medical Benefits deductible during any Year (not to exceed $100 for one Member). Once that amount has been reached, no further Major Medical Benefits deductible is required for all Members of that family for the rest of that Year. Any amounts applied toward the Major Medical Benefits deductible as well as those in excess of covered expense will be the Member's responsibility to pay.

— Covered expense incurred during the last quarter of a Year (i.e., the months of October, November and December) and applied toward the Major Medical Benefits deductible for that Year is also applied toward the Major Medical Benefits deductible for the next following Year.

— For a Member who enrolls under the Agreement during the last quarter of a Year, any covered expense incurred by that Member which was applied toward a prior carrier's deductible during the last quarter of that same Year is also applied toward that Member's Major Medical Benefits deductible under this plan for the next following Year.

MAJOR MEDICAL BENEFITS CO-PAYMENTS

The Member's co-payments are listed as follows for covered expense that Member incurs in excess of the Major Medical Benefits deductible. Any billed amount exceeding the Customary and Reasonable Charge or Reasonable Charge is not covered expense and is the Member's responsibility to pay. All Major Medical Benefits payments are subject to any maximum amounts stated under **MAJOR MEDICAL BENEFITS MAXIMUMS** in this section.

First Level of Co-Payments*

Until Anthem Blue Cross pays $15,000.00 in Major Medical Benefits for covered expense a Member incurs in a Year, the Member will be responsible to pay for the following percentages of covered expense:

— fifty percent (50%) of the covered expense the Member incurs for outpatient psychotherapy and psychological testing, including outpatient biofeedback procedures for treatment of a Mental Disorder.

— twenty percent (20%) of the covered expense the Member incurs for all services and supplies other than outpatient psychotherapy and psychological testing.

***Note:** In addition to the first level of co-payments shown above, the Member will also be responsible to pay for any billed amounts in excess of covered expense.

MAJOR MEDICAL BENEFITS

Second Level of Co-Payments*

After Anthem Blue Cross pays $15,000.00 in Major Medical Benefits for covered expense a Member incurs in a Year, the Member's co-payment for the rest of that Year is as follows:

— fifty percent (50%) of the covered expense that Member incurs for outpatient psychotherapy and psychological testing, including outpatient biofeedback procedures for treatment of a Mental Disorder.

— no co-payment for covered expense that Member incurs for all services and supplies other than outpatient psychotherapy and psychological testing.

***Note:** In addition to the second level of co-payments shown above, the Member will also be responsible to pay for any billed amounts in excess of covered expense.

MAJOR MEDICAL BENEFITS MAXIMUMS

All Major Medical Benefits paid under this plan are limited to an aggregate maximum payment amount of $2,000,000.00 during each Member's lifetime, including the following plan maximum benefits:

— Benefits paid for Inpatient or outpatient Physician's visits covered under **Mental Disorders** are limited as follows:

1. outpatient psychotherapy and psychological testing are limited to a plan maximum payment of **$20.00** for each visit.

2. Inpatient Physician visits are limited to a plan maximum payment of **$40.00** for each visit.

— Benefits paid for services covered under **Speech Therapy** are limited to a plan maximum payment of **$5,000.00** during each Member's lifetime.

Up to $1,000.00 in Major Medical Benefits paid under this plan are automatically restored to the aggregate maximum payment amount each January 1.

Any additional limits on the number of visits or days covered are stated under the specific benefit listed under Major Medical Benefits Covered Services and Supplies on pages 23 through 28.

MAJOR MEDICAL BENEFITS

MAJOR MEDICAL BENEFITS COVERED SERVICES AND SUPPLIES

Hospital

Outpatient Hospital or Ambulatory Surgical Center services and supplies when not covered by **SUPPLEMENTAL SERVICES AND BENEFITS**.

Professional Services

— Services of a Physician. Acupuncture and chiropractic services are included. Education for pediatric asthma, including education to enable the child to properly use nebulizers, inhaler spacers and peak flow meters, is covered under the plan's benefit for office visits to a Physician.

— Services of an anesthesiologist or anesthetist (M.D. or C.R.N.A.).

— Services of a registered nurse (R.N.) or a licensed vocational nurse (L.V.N.).

Additional Services and Supplies

— 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 from a Hospital.

2. Emergency services or transportation services that are provided to the Member by a licensed ambulance company as a result of a "911" emergency response system* request for assistance if the Member believes her or she has an Emergency medical condition requiring such assistance.

3. Base charge, mileage and non-reusable supplies of a licensed air ambulance company to transport the Member from the area where the Member is first disabled to the nearest Hospital where appropriate treatment is provided if, and only if, such services are Medically Necessary, as determined by Anthem Blue Cross, and ground ambulance service is inadequate.

4. Monitoring, electrocardiogram (EKG or EEG), 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.

* If the Member has an Emergency medical condition that requires an emergency response, please call the "911" emergency response system if in an area where the system is established and operating.

— Outpatient diagnostic radiology and laboratory services, including allergy testing.

— Radiation therapy, chemotherapy and hemodialysis treatment.

— Surgical implants.

— Artificial limbs or eyes. This includes services of an orthotist and prosthetist in connection with evaluation or fitting of an orthotic or prosthetic device when services are billed as part of the charge for the artificial limbs or eyes.

— Rental or purchase of dialysis equipment. Dialysis supplies. Therapeutic shoes and inserts for the prevention and treatment of diabetes-related foot complications. 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:

1. Ordered by a Physician, and
2. Of no further use when medical need ends (but not disposable), and
3. Usable only by the patient, and
4. Not primarily for the Member's comfort or hygiene, and
5. Not for environmental control, and
6. Not for exercise, and
7. Manufactured specifically for medical use.

Rental charges that exceed the reasonable purchase price of the equipment are not covered. Anthem Blue Cross determines whether the item meets the above conditions.

— Routine and diagnostic mammograms, mastectomy and lymph node dissection, complications from a mastectomy including lymphedema, reconstructive surgery performed to restore and achieve symmetry following a Medically Necessary mastectomy, and breast prostheses following mastectomy.

