

Combined Evidence of Coverage and Disclosure Form

Effective January 1, 2022

PORAC Police & Fire Health Basic Plan
Prudent Buyer PPO (non-California resident) Plan

Preferred Provider Organization (PPO)



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

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

COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM

This booklet, called the “Combined Evidence of Coverage and Disclosure Form”, gives you important information about your health plan. This booklet must be consulted to determine the exact terms and conditions of coverage. If you have special health care needs, you should read those sections of the Evidence of Coverage that apply to those needs.

Many words used in this booklet are explained in the “Definitions” section starting on page 105. When reading through this booklet, check that section to be sure that you understand what these words mean. Each time these words are used they are capitalized.

Your health care coverage is self-funded by the Insurance and Benefits Trust of the Peace Officers Research Association of California (IBT of PORAC). The address for the IBT of PORAC is: 2960 Advantage Way, Sacramento, CA 95834 and the phone number is: 800-655-6397.

There is also a 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, 2960 Advantage Way, Sacramento, CA 95834, or you may request a copy by writing to IBT of PORAC. A copy of the Memorandum of Agreement may be purchased from PORAC for a reasonable duplication charge.

If you have questions regarding your benefits, please call the PORAC member services toll-free telephone number at:

1-800-655-6397

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ADMINISTRATIVE AND BENEFIT CHANGES

Effective January 1, 2022, 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.

Refer to the back cover for phone numbers and addresses of the Plan.
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BENEFITS OF THIS PLAN ARE AVAILABLE ONLY FOR SERVICES AND SUPPLIES FURNISHED DURING THE TERM THE PLAN IS IN EFFECT AND WHILE THE BENEFITS YOU ARE CLAIMING ARE ACTUALLY COVERED BY THIS PLAN.

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

TYPES OF PROVIDERS

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

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

- **PPO Providers** are providers who participate in a Blue Cross and/or Blue Shield Plan. PPO Providers have agreed to a rate they will accept as reimbursement for covered services that is generally lower than the rate charged by Traditional Providers. Participating Providers have agreed to a rate they will accept as reimbursement for covered services. The amount of benefits payable under this Plan will be different for Non-Participating Providers than for Participating Providers.
- **Traditional Providers** are providers who might not participate in a Blue Cross and/or Blue Shield Plan, but have agreed to a rate they will accept as reimbursement for covered services for PPO Members.

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

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

A directory of Participating Providers is available. You can get a directory from us.

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

Centers of Medical Excellence and Blue Distinction Centers. We are providing access to Centers of Medical Excellence (CME) network facilities and Blue Distinction Centers for Specialty Care (BDCSC) to provide services for the following specified medical services:

- **Transplant Facilities.** Transplant facilities have been organized to provide services for the following specified transplants: heart, liver, lung, combination heart-lung, kidney, pancreas, simultaneous pancreas-kidney, or bone marrow/stem cell and similar procedures. The CME network is comprised of the Centers of Medical Excellence and the Blue Distinction Centers for Specialty Care (BDCSC). The Centers of Medical Excellence (CME) and Blue Distinction Centers for Specialty Care (BDCSC) meet specific participation criteria and offer comprehensive services through coordinated, streamlined referral management. **The specified transplants are covered only at a CME or BDCSC.**

- **Bariatric Facilities.** Hospital facilities have been organized to provide services for bariatric surgical procedures such as gastric bypass and other surgical procedures for weight loss programs. **These procedures are covered only when performed at a BDCSC.**

CME and BDCSC have agreed to a rate they will accept as payment in full for covered services. A participating provider in the Blue Cross and/or Blue Shield Plan is not necessarily a CME or BDCSC facility.

Non-Participating Providers. Non-Participating Providers are Hospitals and Physicians which have not agreed to participate in a Blue Cross and/or Blue Shield Plan. They have not agreed to the reimbursement rates and other provisions.

We have processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. Members seeking services from Non-Participating Providers could be balance billed by the Non-Participating Provider for those services that are determined to be not payable as a result of these review processes and meets the criteria set forth in any applicable state regulations adopted pursuant to state law. A claim may also be determined to be not payable due to a provider's failure to submit medical records with the claims that are under review in these processes.

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

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

Participating and Non-Participating Pharmacies. "Participating Pharmacies" agree to charge only the Prescription Drug Maximum Allowed Amount (defined on page 112) to fill the prescription. You pay only your copayment amount.

"Non-Participating Pharmacies" have not agreed to the Prescription Drug Negotiated Rate. The amount that will be covered as Prescription Drug Maximum Allowed Amount (defined on page 112) is significantly lower than what these providers customarily charge.

Care Outside the United States—Blue Cross Blue Shield Global Core

Prior to travel outside the United States, call the member services telephone number listed on your ID card to find out if your Plan has Blue Cross Blue Shield Global Core benefits. Your coverage outside the United States is limited and it is recommended:

- Before you leave home, call the member services number on your ID card for coverage details. **You have coverage for services and supplies furnished in connection only with Urgent Care or an Emergency when travelling outside the United States.**
- Always carry your current ID card.
- In an emergency, seek medical treatment immediately.
- **The Blue Cross Blue Shield Global Core Service Center is available 24 hours a day, seven days a week toll-free at (800) 810-BLUE (2583) or by calling collect at (804) 673-1177.** An assistance coordinator, along with a medical professional, will arrange a Physician appointment or hospitalization, if needed.

TYPES OF PROVIDERS

Payment Information

- **Participating Blue Cross Blue Shield Global Core hospitals.** In most cases, you should not have to pay upfront for Inpatient care at participating Blue Cross Blue Shield Global Core Hospitals except for the out-of-pocket costs you normally pay (non-covered services, deductible, copays, and coinsurance). The Hospital should submit your claim on your behalf.
- **Doctors and/or non-participating hospitals.** You will have to pay upfront for outpatient services, care received from a Physician, and Inpatient care from a Hospital that is not a participating Blue Cross Blue Shield Global Core Hospital. Then you can complete a Blue Cross Blue Shield Global Core claim form and send it with the original bill(s) to the Blue Cross Blue Shield Global Core Service Center (the address is on the form).

Claim Filing

- **Participating Blue Cross Blue Shield Global Core hospitals will file your claim on your behalf.** You will have to pay the Hospital for the out-of-pocket costs you normally pay.
- **You must file the claim** for outpatient and Physician care, or Inpatient Hospital care not provided by a participating Blue Cross Blue Shield Global Core Hospital. You will need to pay the health care provider and subsequently send an international claim form with the original bills to us.

Claim Forms

- International claim forms are available from us, from the Blue Cross Blue Shield Global Core Service Center, or online at:

www.bcbs.com/bluecardworldwide.

The address for submitting claims is on the form.

SUMMARY OF BENEFITS

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

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

If there is a discrepancy between what is explained over the phone and what is set out in this Evidence of Coverage, the EOC will control.

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

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.

Telehealth. This plan provides benefits for covered services that are appropriately provided through telehealth, subject to the terms and conditions of the plan. In-person contact between a health care provider and the patient is not required for these services, and the type of setting where these services are provided is not limited. "Telehealth" is the means of providing health care services using information and communication technologies in the consultation, diagnosis, treatment, education, care management and self-management of the patient's health care when the patient is located at a distance from the health care provider. Telehealth does not include consultations between the patient and the health care provider, or between health care providers, by telephone, facsimile machine, or electronic mail.

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

SUMMARY OF BENEFITS

MEDICAL BENEFITS

The Maximum Allowed Amount and the terms of this MEDICAL BENEFITS subsection do not include any amount payable under the section entitled PRESCRIPTION DRUG BENEFITS.