— Contraceptive services and supplies, limited to injectable Drugs and implants for birth control administered in a Physician's office if Medically Necessary. IUDs and diaphragms dispensed by a Physician, and the services of a Physician in connection with the prescribing, fitting, and insertion of intrauterine contraceptive devices or diaphragms.

— Diabetes instruction 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.

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

— Biofeedback for treatment of a condition other than a Mental Disorder. Benefits for biofeedback for treatment of a Mental Disorder are provided under **Mental Disorders.**

Dental Injury

Benefits are payable at the levels of payment shown under **CO-PAYMENTS** for 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 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.

MAJOR MEDICAL BENEFITS

Important: If you decide to receive dental services that are not covered under this plan, a dentist may charge you his or her usual and customary rate for those services. Prior to providing you with dental services that are not a covered benefit, the dentist should provide a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about the dental services that are covered under this plan, please call the customer service telephone number listed on your ID card. To fully understand your coverage under this plan, please carefully review this Evidence of Coverage document.

Mental Disorders

Benefits are payable at the levels of payment shown under **CO-PAYMENTS** and subject to the amounts stated under **MAXIMUM BENEFITS** for covered expense as follows:

— Services and supplies, including biofeedback procedures furnished by a Hospital and a Physician for treatment of Mental Disorders while confined in a Hospital as a registered bed patient. Charges of a Hospital for room and board in excess of the semi-private (two-bed) room rate will not be considered covered expense. Benefits for Inpatient Physician visits are limited to a plan maximum payment of **$40.00** for each visit.

— Psychiatric services of a Physician and biofeedback procedures for treatment of Mental Disorders while not confined in a Hospital as a registered bed patient. Benefits for outpatient psychotherapy and psychological testing are limited to a plan maximum payment of **$20.00** for each visit. Such treatment shall be limited to conditions which are subject to significant improvement through acute short term treatment.

Speech Therapy

Services of a qualified speech therapist for correction of a speech impediment if caused by injury, non-congenital organic disease or surgery. Speech impediments due to congenital anomalies are included only after corrective surgery. However, speech impediments due to cerebral palsy, considered a congenital condition, will be covered without corrective surgery. Charges for speech therapy due to functional Mental Disorders are excluded. The plan will pay up to a maximum of **$5,000** during your lifetime for services covered under this Speech Therapy benefit.

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 the 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; maintenance and repair charges for such equipment;

5. Laboratory services to monitor the patient's response to therapy regimen.

SPECIAL BENEFIT INFORMATION

— The benefits of this Evidence of Coverage are provided for pregnancy, maternity care, abortion and sterilizations.

— All benefits provided elsewhere in this Evidence of Coverage are provided for an organ transplant if:

1. The transplant is of a cornea, kidney or bone marrow; and

2. The recipient of such transplant is a Member.

HOSPITAL – MEDICAL BENEFITS OUTSIDE OF THE UNITED STATES

Medicare does not provide benefits when a Member is outside the United States or its territories and needs medical attention or hospitalization for illness or injury. When covered charges are incurred during the first six (months) of a temporary absence outside the United States and its territories, Anthem Blue Cross will provide the benefits as described in the Anthem Blue Cross Prudent Buyer Classic Plan (basic health benefits plan) Evidence of Coverage for PORAC Members as though the Member incurring such charges were insured under that plan. Benefits will be the same as those provided for non-Prudent Buyer Plan providers. An Evidence of Coverage booklet stating these benefits is available upon request.

Benefits are limited to temporary absences outside of the United States and its territories of six (6) months or less. In the event a Member is confined in a Hospital on the last day of the six (6) months, the Hospital - Inpatient benefits will be continued until his or her discharge from the hospital or until the benefit maximums have been provided, whichever occurs earliest.

PLAN EXCLUSIONS AND LIMITATIONS

GENERAL EXCLUSIONS AND LIMITATIONS

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

Benefits of this Evidence of Coverage are not provided for or in connection with the following items. (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.)

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

2. **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.

3. **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.

4. **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, except when such services supplement benefits under Original Medicare. Custodial Care or rest cures, except as specifically stated in Home Infusion Therapy under MAJOR MEDICAL BENEFITS. 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 Skilled Nursing Facility Benefits under SUPPLEMENTAL SERVICES AND BENEFITS.

5. **Dental Services or Supplies.** Cosmetic dental surgery or other dental services for beautification. Dental plates, bridges, crowns, caps or other dental prostheses, dental implants, dental services, extraction of teeth or treatment to the teeth or gums, except for surgery of the jaw or related structures, setting fractures of the jaw or facial bones, or services that would be covered when provided by a Physician.

   This exclusion also does not apply to 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 you are developmentally disabled or your health is compromised and general anesthesia is Medically Necessary. Charges for the dental procedure itself, including professional fees of a dentist, are not covered.

6. **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, except when such services supplement benefits under Original Medicare.

7. **Excess Amounts.** Any amounts in excess of:

   - Allowable Charges as determined by Medicare, for benefits provided under the sections entitled BENEFITS TO SUPPLEMENT ORIGINAL MEDICARE PLAN PART A (HOSPITAL) and BENEFITS TO SUPPLEMENT ORIGINAL MEDICARE PLAN PART B (MEDICAL) ; and
   - The negotiated rate, for professional Part B services of a participating provider who does not accept Medicare assignment; and
   - Reasonable Charges, as Anthem Blue Cross determines, for benefits provided under the sections entitled INPATIENT HOSPITAL BENEFITS BEYOND ORIGINAL MEDICARE and HOSPITAL – MEDICAL BENEFITS OUTSIDE OF THE UNITED STATES; and
   - Any maximums for all covered services as stated in the provision MAJOR MEDICAL BENEFITS MAXIMUMS.

8. **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 Investigative, you may request an independent medical review as described in CLAIMS REVIEW / GRIEVANCE PROCEDURES.

9. **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.

10. **Government Services.** Any services actually given to you by a local, state or federal government agency, or by a public school system or school district, except when payment under this plan is expressly required by federal or state law. This limitation does not apply to services provided by Medi-Cal. Services provided by VA Hospitals and military treatment facilities will be considered for payment according to current legislation. The plan 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. **Hearing Aids or Tests.** Hearing aids or routine hearing tests, except as specifically stated under the section entitled BENEFITS FOR SERVICES NOT COVERED BY ORIGINAL MEDICARE.

PLAN EXCLUSIONS AND LIMITATIONS

12. **Learning Disorders.** Hyperkinetic syndromes and/or attention deficit disorders, learning disabilities, behavior problems, mental retardation or autistic disease of childhood.

13. **Medicare Services.** Anthem Blue Cross will not provide the benefits under this plan that duplicate any benefits to which a Member would be entitled under Medicare.

14. **Mental Disorders or Chemical Dependency.** Services for conditions attributable to a Mental Disorder, except as specifically stated under SUPPLEMENTAL SERVICES AND BENEFITS and MAJOR MEDICAL BENEFITS or except when services for such conditions supplement benefits under Original Medicare. Chemical dependency, except when services for these conditions supplement benefits under Original Medicare.

15. **Nicotine or Caffeine Addiction.** Services for smoking cessation or reduction, nicotine use or addiction; caffeine addiction.

16. **Non-Licensed Providers.** Treatment or services rendered by non-licensed health care providers and treatment or services for which the provider of services is not required to be licensed. This includes treatment or services from a non-licensed provider under the supervision of a licensed Physician, except as specifically provided or arranged by Anthem Blue Cross.

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

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

19. **Organ Transplants.** Any charges made in connection with an organ transplant, except that this exclusion shall not apply when:

    a. the transplant is of a cornea, kidney or bone marrow, and

    b. The recipient of such transplant is a Member.

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

21. **Orthopedics.** Orthopedic shoes and shoe inserts. This exclusion does not apply to orthopedic footwear used as an integral part of a brace, shoe inserts that are custom molded to the patient, or therapeutic shoes and inserts designed to treat foot complications due to diabetes, as specifically stated under “Covered Services and Supplies” under MAJOR MEDICAL BENEFITS.

22. **Outpatient Prescription Drugs and Medications.** Outpatient Prescription Drugs or medications, insulin, and niacin for lowering cholesterol, except as specifically stated in the Home Infusion Therapy provision under MAJOR MEDICAL BENEFITS. Non-prescription, over-the-counter patent or proprietary drugs or medicines. Cosmetics, dietary supplements, health or beauty aids.

23. **Outpatient Speech Therapy.** Outpatient speech therapy, except as specifically stated under MAJOR MEDICAL BENEFITS.

PLAN EXCLUSIONS AND LIMITATIONS

24. **Outside United States.** Services and benefits rendered outside the United States and its territories, except as provided under HOSPITAL - MEDICAL BENEFITS OUTSIDE OF THE UNITED STATES.

25. **Personal Items and Services.** Air purifiers, air conditioners, humidifiers, exercise equipment and supplies for comfort, hygiene or beautification. Educational services, nutritional counseling or food supplements. Consultations provided by telephone or facsimile machine.

26. **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.

27. **Refractive Eye Surgery.** Any eye surgery solely for the purpose of correcting refractive defects of the eye such as near-sightedness (myopia) or astigmatism.

28. **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 MAJOR MEDICAL BENEFITS.

29. **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.

30. **Services Not Covered By Medicare.** Services not covered by Medicare unless specifically listed as benefits in this Evidence of Coverage.

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

32. **Sterilization Reversal and Artificial Insemination.** Sterilization reversal. Artificial insemination, in vitro fertilization and gamete intrafallopian transfer including any medical or surgical treatment performed in connection with such procedures. Prescription Drugs for the purpose of birth control. Contraceptive devices, except as specifically stated under MAJOR MEDICAL BENEFITS.

33. **Vision Services or Supplies.** Optometric services, eye exercises including orthoptics, routine eye exams and routine eye refractions, except as specifically stated in Vision Care Benefits under BENEFITS FOR SERVICES NOT COVERED BY ORIGINAL MEDICARE. Eyeglasses or contact lenses, except as specifically stated in Vision Care Benefits under BENEFITS FOR SERVICES NOT COVERED BY ORIGINAL MEDICARE.

34. **Waived Cost-Shares Non-Participating Provider.** For any service for which you are responsible under the terms of this plan to pay a co-payment or deductible, and the co-payment or deductible is waived by a Non-Participating Plan Provider.

35. **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.

PLAN EXCLUSIONS AND LIMITATIONS

COORDINATION OF BENEFITS

The benefits of this Evidence of Coverage may be reduced if the Member has any other group health, dental or vision coverage so that the benefits and services the Member receives do not exceed 100 percent of the covered expense.

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 will advance the benefits of this Evidence of Coverage to the Member subject to the following:

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

   1. If Anthem Blue Cross paid the provider other than on a capitated basis, its lien will not be more than amount it paid for those services.

   2. If Anthem Blue Cross 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.

   3. If you hired an attorney to gain your recovery from the third party, Anthem Blue Cross' lien will not be for more than one-third of the money due you under any final judgment, compromise, or settlement agreement.

   4. If you did not hire an attorney, Anthem Blue Cross' lien will not be for more than one-half of the money due you under any final judgment, compromise or settlement agreement.

   5. If a final judgment includes a special finding by a judge, jury, or arbitrator that you were partially at fault, Anthem Blue Cross' lien will be reduced by the same comparative fault percentage by which your recovery was reduced.

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

C. Anthem Blue Cross will be entitled to collect on its lien even if the amount you or anyone recovered for you (or your 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 you suffered.

PLAN EXCLUSIONS AND LIMITATIONS

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, and such third party disputes that responsibility, Anthem Blue Cross shall provide the benefits of this Evidence of Coverage and Anthem Blue Cross shall automatically acquire thereby, by operation of law, a lien to the extent of benefits paid by Anthem Blue Cross. The Member agrees to take no action that may prejudice Anthem Blue Cross' rights under such lien. The lien may be filed with the responsible third party, his or her agent, or the court, and Anthem Blue Cross may exercise all rights available to it as a lien holder.