Calendar Year Deductibles

- Primary Deductible:

Member Deductible **\$300**

Family Deductible **\$900***

*Not to exceed \$300 for any one Member. For any given family member, the deductible is met either after he/she meets the Member Deductible, or after the entire Family Deductible is met. The Family Deductible can be met by any combination of amounts from any family member.

- For Non-Participating Providers:

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

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

*Not to exceed \$600 for any one Member. For any given family member, the deductible is met either after he/she meets the Member Deductible, or after the entire Family Deductible is met. The Family Deductible can be met by any combination of amounts from any family member.

Exceptions:

1. The Calendar Year Deductibles will not apply to the following services:
 - a. Office visit charges by a Physician who is a Participating Provider. (This applies only to the charge for the visit itself. Deductible will apply to any other charges made during that visit, such as testing procedures, surgery, etc.)
 - **The deductible WILL apply to Non-Participating Providers -**
 - b. Diabetes education program services provided by a Physician who is a Participating Provider.
 - **The deductible WILL apply to Non- Participating Providers -**
 - c. Services under Preventive Care Services.
 - d. Services under Smoking Cessation Programs.
 - e. Services under Hearing Aid Benefits.
 - f. Services under Nonprescription Medical Formulas.

SUMMARY OF BENEFITS

Calendar Year Deductibles (continued)

- g. Services for prenatal care.
 - h. Covered travel expenses in connection an authorized transplant procedure at an approved Centers of Medical Excellence or Blue Distinction Centers for Specialty Care. Transplant travel expense coverage is available when the closest CME or BDCSC is 75 miles or more from the recipient's or donor's residence.
 - i. Covered travel expense in connection with an authorized bariatric surgical procedure provided at an approved Blue Distinction Centers for Specialty Care.
 - j. Covered transgender travel expenses in connection an approved transgender surgery.
 - k. Services under Body Scan.
 - l. Inpatient physical therapy and occupational therapy.
2. The following services are NOT subject to the Non-Participating Provider Deductible:
- a. Emergency or Accidental Injury services; or
 - b. Charges by a type of Physician not represented in a Blue Cross and/or Blue Shield Plan.

SUMMARY OF BENEFITS

Co-Payments

The following Co-Payments will apply for the Maximum Allowed Amount in excess of any applicable Deductible. All Co-Payments are subject to any maximum amounts stated under MEDICAL BENEFIT MAXIMUMS.

• Preventive Care Services, Prenatal Care and Smoking Cessation Programs	No Co-payment
• Office Visits to a Participating Provider	\$10 (not a Specialist) / \$35 (Specialist) (Office visits to Non-Participating Providers are subject to the 20% Co-Payment)
• Diabetes Education Program services by a Physician who is a Participating Provider	\$10 (not a Specialist) / \$35 (Specialist) (Non-Participating Provider services are subject to the 20% Co-Payment)
• Ambulance, Durable Medical Equipment, Prosthetic Devices, Blood, Special Duty Nursing and Hearing Aid Benefits (as shown on pages 19-20, 21, 25, 34 & 35)	20%
• Non-Emergency Use of Hospital Emergency Room	50%
• Infertility Treatment	50%
• Physical Therapy and Occupational Therapy provided by a Participating Provider:	
Inpatient	No Co-payment
Outpatient	\$15
• Acupuncture Treatment	\$15

ALL OTHER SERVICES NOT LISTED ABOVE:

• For All Covered Charges	20%
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Exceptions:

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

SUMMARY OF BENEFITS

- You will not be required to pay a Co-Payment for mammograms to detect breast cancer.
- Co-Payments do not apply to transgender travel expenses authorized by us. Transgender travel expense coverage is available when the facility at which the surgery or series of surgeries will be performed is 75 miles or more from the Member's residence.

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

Out-Of-Pocket Expense Amount

After you or your Family Members have made the following total out-of-pocket payments for Covered charges incurred during a Calendar Year, you will no longer be required to pay a Co-Payment for the remainder of that Calendar Year, but you remain responsible for costs in excess of the Maximum Allowed Amount for covered services provided by Non-Participating Providers and Other Health Care Providers.

- **Per Member** **\$2,000***
- **Two or more Members of the same family**..... **\$4,000*†**

† Not to exceed \$2,000 for any one Member. For any given family member, the Out-of-Pocket Amount is met either after he/she meets the amount for Per Member, or after the entire family Out-of-Pocket Amount is met. The family Out-of-Pocket Amount can be met by any combination of amounts from any family member.

***Exception:**

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

Please read the definition of Out-of-Pocket Expense carefully, and refer to MAXIMUM ALLOWED AMOUNT to see how covered charges are determined.

SUMMARY OF BENEFITS

Medical Benefit Maximums

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

Skilled Nursing Facility

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

Home Health Care

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

Physical Therapy - Physical Medicine

- For all covered services when provided by a
Participating Provider **20 visits***
per Calendar Year

*There is no limit on the number of covered visits for Medically Necessary physical therapy, physical medicine, and occupational therapy. But additional visits in excess of the number of visits stated above must be authorized in advance.

Hearing Aid Services

- For covered hearing aids..... **1 hearing aid**
for each ear during any 36 month period

Body Scan

- For all covered services..... **\$1,000 per scan**
limited to one scan every 36 months

Infertility Treatment

- For covered infertility treatment **\$8,000**
during your lifetime

SUMMARY OF BENEFITS

PRESCRIPTION DRUG BENEFITS

Prescription Drug Copayments

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

	Participating Pharmacy	Non-Participating Pharmacy
Retail Pharmacies		
Generic Drug	\$10	\$10
Formulary Brand Name Drug*	\$25	\$25
Non-Formulary Brand Name Drug*	\$45	\$45
Compound Medication	\$45	Not Covered
Home Delivery Program		
Generic Drug	\$20	N/A
Formulary Brand Name Drug*	\$40	
Non-Formulary Brand Name Drug*	\$75	

Prescription Drug Out-of-Pocket Amount

After a Member pays **\$2,000** in total copayments in a Calendar Year (**\$4,000** for two or more Members of the same family) for drugs, the Member will have reached the Prescription Drug Out-of-Pocket Amount and the Member will not need to pay any more copayments for Drugs the rest of the Calendar Year.

After we determines that the Member has reached the Prescription Drug Out-of-Pocket Amount, we will let the Participating Pharmacies know that the Member will not need to pay copayments for the rest of the Calendar Year for Drugs.

Exception to Prescription Drug Copayments:

- There will be no copayment required for services and supplies under the “Preventive Prescription Drugs and Other Items” under the PRESCRIPTION DRUG BENEFITS section.
- Your copayment for all other Drugs covered under this Plan will not exceed the lesser of any applicable copayment listed above or:
 - For a 30-day supply from a retail Pharmacy \$250

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

YOUR MEDICAL BENEFITS

MAXIMUM ALLOWED AMOUNT

GENERAL

This section describes the term Maximum Allowed Amount as used in this Evidence of Coverage and Disclosure Form, and what the term means to you when obtaining covered services under this plan. The Maximum Allowed Amount is the total reimbursement payable under your plan for covered services you receive from Participating and Non-Participating Providers. It is the Plan's payment towards the services billed by your provider combined with any Deductible or Co-Payment owed by you. In some cases, you may be required to pay the entire Maximum Allowed Amount. For instance, if you have not met your Deductible under this plan, then you could be responsible for paying the entire Maximum Allowed Amount for covered services. In addition, if these services are received from a Non-Participating Provider, you may be billed by the provider for the difference between their charges and the Maximum Allowed Amount. In many situations, this difference could be significant.

Provided below are two examples below, which illustrate how the Maximum Allowed Amount works. These examples are for illustration purposes only.

Example: The plan has a member Co-Payment of 30% for participating provider services after the Deductible has been met.

- The member receives services from a participating surgeon. The charge is \$2,000. The Maximum Allowed Amount under the plan for the surgery is \$1,000. The member's Co-Payment responsibility when a participating surgeon is used is 30% of \$1,000, or \$300. This is what the member pays. The plan pays 70% of \$1,000, or \$700. The participating surgeon accepts the total of \$1,000 as reimbursement for the surgery regardless of the charges.

Example: The plan has a member Co-Payment of 50% for non-participating provider services after the Deductible has been met.

- The member receives services from a non-participating surgeon. The charge is \$2,000. The Maximum Allowed Amount under the plan for the surgery is \$1,000. The member's Co-Payment responsibility when a non-participating surgeon is used is 50% of \$1,000, or \$500. The plan pays the remaining 50% of \$1,000, or \$500. In addition, the non-participating surgeon could bill the member the difference between \$2,000 and \$1,000. So the member's total out-of-pocket charge would be \$500 plus an additional \$1,000, for a total of \$1,500.

When you receive covered services, we will, to the extent applicable, apply claim processing rules to the claim submitted. We use these rules to evaluate the claim information and determine the accuracy and appropriateness of the procedure and diagnosis codes included in the submitted claim. Applying these rules may affect the Maximum Allowed Amount if we determine that the procedure and/or diagnosis codes used were inconsistent with procedure coding rules and/or reimbursement policies. For example, if your provider submits a claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed, the Maximum Allowed Amount will be based on the single procedure code.

Provider Network Status

The Maximum Allowed Amount may vary depending upon whether the provider is a Participating Provider, a Non-Participating Provider or Other Health Care Provider.

YOUR MEDICAL BENEFITS

Participating Providers and Centers of Medical Excellence (CME). For covered services performed by a Participating Provider or CME the Maximum Allowed Amount for this plan will be the rate the Participating Provider or CME have agreed with us to accept as reimbursement for the covered services. Because Participating Providers or CME have agreed to accept the Maximum Allowed Amount as payment in full for those covered services, they should not send you a bill or collect for amounts above the Maximum Allowed Amount. However, you may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Co-Payment. Please call the member services telephone number on your ID card for help in finding a Participating Provider or visit www.anthem.com/ca.

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

If you are planning to have outpatient surgery, you should first find out if the facility where the surgery is to be performed is an Ambulatory Surgical Center. An Ambulatory Surgical Center is licensed as a separate facility even though it may be located on the same grounds as a Hospital although this is not always the case). If the center is licensed separately, you should find out if the facility is a Participating Provider before undergoing the surgery.

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

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

Non-Participating Providers and Other Health Care Providers.* Providers who are not in the Participating Provider network are Non-Participating Providers or Other Health Care Providers, subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary providers. For covered services you receive from a Non-Participating Provider or Other Health Care Provider, the Maximum Allowed Amount will be based on the applicable Non-Participating Provider rate or fee schedule for this plan, an amount negotiated by us or a third party vendor which has been agreed to by the Non-Participating Provider, an amount derived from the total charges billed by the Non-Participating Provider, an amount based on information provided by a third party vendor, or an amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services ("CMS"). When basing the Maximum Allowed Amount upon the level or method of reimbursement used by CMS, we will update such information, which is unadjusted for geographic locality, no less than annually.

Providers who are not contracted for this product, but are contracted for other products, are also considered Non-Participating Providers. For this plan, the Maximum Allowed Amount for services from these providers will be one of the methods shown above unless the provider's contract specifies a different amount.

For covered services rendered outside the network service area by Non-Participating Providers, claims may be priced using the local Blue Cross Blue Shield plan's Non-Participating Provider fee schedule / rate or the pricing arrangements required by applicable state or federal law. In certain situations, the Maximum Allowed Amount for out of area claims may be based on billed charges, the pricing we would use if the healthcare services had been obtained within the network service area, or a special negotiated price.

YOUR MEDICAL BENEFITS

Unlike Participating Providers, Non-Participating Providers and Other Health Care Providers may send you a bill and collect for the amount of the Non-Participating Provider's or Other Health Care Provider's charge that exceeds our Maximum Allowed Amount under this plan. You may be responsible for paying the difference between the Maximum Allowed Amount and the amount the Non-Participating Provider or Other Health Care Provider charges. This amount can be significant. Choosing a Participating Provider will likely result in lower out of pocket costs to you. Please call the member services number on your ID card for help in finding a Participating Provider or visit our website at <http://ibtoforac.org>. Member services is also available to assist you in determining this plan's Maximum Allowed Amount for a particular covered service from a Non-Participating Provider or Other Health Care Provider.

***Exceptions:**

- **Clinical Trials.** The Maximum Allowed Amount for Non-Participating Providers for services and supplies provided in connection with Clinical Trials will be the lesser of the billed charge or the amount that ordinarily applies when services are provided by a Participating Provider.
- **If Medicare is the primary payer, the Maximum Allowed Amount does not include any charge:**
 1. By a Hospital, in excess of the approved amount as determined by Medicare; or
 2. By a Physician who is a Participating Provider who accepts Medicare assignment, in excess of the approved amount as determined by Medicare; or
 3. By a Physician who is a Non-Participating Provider or Other Health Care Provider who accepts Medicare assignment, in excess of the lesser of the Maximum Allowed Amount stated above, or the approved amount as determined by Medicare; or
 4. By a Physician or Other Health Care Provider who does not accept Medicare assignment, in excess of the lesser of the Maximum Allowed Amount stated above, or the limiting charge as determined by Medicare.

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

Cost Share

For certain covered services, and depending on your plan design, you may be required to pay all or a part of the Maximum Allowed Amount as your cost share amount (Deductibles or Co-Payments). Your cost share amount and the Out-Of-Pocket Amounts may be different depending on whether you received covered services from a Participating Provider or Non-Participating Provider. Specifically, you may be required to pay higher cost-sharing amounts or may have limits on your benefits when using Non-Participating Providers. Please see the SUMMARY OF BENEFITS section for your cost share responsibilities and limitations, or call the member services telephone number on your ID card to learn how this plan's benefits or cost share amount may vary by the type of provider you use.

We will not provide any reimbursement for non-covered services. You may be responsible for the total amount billed by your provider for non-covered services, regardless of whether such services are performed by a Participating Provider or Non-Participating Provider. Non-covered services include services specifically excluded from coverage by the terms of your plan and services received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, Medical Benefit Maximums or day/visit limits.

In some instances you may only be asked to pay the lower Participating Provider cost share percentage when you use a Non-Participating Provider. For example, if you go to a Participating hospital or facility and receive covered services from a Non-Participating Provider such as a radiologist, anesthesiologist or pathologist, you will pay the Participating

YOUR MEDICAL BENEFITS

Provider cost share percentage of the Maximum Allowed Amount for those covered services, and, you may also be liable for the difference between the Maximum Allowed Amount and the Non-Participating Provider's charge.

We and our designated pharmacy benefits manager may receive discounts, rebates, or other funds from *drug* manufacturers, wholesalers, distributors and/or similar vendors which may be related to certain prescription drug purchases under this *plan* and which positively impact the cost effectiveness of covered services and are included when our costs are calculated.

Authorized Referrals

In some circumstances we may authorize Participating Provider cost share amounts (Deductibles or Co-Payments) to apply to a claim for a covered service you receive from a Non-Participating Provider. In such circumstance, you or your Physician must contact us in advance of obtaining the covered service. It is your responsibility to ensure that we have been contacted. If we authorize a Participating Provider cost share amount to apply to a covered service received from a Non-Participating Provider, you also may still be liable for the difference between the Maximum Allowed Amount and the Non-Participating Provider's charge. Please call the member services telephone number on your ID card for Authorized Referral information or to request authorization.