MEDICARE NON-DUPLICATION OF BENEFITS

Anthem Blue Cross shall provide the benefits of this plan only to the extent they do not duplicate any benefits to which a Member would be entitled under Medicare.

CONTINUATION OF GROUP COVERAGE (COBRA)

A. Eligibility for Continuation - Qualifying Events

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

For Subscriber and Family Members . . .

1. The Subscriber's termination of employment, for any reason other than gross misconduct;
2. Loss of coverage under an employer's health plan due to a reduction in the Subscriber's work hours;
3. For Members who may be covered as retirees, cancellation of that retiree coverage due to the 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 Subscriber;
5. The Spouse's divorce or legal separation from the Subscriber; or if the Spouse vacates the residence shared with the Subscriber;
6. The end of a child's status as a Family Member, in accordance with the Act and Regulations.

B. Requirements for Continuation

1. Notice

For qualifying events 1, 2 or 3 above, the Subscriber's Employer will notify the Subscriber of the right to continue coverage. In the event of the Subscriber's death (4 above), 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 Subscriber 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 Subscribers 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.

CONTINUATION OF GROUP COVERAGE (COBRA)

Once the continuation of coverage under the Agreement is elected, written notice of his/her rights to continuation of coverage shall be sent to each covered Insured Subscriber or annuitant. In addition to the notice, an Evidence of Coverage booklet shall be sent to each enrolled Insured Subscriber 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 Subscriber during the COBRA continuation period will be eligible for a separate continuation if a subsequent qualifying event results in the person's loss of coverage.

3. Cost of Coverage

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

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

Thereafter, the required subscription charge shall be paid on or before the first day of each month for which continuation coverage is to be provided. If any subscription charge for continuation coverage is not paid when due, Anthem Blue Cross 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, Anthem Blue Cross 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 subscription charge has not been received.

For a Subscriber 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, Anthem Blue Cross shall charge 150 percent of the Subscriber's subscription charge prior to the disability. Anthem Blue Cross must receive timely payment of the subscription 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 subscription charge shall then be 150 percent of the applicable rate for the 19th through 36th month.

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

Exception: A qualified beneficiary whose coverage is continued may extend that continuation coverage for up to an additional 11 months, provided that the disabled Member has been determined by the Social Security Administration to be totally and permanently disabled according to the statutory requirements of either Title II or Title XVI of the Social Security Act. The extension applies to all covered Members as well as the disabled Member. The 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 Subscriber's coverage terminated due to the loss of employment, whichever occurs first.

2. The end of 36 months from the date the Member's coverage terminates, if the qualifying event was the death of the Subscriber; divorce, legal separation, the Spouse vacates the residence shared with the Subscriber; or the end of dependent child status. For a Member whose continuation coverage began under a prior plan, this term will be dated from the time the Member's coverage terminated under that prior plan due to the qualifying event.
3. The date the Agreement terminates.
4. The end of the last period for which the final subscription charge was paid.
5. The date after the date of election of COBRA, the Member first becomes eligible for Medicare.
6. 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 Agreement remaining in effect, a retired Subscriber whose coverage began due to a Chapter 11 bankruptcy may continue coverage for the remainder of his life; that Subscriber's covered Family Members may continue coverage for 36 months after their coverage terminates due to the Subscriber's death. However, coverage could terminate prior to such time for either the Subscriber or Family Member in accordance with items 3, 4 or 6 above.

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

GENERAL PROVISIONS

Evidence of Coverage

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

Identification Cards

In addition to the card issued to the Subscriber and/or Family Member by Medicare, Anthem Blue Cross shall issue to the Subscriber an identification card to which the Subscriber and Family Members are entitled. Possession of an Anthem Blue Cross identification card confers no right to services or other benefits of this plan. To be entitled to services or benefits, the holder of the card must, in fact, be a Member on whose behalf applicable prepayment fees under the Agreement 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 Agreement is chargeable therefor at prevailing rates.

Medical Necessity

The benefits of this Evidence of Coverage are provided only for services that are Medically Necessary as determined by Anthem Blue Cross. The services must be ordered by the attending Physician for the direct care and treatment of a covered illness, injury or condition. 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 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 the Member upon request.

Expense in Excess of Benefits

Anthem Blue Cross is not liable for any expense the Member incurs in excess of the benefits of this plan.

Payment to Providers

Anthem Blue Cross pays the benefits of this plan directly to Contracting Hospitals, Participating Hospitals and medical transportation providers. Also, Anthem Blue Cross may pay Non-Contracting Hospitals and other providers of service directly when the Member assigns benefits in writing. These payments fulfill the obligation of Anthem Blue Cross to the Member for those services.

Provider Reimbursement

Physicians and other professional providers are paid on a fee-for-service basis, according to an agreed schedule.

GENERAL PROVISIONS

Public Policy Participation

We have established a Public Policy Committee (that we call our Consumer Relations Committee) to advise our Board of Directors. This Committee advises the Board about how to assure the comfort, dignity, and convenience of the people we cover. The Committee consists of members covered by our health plan, participating providers and a member of our Board of Directors. The Committee may review our financial information and information about the nature, volume, and resolution of the complaints we receive. The Consumer Relations Committee reports directly to our Board.

Claims Procedures

Unless utilizing the Claim-Free Service, properly completed claim forms, the provider's bill and a copy of the Medicare EOMB (if applicable) itemizing the services received and the charges must be sent to Anthem Blue Cross by the Member or the provider of service. These claim forms must be received by Anthem Blue Cross within 24 months of the date services are received. Anthem Blue Cross is not liable for the benefits of this Evidence of Coverage if claims are not filed within this time period. Claim forms must be used; cancelled checks or receipts are not acceptable.