YOUR MEDICAL BENEFITS

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

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

DEDUCTIBLES

Each deductible under this plan is separate and distinct from the other. Only the covered charges that make up the Maximum Allowed Amount will apply toward satisfaction of any deductible except as specifically indicated in this Evidence of Coverage.

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

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

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

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

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

YOUR MEDICAL BENEFITS

CO-PAYMENTS

After you have satisfied any applicable deductible, we will subtract your Co-Payment from the amount of the Maximum Allowed Amount remaining.

If your Co-Payment is a percentage, we will apply the applicable percentage to the amount of the Maximum Allowed Amount remaining after any deductible has been met. This will determine the dollar amount of your Co-Payment.

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

OUT-OF-POCKET EXPENSE AMOUNT

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

Charges Which Do Not Apply Toward the Out-of-Pocket Expense Amount. Only charges that are considered covered will apply toward satisfaction of any Out-of-Pocket Amount. Charges for services or supplies not covered under this plan and charges which exceed the Maximum Allowed Amount will not be applied toward satisfaction of an Out-of-Pocket Amount.

MEDICAL BENEFIT MAXIMUMS

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

YOUR MEDICAL BENEFITS

CONDITIONS OF COVERAGE

The following conditions of coverage must be met for expense incurred for services or supplies to be covered under this plan.

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

YOUR MEDICAL BENEFITS

MEDICAL CARE THAT IS COVERED

The benefits provided in this Evidence of Coverage are subject to applicable federal and California laws. There are some states that require more generous benefits be provided to their residents even if the master policy was not issued in their state. If your state has such requirements, we will adjust your benefits to meet the minimum requirements.

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

Acupuncture

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

Advanced Imaging Procedures

Imaging procedures, including, but not limited to, Magnetic Resonance Imaging (MRI), Computerized Tomography (CT scans), Positron Emission Tomography (PET scan), Magnetic Resonance Spectroscopy (MRS scan), Magnetic Resonance Angiogram (MRA scan), Echocardiography and nuclear cardiac imaging are subject to pre-service review to determine medical necessity. You may call the toll-free member services telephone number on your identification card to find out if an imaging procedure requires pre-service review. See the UTILIZATION REVIEW PROGRAMS section beginning on page 50 for details.

Allergy

Allergy testing and Physician services for allergy injections.

Ambulance

Ambulance services are covered when you are transported by a state licensed vehicle that is designed, equipped, and used to transport the sick and injured and is staffed by Emergency Medical Technicians (EMTs), paramedics, or other licensed or certified medical professionals. Ambulance services are covered when one or more of the following criteria are met:

- For ground ambulance, you are transported:
 - From your home, or from the scene of an accident or medical Emergency, to a Hospital,
 - Between Hospitals, including when you are required to move from a Hospital that does not contract with us to one that does, or
 - Between a Hospital and a Skilled Nursing Facility or other approved facility.
- For air or water ambulance, you are transported:
 - From the scene of an accident or medical Emergency to a Hospital,
 - Between hospitals, including when you are required to move from a hospital that does not contract with us to one that does, or
 - Between a hospital and another approved facility.

YOUR MEDICAL BENEFITS

Non-emergency ambulance services are subject to medical necessity reviews. Emergency ground ambulance services do not require pre-service review. Pre-service review is required for air ambulance in a non-medical Emergency. When using an air ambulance in a non-emergency situation, we reserve the right to select the air ambulance provider. If you do not use the air ambulance we select in a non-emergency situation, no coverage will be provided.

You must be taken to the nearest facility that can provide care for your condition. In certain cases, coverage may be approved for transportation to a facility that is not the nearest facility.

Coverage includes Medically Necessary treatment of an illness or injury by medical professionals from an ambulance service, even if you are not transported to a Hospital. If provided through the 911 emergency response system*, ambulance services are covered if you reasonably believed that a medical Emergency existed even if you are not transported to a Hospital. Ambulance services are not covered when another type of transportation can be used without endangering your health. Ambulance services for your convenience or the convenience of your Family Members or Physician are not a covered service.

Other non-covered ambulance services include, but are not limited to, trips to:

- A Physician's office or clinic;
- A morgue or funeral home.

Important information about air ambulance coverage. Coverage is only provided for air ambulance services when it is not appropriate to use a ground or water ambulance. For example, if using a ground ambulance would endanger your health and your medical condition requires a more rapid transport to a Hospital than the ground ambulance can provide, this plan will cover the air ambulance. Air ambulance will also be covered if you are in a location that a ground or water ambulance cannot reach.

Air ambulance will not be covered if you are taken to a Hospital that is not an acute care Hospital (such as a skilled nursing facility or a rehabilitation facility), or if you are taken to a Physician's office or to your home.

Hospital to hospital transport: If you are being transported from one Hospital to another, air ambulance will only be covered if using a ground ambulance would endanger your health and if the Hospital that first treats you cannot give you the medical services you need. Certain specialized services are not available at all Hospitals. For example, burn care, cardiac care, trauma care, and critical care are only available at certain Hospitals. For services to be covered, you must be taken to the closest Hospital that can treat you. Coverage is not provided for air ambulance transfers because you, your family, or your Physician prefers a specific Hospital or Physician.

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

Bariatric Surgery

Services and supplies in connection with Medically Necessary surgery for weight loss, only for morbid obesity and only when performed at an approved BDCSC facility. **Charges for services provided for or in connection with a bariatric surgical procedure performed at a facility other than a BDCSC will not be covered.**

Bariatric surgical procedures are subject to utilization review to determine medical necessity. Please refer to the UTILIZATION REVIEW PROGRAMS section beginning on page 50 for information on how to obtain the proper reviews.

YOUR MEDICAL BENEFITS

Bariatric Surgery Travel Expense. Certain travel expenses incurred in connection with an approved, specified bariatric surgery, performed at a designated BDCSC that is fifty (50) miles or more from the Member's place of residence, are covered, provided the expenses are authorized in advance. The fifty (50) mile radius around the BDCSC will be determined by the bariatric BDCSC coverage area (See DEFINITIONS). The following travel expenses incurred by the Member and/or one companion:

- Transportation for the Member and/or one companion to and from the BDCSC.
- Lodging, limited to one room, double occupancy.
- Other reasonable expenses. Tobacco, alcohol, drug expenses, and meals are excluded from coverage.

Member Services will confirm if the "Bariatric Travel Expense" benefit is available in connection with access to the selected bariatric BDCSC. Details regarding reimbursement can be obtained by calling the Member Services number on your ID card. A travel reimbursement form will be provided for submission of legible copies of all applicable receipts in order to obtain reimbursement.

Biofeedback Procedures

Blood

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

Breast Cancer

Services and supplies provided in connection with the screening for, diagnosis of, and treatment for breast cancer whether due to illness or injury, including:

1. Diagnostic mammogram examinations in connection with the treatment of a diagnosed illness or injury. Routine mammograms will be covered initially with Preventive Care Services benefit.
2. Breast cancer (BRCA) testing, if appropriate, in conjunction with genetic counseling and evaluation. When done as a Preventive Care Service, BRCA testing will be covered under the Preventive Care Services benefit.
3. Mastectomy and lymph node dissection; complications from a mastectomy including lymphedema.
4. Reconstructive Surgery of both breasts performed to restore and achieve symmetry following a Medically Necessary mastectomy.
5. Breast prostheses following a mastectomy (see the Prosthetic Devices provision on page 34).

This coverage is provided in a manner determined in consultation with the attending physician and patient. This coverage is also provided according to the terms and conditions of this plan that apply to all other medical conditions.