Claim-Free Service

You need not file a claim for Supplement to Original Medicare benefits if you are a California resident who has enrolled in the Anthem Blue Cross Claim-Free program, and if your provider billed Medicare and the Medicare claim is processed by Anthem Blue Cross, Blue Shield of California or the California offices of Trans-America Insurance or Occidental Insurance. Your Supplement to Original Medicare benefits will automatically be paid through Anthem Blue Cross' Claim-Free process, which makes it possible for Anthem Blue Cross to electronically obtain Medicare Claims data directly from those Medicare claims processors. If your Medicare claim is not processed by one of the above claims processors or if you are not enrolled in the Claim-Free program, then you will need to submit a claim as described above. Members who wish to enroll in or have questions about the Claims-Free system may call Anthem Blue Cross at 1-800-288-6928.

Right of Recovery

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

Free Choice of Hospital and Physician

The Evidence of Coverage in no way interferes with the right of any Member entitled to Hospital benefits to select the 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 Evidence of Coverage and is properly licensed according to appropriate state and local laws. However, benefits payable according to the terms of this Evidence of Coverage will be different for non-participating providers than those benefits payable for participating providers.

GENERAL PROVISIONS

Workers' Compensation Insurance

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

Providing of Care

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

Right to Receive Benefit

There is no vested right to receive any particular benefit set forth in the plan. Plan benefits may be modified. Any modified benefit (such as the elimination of a particular benefit or an increase in the Member's Co-payment) applies to services or supplies furnished on or after the effective date of the modification.

Non-Regulation of Providers

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

Services Non-Transferable

No person other than the Member is entitled to receive hospital services and benefits and surgical and medical benefits furnished under this Evidence of Coverage. Such right to services and benefits is not transferable.

Clerical Error

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

Warranty of Information Provided

Members or applicants for membership shall complete and submit to Anthem Blue Cross such applications or other forms or statements as Anthem Blue Cross may reasonably request. Members warrant that all information contained in such applications, forms or statements submitted to Anthem Blue Cross pursuant to enrollment under the Agreement or the administration thereof is true, correct and complete, and all rights to services and benefits thereunder are subject to the condition that all such information is true, correct and complete.

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 Anthem Blue Cross' rights as set forth in the Agreement; (b) take no action to harm Anthem Blue Cross' rights or interests; and (c) tell Anthem Blue Cross of circumstances that may give rise to its rights.

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

GENERAL PROVISIONS

Protection of Coverage

Anthem Blue Cross does not have the right to cancel the coverage of any Member under the Agreement while:

A. The Agreement is still in effect, and

B. The Member is still eligible, and

C. The Member's subscription charges are paid according to the terms of the Agreement.

Terms of Coverage

A. In order for a Member to be entitled to benefits under the Agreement, both the Agreement and the Member's coverage under the Agreement must be in effect on the date the expense giving rise to a claim or 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 Agreement is subject to amendment, modification or termination according to the provisions of the Agreement without the consent or concurrence of Members.

Financial Arrangements with Providers

Anthem Blue Cross 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 Subscribers and Members entitled to health care benefits under individual certificates and group policies or contracts to which Anthem Blue Cross or an affiliate is a party, including all persons covered under the Agreement.

Under the above-referenced contracts between Providers and Anthem Blue Cross or an affiliate, the negotiated rates paid for certain medical services provided to persons covered under the Agreement may differ from the rates paid for persons covered by other types of products or programs offered by Anthem Blue Cross or an affiliate for the same medical services. In negotiating the terms of the Agreement, PORAC was aware that Anthem Blue Cross or its affiliates offer several types of products and programs. The Subscribers, 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 Agreement.

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 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 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 or an affiliate in determining its fees or subscription charges or premiums.

GENERAL PROVISIONS

Confidentiality and Release of Medical Information

Anthem Blue Cross will use reasonable efforts, and take the same care to preserve the confidentiality of the Member's medical information. Anthem Blue Cross may use data collected in the course of providing services hereunder for statistical evaluation and research. If such data is ever released to a third party, it shall be released only in aggregate statistical form without identifying the Member. Medical information may be released only with the written consent of the Member or as required by law. It must be signed, dated and must specify the nature of the information and to which persons and organizations it may be disclosed. Members may access their own medical records.

Anthem Blue Cross may release your medical information to professional peer review organizations and to the Trust for purposes of reporting claims experience or conducting an audit of our operations, provided the information disclosed is reasonably necessary for the Trust to conduct the review or audit.

A statement describing Anthem Blue Cross policies and procedures for preserving the confidentiality of medical records is available and will be furnished to you upon request.

Medical Policy and Technology Assessment

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

HOW TO SUBMIT CLAIMS

All claims (except out-of-state hospital claims for Inpatient Hospital Benefits Beyond Medicare and those processed through the Claims-Free Service) for Supplement to Original Medicare Benefits must be submitted to the following:

Anthem Blue Cross
PORAC Unit
P.O. Box 60007
Los Angeles, CA 90060-0007

Call this toll-free number for PORAC Members if you need claim forms or assistance with your claims:

1-800-288-6928

Claim-Free Service

Members need not file a claim for Supplement to Original Medicare benefits if you are a California resident who has enrolled in the Anthem Blue Cross Claim-Free program, and if your provider billed Medicare and the Medicare claim is processed by Anthem Blue Cross, Blue Shield of California or the California offices of Trans-America Insurance or Occidental Insurance. Your Supplement to Original Medicare benefits will automatically be paid through Anthem Blue Cross' Claim-Free process, which makes it possible for Anthem Blue Cross to electronically obtain Medicare Claims data directly from those Medicare claims processors. If your Medicare claim is not processed by one of the above claims processors or if you are not enrolled in the Claim-Free program, then you will need to submit a claim as described above. Members who wish to enroll in or have questions about the Claims-Free system may call Anthem Blue Cross at 1-800-288-6928.

HOSPITAL BENEFITS (ORIGINAL MEDICARE PART A BENEFITS)

Always consult your Physician first. If your Physician decides hospitalization is necessary, he or she will make the arrangements. Your Anthem Blue Cross identification card should be presented along with your Social Security Medicare identification card at the Hospital admission desk. The Hospital will commence action on both your claims by billing Anthem Blue Cross under your CalPERS Supplement to Original Medicare Plan at the same time that they notify the fiscal intermediary of your Medicare claim. If you do not have your identification card when you enter the Hospital or if the status of your contract is questioned, please request the Hospital to write, or in case of emergency to call, the PORAC Anthem Blue Cross customer service unit (see address and telephone number above).