YOUR MEDICAL BENEFITS

Body Scan

The Plan will pay for services and supplies provided in connection to body scan for screening purposes, for the Subscriber only, up to **\$1,000** per scan, limited to one scan every 36 months.

Clinical Trials

Coverage is provided for routine patient costs you receive as a participant in an approved clinical trial. The services must be those that are listed as covered by this plan for Members who are not enrolled in a clinical trial.

Routine patient care costs include items, services, and drugs provided to you in connection with an approved clinical trial that would otherwise be covered by the Plan.

An “approved clinical trial” is a phase I, phase II, phase III, or phase IV clinical trial that studies the prevention, detection, or treatment of cancer or another life-threatening disease or condition, from which death is likely unless the disease or condition is treated. Coverage is limited to the following clinical trials:

1. Federally funded trials approved or funded by one or more of the following:
 - a. The National Institutes of Health,
 - b. The Centers for Disease Control and Prevention,
 - c. The Agency for Health Care Research and Quality,
 - d. The Centers for Medicare and Medicaid Services,
 - e. A cooperative group or center of any of the four entities listed above or the Department of Defense or the Department of Veterans Affairs,
 - f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants, or
 - g. Any of the following departments if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of Health and Human Services determines (1) to be comparable to the system of peer review of investigations and studies used by the National Institutes of Health, and (2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review:
 - i. The Department of Veterans Affairs,
 - ii. The Department of Defense, or
 - iii. The Department of Energy.
2. Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration.
3. Studies or investigations done for drug trials that are exempt from the investigational new drug application.

Participation in the clinical trial must be recommended by your Physician after determining participation has a meaningful potential to benefit you. All requests for clinical trials services, including requests that are not part of approved clinical trials, will be reviewed according to our Clinical Coverage Guidelines, related policies and procedures.

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

YOUR MEDICAL BENEFITS

1. The investigational item, device, or service.
2. Any item or service provided solely to satisfy data collection and analysis needs and that is not used in the clinical management of the patient.
3. Any service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
4. Any item, device, or service that is paid for by the sponsor of the trial or is customarily provided by the sponsor free of charge for any enrollee in the trial.

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

Disagreements regarding the coverage or medical necessity of possible clinical trial services may be subject to Special Independent Medical Reviews as described in YOUR RIGHT TO APPEALS.

Contraceptives

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

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

Contraceptive supplies prescribed by a Physician for reasons other than contraceptive purposes for Medically Necessary treatment such as decreasing the risk of ovarian cancer, eliminating symptoms of menopause or for contraception that is necessary to preserve life or health may also be covered.

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

Certain contraceptives are covered under the "Preventive Care Services" benefit. Please see that provision for further details.

Note: For FDA-approved, Self-administered Hormonal Contraceptives, up to a 12-month supply is covered when dispensed or furnished at one time by a provider or pharmacist, or at a location licensed or otherwise authorized to dispense Drugs or supplies.

Dental Care

1. **Admissions for Dental Care.** Listed Inpatient Hospital services during a Hospital Stay or Ambulatory Surgical Center services when required for dental treatment and ordered by a Physician (M.D.) and a Dentist (D.D.S. or D.M.D.). We will make the final determination as to whether the dental treatment could have been safely rendered in another setting due to the nature of the procedure or your medical condition. Hospital Stays for the purpose of administering general anesthesia are not considered Medically Necessary and are not covered except as specified below.

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2. **General Anesthesia.** General anesthesia and associated facility charges when your clinical status or underlying medical condition requires that dental procedures be rendered in a Hospital or Ambulatory Surgical Center. This applies only if (a) the Member is less than eight years old, (b) the Member is developmentally disabled, (c) the Member's health is compromised and general anesthesia is Medically Necessary, or (d) the Member has suffered extensive facial or dental trauma. Charges for the dental procedure itself, including professional fees of a dentist, are not covered.
3. **Dental Injury.** Services of a Physician (M.D.) or Dentist (D.D.S. or D.M.D.) solely to treat an Accidental Injury to teeth. Coverage shall be limited to only such services that are Medically Necessary to repair the damage done by the Accidental Injury and/or restore function lost as a direct result of the Accidental Injury. Damage to teeth due to chewing or biting is not Accidental Injury unless chewing or biting results from a medical or mental condition.
4. **Cleft Palate.** Medically Necessary dental or orthodontic services that are an integral part of Reconstructive Surgery for cleft palate procedures. "Cleft palate" means a condition that may include cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate.
5. **Orthognathic surgery.** Orthognathic surgery for a physical abnormality that prevents normal function of the upper or lower jaw and is Medically Necessary to attain functional capacity of the affected part.

Important: If you decide to receive dental services that are not covered under this plan, a Participating Provider who is 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 member services telephone number listed on your ID card. To fully understand your coverage under this plan, please carefully review this Evidence of Coverage document.

Diabetes Education Program

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

Screenings for gestational diabetes are covered under your Preventive Care Services benefit. Please see that provision for further details.

Diagnostic Services

Outpatient diagnostic radiology, laboratory services and genetic tests, including Infertility testing. Genetic tests are subject to pre-service review to determine medical necessity. Please refer to the UTILIZATION REVIEW PROGRAMS section beginning on page 50 for information on how to obtain the proper reviews. This does not include services covered under the Advanced Imaging Procedures benefit.

YOUR MEDICAL BENEFITS

Durable Medical Equipment

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

- a. Ordered by a Physician, and
- b. Of no further use when medical need ends (but not disposable), and
- c. Usable only by the patient, and
- d. Not primarily for the Member's comfort or hygiene, and
- e. Not for environmental control, and
- f. Not for exercise, and
- g. Manufactured specifically for medical use.

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

Specific Durable Medical Equipment is subject to pre-service review to determine medical necessity. See the UTILIZATION REVIEW PROGRAMS section beginning on page 50 for details.

Hearing Aid Services

The following hearing aid services:

1. Hearing aids and bone-anchored hearing aids, including replacements, only when purchased as a result of a written recommendation by a Physician certified as either an otologist, an otolaryngologist or a state certified audiologist. Benefits are limited to one hearing aid per ear during any **36** month period.
2. Evaluation and audio-metric examinations to measure the extent of hearing loss and determine the most appropriate make and model of hearing aid.

Home Health Care

Benefits are available for covered services performed by a Home Health Agency or other provider in your home. The following services and supplies when provided by a Home Health Care Agency:

1. Services of a registered nurse or licensed vocational nurse under the supervision of a registered nurse or a Physician.
2. Services of a licensed therapist for physical therapy, occupational therapy, respiratory therapy or speech therapy.
3. Services of a medical social service worker.
4. Services of a health aide who is employed by (or under arrangement with) a Home Health Agency. Services must be ordered and supervised by a registered nurse employed by the Home Health Agency as professional coordinator. Other organizations may give services only when approved by the Review Center, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Agency or other provider as approved by the Review Center. These services are only covered if the Member is also receiving the services listed in 1. or 2. above.

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5. Necessary medical supplies provided by the Home Health Agency.

When available in your area, benefits are also available for intensive in-home behavioral health services. These do not require confinement to the home. These services are described in the Benefits for Mental Health Conditions and Substance Abuse section.

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

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

Home Infusion Therapy

The following services and supplies when provided by a Home Infusion Therapy Provider in the Member's home for the intravenous administration of a Member's total daily nutritional intake or fluid requirements, including but not limited to Parenteral Therapy and Total Parenteral Nutrition (TPN), medication related to illness or injury, chemotherapy, antibiotic therapy, aerosol therapy, tocolytic therapy, special therapy, intravenous hydration, or pain management:

1. Medication, ancillary medical supplies and supply delivery, (not to exceed a 14-day supply); however, medication which is delivered but not administered is not covered;
2. Pharmacy compounding and dispensing services (including pharmacy support) for intravenous solutions and medications;
3. Hospital and home clinical visits related to the administration of infusion therapy, including skilled nursing services including those provided for: (a) patient or alternative caregiver training; and (b) visits to monitor the therapy;
4. Rental and purchase charges for Durable Medical Equipment (as shown below); maintenance and repair charges for such equipment;
5. Laboratory services to monitor the patient's response to therapy regimen.
6. Total Parenteral Nutrition (TPN), Enteral Nutrition Therapy, antibiotic therapy, pain management, chemotherapy, and may also include injections (intra-muscular, subcutaneous, or continuous subcutaneous).

Hospice Care

The Member is eligible for *hospice* care if your *physician* and the *hospice* medical director certify that you are terminally ill and likely have less than twelve (12) months to live. You may access *hospice* care while participating in a clinical trial or continuing disease modifying therapy, as ordered by your treating *physician*. Disease modifying therapy treats the underlying terminal illness.

The following services and supplies are covered when provided by an approved Hospice for the palliative treatment of pain and other symptoms associated with a terminal disease. Palliative care is care that controls pain and relieves symptoms but is not intended to cure the illness. Covered services include:

YOUR MEDICAL BENEFITS

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

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

Benefits for services beyond those listed above that are given for disease modification or palliation, such as but not limited to chemotherapy and radiation therapy, are available to a Member in Hospice. These services are covered under other parts of this Plan.

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

1. Food, home-delivered meals or housing charges.
2. Transportation charges.
3. Any services which would normally be provided free of charge.
4. Services provided in the areas of both legal and/or financial advice (preparation and execution of wills; estate planning and liquidation; financial investment, etc.).
5. Counseling by clergy or any volunteer group.
6. Personal comfort items.

YOUR MEDICAL BENEFITS

7. Private duty nursing (a continuous bedside nursing service rendered by one nurse to one patient, either in a Hospital, Hospice facility or patient's home, as opposed to a general-duty nurse, who renders services to a number of Hospital or Hospice facility patients), except during periods of crisis to provide management of acute medical symptoms.

Hospital - Inpatient

The following services and supplies are covered when provided by a Hospital:

1. Accommodations in a room of two or more beds, or the prevailing charge for two-bed room accommodations in that Hospital if a private room is used, unless your Physician orders, and we authorize, a private room as Medically Necessary.
2. Services in Special Care Units.
3. Operating, delivery and special treatment rooms.
4. Supplies and ancillary services including laboratory, cardiology, pathology and radiology. Professional component fees for these services will be covered only if a separate charge for professional interpretation is determined by us to be Medically Necessary.
5. Physical therapy, radiation therapy, chemotherapy and hemodialysis treatment.
6. Drugs and medicines approved for general use by the FDA which are supplied by the Hospital for use during the Member's Stay.
7. Blood transfusions, including blood processing and the cost of unreplaced blood and blood products.

Inpatient Hospital services are subject to utilization review to determine medical necessity. Please refer to the UTILIZATION REVIEW PROGRAMS section beginning on page 50 for information on how to obtain the proper reviews.

Hospital - Outpatient

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

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

Specific outpatient services, including diagnostic and other services are subject to pre-service review to determine medical necessity, and outpatient surgeries performed in an outpatient facility or a doctor's office. See the UTILIZATION REVIEW PROGRAMS section beginning on page 50 for details.

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Infertility Treatment

Services and supplies, up to **\$8,000** during each Members lifetime, provided in connection with diagnosis and treatment of Infertility, provided that:

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

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

Jaw Joint Disorders

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

Mental or Nervous Disorders or Substance Abuse

Covered services shown below for the Medically Necessary treatment of Mental or Nervous Disorders or substance abuse or to prevent the deterioration of chronic conditions.

1. Inpatient Hospital and services from a Residential Treatment Center as stated in the "Hospital" provision of this section for inpatient services and supplies.
2. Partial hospitalization, including intensive outpatient programs and visits to a Day Treatment Center. Partial hospitalization is covered as stated in the "Hospital" provision of this section, for outpatient services and supplies.
3. Physician's visits during a covered Inpatient Stay.
4. Physician's visits and intensive in-home behavioral health programs for outpatient psychotherapy or psychological testing for the treatment of Mental or Nervous Disorders or substance abuse. This includes nutritional counseling for the treatment of eating disorders such as anorexia nervosa and bulimia nervosa.
5. Behavioral health treatment for pervasive developmental disorder or autism. See the section BENEFITS FOR PERVASIVE DEVELOPMENTAL DISORDER OR AUTISM for a description of the services that are covered. **Note:** You must obtain pre-service review for all behavioral health treatment services for the treatment of pervasive developmental disorder or autism in order for these services to be covered by this plan (see UTILIZATION REVIEW PROGRAM for details).
6. Diagnosis and all Medically Necessary treatment of severe mental illness or a person of any age and serious emotional disturbances of a child.

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Treatment for substance abuse does not include smoking cessation programs, nor treatment for nicotine dependency or tobacco use. Certain services are covered under the “Preventive Care Services” benefit or as specified in the “Preventive Prescription Drugs and Other Items” covered under PRESCRIPTION DRUG BENEFITS. Please see those provisions for further details.

Nonprescription Medical Formulas

Non-prescription medical formulas upon written order of a Physician for:

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

Online Visits

When available in your area, covered services will include medical consultations using the internet via webcam, chat, or voice. Online visits are covered under plan benefits for office visits to Physicians.

Non-covered services include, but are not limited to, the following:

- Reporting normal lab or other test results.
- Office visit appointment requests or changes.
- Billing, insurance coverage, or payment questions.
- Requests for referrals to other Physicians or healthcare practitioners.
- Benefit precertification.
- Consultations between Physicians.
- Consultations provided by telephone, electronic mail, or facsimile machines.

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

Osteoporosis. Coverage for services related to diagnosis, treatment, and appropriate management of osteoporosis including, but not limited to, all Food and Drug Administration approved technologies, including bone mass measurement technologies as deemed Medically Necessary.

Outpatient Drugs and Medicines

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

- a. dispensed by a Physician, or

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

Exceptions: The following are not included:

- Drugs which are sold by a retail pharmacy and prescribed for the Member to self-administer. (See pages 59 through 72 for your PRESCRIPTION DRUG BENEFITS.)
- Intravenous drugs in a setting other than a Physician's office or the outpatient department of a Hospital.

Physical Therapy – Physical Medicine

The following services provided by a Physician under a treatment plan:

1. Physical therapy and physical medicine provided on an outpatient basis for the treatment of illness or injury, including therapeutic use of heat, cold, exercise, electricity, ultra violet radiation, manipulation of the spine or massage for the purpose of improving circulation, strengthening muscles, or encouraging the return of motion. (This includes many types of care which are customarily provided by chiropractors, physical therapists and osteopaths. It does not include massage therapy services at spas or health clubs.)
2. Occupational therapy provided on an outpatient basis when the ability to perform daily life tasks has been lost or reduced by, or has not been developed due to illness or injury, including programs which are designed to rehabilitate mentally, physically or emotionally disabled persons. Occupational therapy programs which are designed to maximize or improve a patient's upper extremity function, perceptual motor skills and ability to function in daily living activities.

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

Up to a combined maximum of **20** visits in a Year for all covered services provided by a Participating Provider are payable if Medically Necessary. If additional visits are needed after receiving 20 visits in a Year, pre-service review must be obtained prior to receiving the services. If it is determined an additional period of physical therapy, physical medicine or occupational therapy is Medically Necessary, we will specify a specific number of additional visits. For the purposes of this benefit, the term "visit" shall include any visit by a Physician in that Physician's office, or in any other outpatient setting, during which one or more of the services covered under this limited benefit are rendered, even if other services are provided during the same visit.