Inpatient Hospital Benefits Beyond Original Medicare - Out-of-State

If you are traveling or live outside of California and require Inpatient hospitalization, the BlueCard Program allows the Hospital to submit a claim directly to their local Blue Cross and/or Blue Shield Plan. The BlueCard Program ensures you receive the Inpatient Hospital Benefits Beyond Original Medicare of your PORAC Supplement to Original Medicare Plan just as if you were hospitalized in California.

HOW TO SUBMIT CLAIMS

MEDICAL BENEFITS (ORIGINAL MEDICARE PART B BENEFITS)

First, the provider of services will submit all medical claims to the Social Security Medicare fiscal intermediary for Medicare benefits.

When Medicare has processed your claim, you will receive an "Explanation of Medicare Benefits" notice.

Submit a copy of this Explanation of Medicare Benefits along with a copy of your medical bill and a completed Member Claim Form. Anthem Blue Cross will then make supplemental payments, payable to you or to the Physician if benefits are assigned.

Important: All medical bills must be completely itemized, showing the following information:

- The name, address and Medicare provider number of the provider who treated you;
- The date the service(s) were received;
- The type of service(s) received;
- The charge for the service(s) received;
- The Member's name and address;
- If the provider accepts assignment of Supplement to Original Medicare Benefits, your authorization to pay the provider directly. Without that authorization, benefits will be paid directly to you.

Cancelled checks or receipts are not acceptable.

VISION BENEFITS AND HEARING AID BENEFITS

Properly completed claim forms including a bill itemizing the services received and the charges must be sent to Anthem Blue Cross by the Member or provider of service. These forms are available from Anthem Blue Cross. Send claims to Anthem Blue Cross at the address shown on page 45.

SERVICES RECEIVED OUTSIDE THE UNITED STATES

If it is Medically Necessary to be hospitalized or to receive medical treatment while traveling during a temporary absence of 6 months or less outside the United States or its territories, pay the entire bill and submit it, along with the receipt, a copy of the itemized bill (preferably written in English), and a report from the attending Physician for reimbursement. Claims for services received outside the United States and its territories should be sent to Anthem Blue Cross at the address shown on page 45.

GENERAL INFORMATION

Enrollment Information

Information pertaining to eligibility, enrollment, cancellation or termination of insurance, etc., is found in the informational pamphlet entitled *CalPERS Health Program Guide*. This pamphlet is prepared by CalPERS in Sacramento, California. You may request a copy of this pamphlet online by visiting the CalPERS web site at www.calpers.ca.gov or by calling CalPERS 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 Member Account Management Division at P.O. Box 942715, Sacramento, CA 94229-2715, or telephone the appropriate number shown below:

CalPERS Customer Service

Toll free number --- **888 CalPERS** (or **888**-225-7377)
Fax number --- (800) 959-6545
TTY --- (877) 249-7442

Information Practices

Anthem Blue Cross may collect personal information about you in order to evaluate your application or to properly process your claim. This information is normally limited to information relating to the condition of your health, what services were provided and at what cost. Under California law this information, under certain circumstances, may be given to others without your specific authorization. For example, Anthem Blue Cross may provide information to insurance companies in order to coordinate benefits.

Upon your request, Anthem Blue Cross will provide details of the nature of personal information that may be collected, the circumstances under which it may be disclosed without an authorization, and your right of access and correction if you believe it to be inaccurate. Anthem Blue Cross will furnish this medical record information either directly to you or to a medical professional designated by you.

Information and Assistance With Medicare

If you have questions or concerns about your Medicare benefits you may contact the following resources:

—Visit your local Social Security Administration Office or call 1-800-772-1213.

—Medicare at 1-800-MEDICARE (1-800-633-4227) or access the Medicare web site at www.medicare.gov.

—Health Insurance Counseling and Advocacy Program (HICAP) which offers health insurance counseling for California seniors: 1-800-434-0222.

CLAIMS REVIEW / GRIEVANCE PROCEDURES

STEP 1: Disagreements with Anthem Blue Cross Claims Determinations

Anthem Blue Cross wants your experience with them to be as positive as possible. There may be times, however, when you have a complaint, problem, or question about your plan or a service you have received. If you have a question or complaint, you may telephone Anthem Blue Cross at 800-288-6928 or send a written request to Anthem Blue Cross at P.O. Box 60007, Los Angeles, CA 90060-0007, Attn: PORAC Unit. Anthem Blue Cross' customer service staff will answer your questions or assist you in resolving your issue.

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 has the responsibility for determining whether claims are payable. A practicing physician-consultant retained by Anthem Blue Cross must agree if the denial is based on the lack of medical necessity. 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. If you do not agree, either you or your attending physician, acting as your authorized representative, may request reconsideration. To request a reconsideration you may telephone Anthem Blue Cross at 800-288-6928 or send a written request to Anthem Blue Cross at P.O. Box 60007, Los Angeles, CA 90060-0007, Attn: PORAC Unit. Anthem Blue Cross' 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, 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 through the Anthem Blue Cross web site at www.anthem.com/ca. You must submit your grievance to Blue Cross no later than 180 days following the date you receive a denial notice from Anthem Blue Cross or any other incident or action with which you are dissatisfied. Your issue will then become part of Anthem Blue Cross' formal grievance process and will be resolved accordingly.

All grievances received by Anthem Blue Cross will be acknowledged in writing, together with a description of how Anthem Blue Cross proposes to resolve the grievance. After Anthem Blue Cross 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 Anthem Blue Cross 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 STEP 3 or STEP 4 below.

NOTE: You should follow the Anthem Blue Cross 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 Member Account Management Division, P.O. Box 942715, Sacramento, CA, 94229-2715.

For grievances not resolved after completing STEP 1 procedures:

1. Coverage grievances: A coverage grievance concerns 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. It does not include a plan or contracting provider decision regarding a disputed health care service.

CLAIMS REVIEW / GRIEVANCE PROCEDURES

If you have followed the grievance procedures on the previous page and are still dissatisfied you may proceed to STEP 3: Administrative Hearing or STEP 4: Binding Arbitration in the alternative, only if the coverage grievance concerns services not covered by Original Medicare but covered by Anthem Blue Cross. For coverage grievances which concern services covered by Original Medicare and Anthem Blue Cross you may proceed to STEP 4: Binding Arbitration. If your 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.

2. Disputed Health Care Service grievances: A disputed health care service grievance concerns any heath 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 includes decisions as to whether a particular service is experimental or investigational.

   If you have followed the grievance procedures on the previous page and are still dissatisfied you may proceed to STEP 3: Administrative Hearing or STEP 4: Binding Arbitration in the alternative, only if the disputed health care grievance concerns services not covered by Original Medicare but covered by Anthem Blue Cross. For disputed health care grievances which concern services covered by Original Medicare and Anthem Blue Cross you may proceed to STEP 4: Binding Arbitration. If your 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.

3. Eligibility grievances: These issues should always be referred directly to CalPERS at the address noted on page 48.

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

5. Bad faith grievances: You must proceed to STEP 4: Binding Arbitration for claims for benefits involving charges of bad faith.

STEP 2: Special Independent Medical Review

A. Objection to Denial of Experimental or Investigative Treatment: If coverage for a proposed treatment is denied because Anthem Blue Cross determines that the treatment is Experimental or Investigative, you may ask that the denial be reviewed by an external independent medical review organization contracting with the Department of Managed Health Care (DMHC). Your request for this review may be submitted to the DMHC. You pay no application or processing fees of any kind for this review. You have the right to provide information in support of your request for review. A decision not to participate in this review process may cause you to forfeit any statutory right to pursue legal action against Anthem Blue Cross regarding the disputed health care service. Anthem Blue Cross will send you an application form and an addressed envelope for you to use to request this review with any grievance disposition letter denying coverage for this reason. To request an application form, please call or write to Anthem Blue Cross at the location shown above under item 1. To qualify for this review, all of the following conditions must be met:

CLAIMS REVIEW / GRIEVANCE PROCEDURES

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

   a) 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.

   b) 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 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 Physician, 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 or accepted for publication by medical journals that meet nationally recognized standards;

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

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

   d) Either of the following: (i) The American Hospital Formulary Services Drug Information, or (ii) the American Dental Association Accepted Dental Therapeutics;

   e) Any of the following references, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen: (i) the Elsevier Gold Standard's Clinical Pharmacology, (ii) the National Comprehensive Cancer Network Drug and Biologics Compendium, or (iii) the Thomson Micromedex DrugDex;

   f) Findings, studies or research conducted by or under the auspices of federal governmental agencies and nationally recognized federal research institutes, including the Federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Centers for Medicare and Medicaid Services, Congressional Office of Technology Assessment, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services; and

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

   In all cases, the certification must include a statement of the evidence relied upon.

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 DMHC for good cause.

Within three business days of receiving notice from the DMHC of your request for review, Anthem Blue Cross will send the reviewing panel all relevant medical records and documents in their possession, as well as any additional information submitted by you or your Physician. Any newly developed or discovered relevant medical records identified by Anthem Blue Cross or by a Prudent Buyer Plan 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 if your physician determines that the proposed treatment would be significantly less effective if not provided promptly). 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 Department of Managed Health Care ("DMHC") if you believe that Anthem Blue Cross has 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 Anthem Blue Cross, 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. Anthem Blue Cross 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 Anthem Blue Cross regarding the disputed health care service.

Eligibility: The DMHC 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 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 Anthem Blue Cross, 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 Anthem Blue Cross 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 DMHC's attention. The DMHC 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 if your case involves an imminent threat to your health, whichever applies. This application deadline may be extended by the DMHC 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 will provide benefits for the health care service.

For non-urgent cases, the IMR organization designated by the DMHC 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 3 business days.

For more information regarding the IMR process, or to request an application form, please call Anthem Blue Cross customer service at 800-288-6928.

STEP 3: CalPERS Administrative Appeal Process

Only eligibility grievances, and coverage and disputed health care service grievances that are not covered by Original Medicare, but are covered by Anthem Blue Cross may be appealed to CalPERS. Coverage and disputed health care service grievances for services covered by Original Medicare may be appealed through the Medicare appeal process. You may proceed directly to STEP 4 for issues involving quality of care, access to care or allegations of bad faith.

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

CalPERS staff will conduct an administrative review on eligibility grievances and upon your appeal of Anthem Blue Cross' denial of coverage issues or the denial of a disputed health care grievance which is covered by Anthem Blue Cross and not covered by Original Medicare. **Note: Anthem Blue Cross 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' letter of denial following your grievance. Not every dispute may be appealed to CalPERS. For example, you must proceed directly to STEP 4 for issues involving quality of care, access to care or allegations of bad faith.

If the dispute remains unresolved during the administrative review process, the matter may then proceed to an Administrative Hearing. The Administrative Hearing will be conducted in a formal manner, with evidence and testimony presented to an Administrative Law Judge. As an alternative to this hearing, you 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 the CalPERS Board of Administration at any time, and proceed to STEP 4: Binding Arbitration.

To file for an Administrative Hearing, contact CalPERS Health Plan Administration Division, Health Appeals Coordinator, P.O. Box 1953, Sacramento, CA, 95812-1953 or call CalPERS at **888 CalPERS** (or **888**-225-7377) for information.

STEP 4: Binding Arbitration (Small Claims Court)

If you do not use STEP 3, 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 Agreement, 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 if the amount sought exceeds the jurisdictional limit of the small claims court. Any dispute regarding a claim for damages within the jurisdictional limits of the small claims court will be resolved in such court. **Note: A small claims court judgement cannot be appealed.**

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.