For physical therapy, physical medicine or occupational therapy, covered services are payable if Medically Necessary. After your initial visit to a Physician for physical therapy, physical medicine or occupational therapy, pre-service review must be obtained prior to receiving additional services.

Such additional visits are not payable if pre-service review is not obtained. (See UTILIZATION REVIEW PROGRAMS beginning on page 50.)

There is no limit on the number of covered visits for Medically Necessary physical therapy, physical medicine, and occupational therapy. But additional visits in excess of the number of visits stated above must be authorized in advance.

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Pregnancy, Maternity Care and Family Planning

1. All medical benefits for an enrolled Member when provided for pregnancy, maternity care and abortion. The following services are included:
 - Prenatal, postnatal and postpartum care;
 - Prenatal testing administered by the California Prenatal Screening Program, which is a statewide prenatal testing program administered by the State Department of Public Health. The Calendar Year deductible will not apply and no copayment will be required for services you receive as part of this program;
 - Ambulatory care services (including ultrasounds, fetal non-stress tests, Physician office visits, and other Medically Necessary maternity services performed outside of a Hospital);
 - Involuntary complications of pregnancy.
 - Diagnosis of genetic disorders in cases of high-risk pregnancy; and
 - Inpatient Hospital care including labor and deliver.

Inpatient Hospital benefits in connection with childbirth will be provided for at least 48 hours following a normal delivery or 96 hours following a cesarean section, unless the mother and her Physician decide on an earlier discharge. Please see the section entitled FOR YOUR INFORMATION for a statement of your rights under federal law regarding these services.
2. Services listed under **Hospital** for routine nursery care of a newborn child if the child's natural mother is an enrolled Member. Routine nursery care of a newborn child includes screening of a newborn for genetic diseases, congenital conditions, and other health conditions provided through a program established by law or regulation.
3. Services provided by an approved Alternative Birth Center and a certified nurse midwife are included.
4. All plan benefits when provided for sterilizations, Infertility studies and treatment of Infertility. In no event will benefits of this Evidence of Coverage be provided for or in connection with sterilization reversal or contraceptive devices (other than Prescription oral contraceptives as stated under PRESCRIPTION DRUG BENEFITS or as specifically stated in **Contraceptives** under MEDICAL CARE THAT IS COVERED).
5. Certain services are covered under the "Preventive Care Services" benefit. Please see that provision for further details.

Preventive Care Services

Preventive care includes screenings and other services for adults and children. All recommended preventive services will be covered as required by the Affordable Care Act (ACA). This means for Preventive Care Services the Calendar Year deductible will not apply to these services or supplies when they are provided by a Participating Provider. No Co-Payment will apply to these services or supplies when they are provided by a Participating Provider.

1. A Physician's services for routine physical examinations.
2. Immunizations prescribed by the examining Physician.
3. Radiology and laboratory services and tests ordered by the examining Physician in connection with a routine physical examination, excluding any such tests related to an illness or injury. Those radiology and laboratory services and tests related to an illness or injury will be covered as any other medical service available under the terms and conditions of the provision "Diagnostic Services".

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4. Health screenings as ordered by the examining Physician for the following: breast cancer, including BRCA testing if appropriate (in conjunction with genetic counseling and evaluation), cervical cancer, including human papillomavirus (HPV), prostate cancer, colorectal cancer, and other medically accepted cancer screening tests, blood lead levels, high blood pressure, type 2 diabetes mellitus, cholesterol, obesity, and screening for iron deficiency anemia in pregnant women.
5. Human immunodeficiency virus (HIV) testing, regardless of whether the testing is related to a primary diagnosis.
6. Counseling and risk factor reduction intervention services for sexually transmitted infections, human immunodeficiency virus (HIV), contraception, tobacco use, smoking cessation and tobacco use-related diseases.
7. Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:
 - a. All FDA-approved contraceptive drugs, devices, and other products for women, including over-the-counter items, if prescribed by a physician. This includes contraceptive drugs, injectable contraceptives, patches and devices such as diaphragms, intra uterine devices (IUDs) and implants, as well as voluntary sterilization procedures, contraceptive education and counseling. It also includes follow-up services related to the drugs, devices, products and procedures, including but not limited to management of side effects, counseling for continued adherence, and device insertion and removal.

At least one form of contraception in each of the methods identified in the FDA's Birth Control Guide will be covered as preventive care under this section. If there is only one form of contraception in a given method, or if a form of contraception is deemed not medically advisable by a physician, the prescribed FDA-approved form of contraception will be covered as preventive care under this section.

In order to be covered as preventive care, contraceptive prescription drugs must be either Generic oral contraceptives or Brand Name Drugs. Brand Name Drugs will be covered as Preventive Care Services when Medically Necessary according to your attending Physician, otherwise they will be covered under your plan's prescription drug benefits (see your PRESCRIPTION DRUG BENEFITS).

Note: For FDA-approved, Self-administered Hormonal Contraceptives, up to a 12-month supply is covered when dispensed or furnished at one time by a provider or pharmacist, or at a location licensed or otherwise authorized to dispense Drugs or supplies.

- b. Breast feeding support, supplies, and counseling. One breast pump will be covered per pregnancy under this benefit.
 - c. Gestational diabetes screening.
 - d. Preventive prenatal care.
8. Preventive services for certain high-risk populations as determined by your Physician, based on clinical expertise.

This list of Preventive Care Services is not exhaustive. Preventive tests and screenings with a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF), or those supported by the Health Resources and Services Administration (HRSA) will be covered with no copayment and will not apply to the Calendar Year deductible when they are provided by a Participating Provider.

See the definition of "Preventive Care Services" in the DEFINITIONS section for more information about services that are covered by this plan as Preventive Care Services.

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Professional Services

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

Prosthetic Devices

1. Surgical implants, including but not limited to cochlear implants and breast prosthesis and surgical bras following a mastectomy.
2. Artificial limbs or eyes, including services of an orthotist and prosthetist in connection with evaluation or fitting of an orthotic or prosthetic device when services are billed as part of the charge for the artificial limbs or eyes.
3. The first pair of contact lenses or the first pair of eyeglasses when required as a result of a covered and Medically Necessary eye surgery.
4. Scalp hair prostheses when required as a result of hair loss due to alopecia areata or alopecia totalis, or permanent hair loss due to injury.
5. Corrective lenses for conditions related to an inborn error of metabolism.
6. Therapeutic shoes and inserts for the prevention and treatment of feet complications in Members with diabetes.

Radiation, Chemotherapy, and Hemodialysis

- **Radiation Therapy.** This includes treatment of disease using x-ray, radium or radioactive isotopes, other treatment methods (such as teletherapy, brachytherapy, intra operative radiation, photon or high energy particle sources), material and supplies used in the therapy process and treatment planning. These services can be provided in a facility or professional setting.
- **Chemotherapy.** This includes the treatment of disease using chemical or antineoplastic agents and the cost of such agents in a professional or facility setting.
- **Hemodialysis Treatment.** This includes services related to renal failure and chronic (end-stage) renal disease, including hemodialysis, home intermittent peritoneal dialysis home continuous cycling peritoneal dialysis and home continuous ambulatory peritoneal dialysis.

The following renal dialysis services are covered:

- Outpatient maintenance dialysis treatments in an outpatient dialysis facility;
- Home dialysis; and
- Training for self-dialysis at home including the instructions for a person who will assist with self-dialysis done at a home setting.

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For radiation therapy, chemotherapy and hemodialysis treatment. See Hospital – Outpatient on page 28 for benefit information.