The Member and Anthem Blue Cross agree to be bound by these arbitration provisions and acknowledge that they are giving up their right to trial by jury for both medical malpractice claims and any other disputes.

California Health & Safety Code section 1363.1 requires that any arbitration agreement include the following notice based on California Code of Civil Procedure 1295(a): **It is understood that any dispute as to medical malpractice, that is, whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, acknowledge that they are giving up their constitutional right to have any and all disputes, including medical malpractice claims, decided in a court of law before a jury, and instead are accepting the use of arbitration.**

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

The arbitration findings will be final and binding except to the extent that state or federal law provides for the judicial review of arbitration proceedings.

The arbitration is initiated by the Member making written demand on Anthem Blue Cross. The arbitration will be conducted by Judicial Arbitration and Mediation Services ("JAMS"), according to its applicable Rules and Procedures. If for any reason JAMS is unavailable to conduct the arbitration, the arbitration will be conducted by another neutral arbitration entity, by agreement of the Member and Anthem Blue Cross, or by order of the court, if the Member and Anthem Blue Cross cannot agree.

The costs of the arbitration will be allocated per the JAMS Policy on Consumer Arbitrations. If the arbitration is not conducted by JAMS, the costs will be shared equally by the parties, except in cases of extreme financial hardship, upon application to the neutral arbitration entity to which the parties have agreed, in which cases, Anthem Blue Cross will assume all or a portion of the costs of the arbitration.

Please send all Binding Arbitration demands in writing to Anthem Blue Cross, 21555 Oxnard Street, Woodland Hills, CA 91367 marked to the attention of the Customer Service Department listed on your identification card.

CLAIMS REVIEW / GRIEVANCE PROCEDURES

NOTE: If the Member wishes to appeal a decision made by Medicare and not by Anthem Blue Cross, the Member must initiate the appeal process by contacting his or her local Social Security Administration office.

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

ADDITIONAL DEPARTMENT OF MANAGED HEALTH CARE GRIEVANCE PROCEDURES:

If you are dissatisfied with the resolution of your grievance as described on pages 48 through 54, or if your grievance has not been resolved after at least 30 days, you may submit your grievance to the California Department of Managed Health Care for review prior to binding arbitration (see DEPARTMENT OF MANAGED HEALTH CARE below). 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, you are not required to complete our grievance process or to wait at least 30 days, but may immediately submit your grievance to the Department of Managed Health Care for review.

If at the conclusion of review of your grievance by the Department of Managed Health Care you continue to be dissatisfied with its resolution, or prior to and instead of review of your case by the Department of Managed Health Care, your remedy is either STEP 3: CalPERS Administrative Appeal Process or STEP 4: Binding Arbitration (see page 53).

DEPARTMENT OF MANAGED HEALTH CARE

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at the **telephone number listed on your identification card** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (**1-888-HMO-2219**) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The department's Internet web site (**http://www.hmohelp.ca.gov**) has complaint forms, IMR applications forms and instructions online.

FOR YOUR INFORMATION

TRIAGE OR SCREENING SERVICES

If you have questions about a particular health condition or if you need someone to help you determine whether or not care is needed, triage or screening services are available to you from Anthem Blue Cross by telephone. Triage or screening services are the evaluation of your health by a Physician or a nurse who is trained to screen for the purpose of determining the urgency of your need for care. Please contact the 24/7 NurseLine at the telephone number listed on your identification card 24 hours a day, 7 days a week.

AFTER HOURS CARE

After hours care is provided by your Physician who may have a variety of ways of addressing your needs. You should call your Physician for instructions on how to receive medical care after their normal business hours, on weekends and holidays, or to receive non-Emergency care and non-urgent care within the service area for a condition that is not life threatening but that requires prompt medical attention. If you have an Emergency, call 911 or go to the nearest emergency room.

ORGAN DONATION

Each year, organ transplantation saves thousands of lives. The success rate for transplantation is rising, but there are far more potential recipients than donors. More donations are urgently needed.

Organ donation is a singular opportunity to give the gift of life. Anyone age 18 or older and of sound mind can become a donor when he or she dies. Minors can become donors with parental or guardian consent.

Organ and tissue donations may be used for transplants and medical research. Today it is possible to transplant more than 25 different organs and tissues. Today it is possible to transplant more than 25 different organs and tissues; this can save the lives of as many as eight people and improve the lives of another 50 people. Your decision to become a donor could someday save or prolong the life of someone you know, perhaps even a close friend or family member.

If you decide to become a donor, please discuss it with your family. Let your physician know your intentions as well. You may register as a donor by obtaining a donor card from the Department of Motor Vehicles. Be sure to sign the donor card and keep it with your driver's license or identification card. In California, you may also register online at:

www.donatelifecalifornia.org/

While organ donation is a deeply personal decision, please consider making this profoundly meaningful and important gift.

FOR YOUR INFORMATION

ANTHEM BLUE CROSS WEB SITE

Information specific to your benefits and claims history are available by calling Anthem Blue Cross toll-free at 1-800-288-6928 or by logging on to the Anthem Blue Cross web site at www.anthem.com/ca. To access benefit information, claims payment status, benefit maximum status, participating providers or to order an ID card, simply log on to the web site, select “Member” and click the "Register" button on your first visit to establish a User ID and Password to access the personalized and secure MemberAccess Web site. Once registered, simply click the "Login" button and enter your User ID and Password to access the MemberAccess Web site. Anthem Blue Cross privacy statement can also be viewed on its website. You may also submit a grievance online or print the Plan Grievance Form through the web site.

LANGUAGE ASSISTANCE PROGRAM

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

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

Written materials available for translation include grievance and appeal letters, consent forms, claim denial letters, and explanations of benefits. These materials are available in the following languages:

- Spanish
- Chinese
- Vietnamese
- Korean
- Tagalog

Oral interpretation services are available in additional languages.

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

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

For claims and customer service, contact:

Anthem Blue Cross
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

1-800-655-6397

www.porac.org/insurance-and-benefits/

Form No. CB14918-2 (117)

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