Reconstructive Surgery

Reconstructive Surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following: (a) improve function; or (b) create a normal appearance, to the extent possible. This includes surgery performed to restore and achieve symmetry following a Medically Necessary mastectomy. This also includes Medically Necessary dental or orthodontic services that are an integral part of Reconstructive Surgery for cleft palate procedures. “Cleft palate” means a condition that may include cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate.

This does not apply to orthognathic surgery. Please see the “Dental Care” provision below for a description of this service.

Retail Health Clinic

Services and supplies provided by medical professionals who provide basic medical services in a retail health clinic including, but not limited to:

1. Exams for minor illnesses and injuries.
2. Preventive services and vaccinations.
3. Health condition monitoring and testing.

Skilled Nursing Facility

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

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

Skilled Nursing Facility services and supplies are subject to pre-service review to determine medical necessity. (See UTILIZATION REVIEW PROGRAMS beginning on page 50.)

Smoking Cessation Programs

Benefits are provided for approved behavior modifying smoking cessation programs. Behavior modification does not consist of hypnosis, shock therapy, acupressure, acupuncture or other similar methods to alter behavior. Benefits are provided when verification of completion of one of the following approved programs is submitted to us:

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Class Supported Programs:

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

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

Benefits will be provided subject to the following:

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

Speech Therapy

Covered charges include Medically Necessary outpatient speech therapy, including speech-language pathology (SLP) services to identify, assess, and treat speech, language, and swallowing disorders in children and adults. Therapy that will develop or treat communication or swallowing skills to correct a speech impairment.

Transgender Services

Services and supplies provided in connection with gender transition when you have been diagnosed with gender identity disorder or gender dysphoria by a Physician. This coverage is provided according to the terms and conditions of the plan that apply to all other covered medical conditions, including medical necessity requirements, utilization management, and exclusions for Cosmetic Services. Coverage includes, but is not limited to, Medically Necessary services related to gender transition such as transgender surgery, hormone therapy, psychotherapy, and vocal training.

Coverage is provided for specific services according to plan benefits that apply to that type of service generally, if the plan includes coverage for the service in question. If a specific coverage is not included, the service will not be covered. For example, transgender surgery would be covered on the same basis as any other covered, Medically Necessary surgery; hormone therapy would be covered under the plan's Prescription Drug benefits (if such benefits are included).

Transgender services are subject to prior authorization in order for coverage to be provided. Please refer to UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews.

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Transgender Travel Expense

Certain travel expenses incurred in connection with an approved transgender surgery, when the Hospital at which the surgery is performed is 75 miles or more from your place of residence, provided the expenses are authorized in advance by us. The following travel expenses incurred by you and one companion are considered covered travel expenses:

- Ground transportation to and from the Hospital when it is 75 miles or more from your place of residence.
- Coach airfare to and from the Hospital when it is 300 miles or more from your residence.
- Lodging, limited to one room, double occupancy.
- Other reasonable expenses. Tobacco, alcohol, drug, and meal expenses are excluded.

The Calendar Year Deductible will not apply and no Co-Payments will be required for transgender travel expenses authorized in advance by us. We will provide benefits for lodging, transportation, and other reasonable expenses up to the current limits set forth in the Internal Revenue Code, not to exceed the maximum amount specified above. This travel expense benefit is not available for non-surgical transgender services.

Details regarding reimbursement can be obtained by calling the member services number on your identification card. A travel reimbursement form will be provided for submission of legible copies of all applicable receipts in order to obtain reimbursement.

Transplant Services

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

1. a Member who is the recipient, or
2. a Member who is the donor.

Benefits for an organ donor are as follows:

- When both the person donating the organ and the person getting the organ are Members, each will get benefits under their plans.
- When the person getting the organ is a Member, but the person donating the organ is not, benefits under this plan are limited to benefits not available to the donor from any other source. This includes, but is not limited to, other insurance, grants, foundations, and government programs.
- If this plan's covered Member is donating the organ to someone who is **not** a Member, benefits are not available under this plan.

The Maximum Allowed Amount for a donor, including donor testing and donor search, is limited to expense incurred for Medically Necessary medical services only. The Maximum Allowed Amount for services incident to obtaining the transplanted material from a living donor or a human organ transplant bank will be covered. Such charges, including complications from the donor procedure for up to six weeks from the date of procurement, are covered. Services for treatment of a condition that is not directly related to, or a direct result of, the transplant are NOT covered.

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Covered services are subject to any applicable deductibles, Co-Payments and medical benefit maximums. The Maximum Allowed Amount does not include charges for services received without first obtaining pre-service review, or which are provided at a facility other than an approved transplant center. See the UTILIZATION REVIEW PROGRAMS section beginning on page 50 for additional information.

To maximize your benefits, you should call the Transplant Department as soon as you think you may need a transplant to talk about your benefit options. You must do this before you have an evaluation or work-up for a transplant. We will help you maximize your benefits by giving you coverage information, including details on what is covered and if any clinical coverage guidelines, medical policies, Centers of Medical Excellence (CME) or Blue Distinction Centers for Specialty Care (BDCSC) rules, or exclusions apply. Call the member services phone number on the back of your ID card and ask for the transplant coordinator.

You or your Physician must call the Transplant Department for pre-service review prior to the transplant, whether it is performed in an Inpatient or outpatient setting. Prior authorization is required before benefits will be provided for a transplant. Your Physician must certify, and we must agree, that the transplant is Medically Necessary. Your Physician should send a written request for prior authorization to us as soon as possible to start this process. Not getting prior authorization will result in a denial of benefits.

Please note that your Physician may ask for approval for HLA (human leukocyte antigen) testing, donor searches, or collection and storage of stem cells prior to the final decision as to what transplant procedure will be needed. In these cases, the HLA testing and donor search charges will be covered as routine diagnostic tests. The collection and storage request will be reviewed for medical necessity and may be approved. However, such an approval for HLA testing, donor search, or collection and storage is NOT an approval for the later transplant. A separate medical necessity decision will be needed for the transplant itself.

Specified Transplants

You must obtain pre-service review for all services including, but not limited to, preoperative tests and postoperative care related to the following specified transplants: heart, liver, lung, combination heart-lung, kidney, pancreas, simultaneous pancreas-kidney, or bone marrow/stem cell and similar procedures. Specified transplants must be performed at Centers of Medical Excellence (CME) or Blue Distinction Centers for Specialty Care (BDCSC). **Charges for services provided for or in connection with a specified transplant performed at a facility other than a CME or BDCSC will not be considered covered.** Call the toll-free telephone number for pre-service review on your identification card if your Physician recommends a specified transplant for your medical care. A case manager transplant coordinator will assist in facilitating your access to a CME or BDCSC. See the UTILIZATION REVIEW PROGRAMS section beginning on page 50 for additional information.

Transplant Travel Expense

Certain travel expenses incurred in connection with an approved, specified transplant (heart, liver, lung, combination heart-lung, kidney, pancreas, simultaneous pancreas-kidney, or bone marrow/stem cell and similar procedures) performed at a designated CME or BDCSC that is 75 miles or more from the recipient's or donor's place of residence are covered, provided pre-service review is obtained. The following travel expenses incurred by the recipient and one companion* or the donor are considered covered travel expenses:

- Ground transportation to and from the CME or BDCSC when the designated CME or BDCSC is 75 miles or more from the recipient's or donor's place of residence.
- Coach airfare to and from the CME or BDCSC when the designated CME or BDCSC is 300 miles or more from the

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recipient's or donor's residence.

- Lodging, limited to one room, double occupancy.
- Other reasonable expenses. Tobacco, alcohol, drug and meal expenses, and other non-food items are excluded.

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

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

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

Details regarding reimbursement can be obtained by calling member services at 1-800-655-6397. A travel reimbursement form will be provided for submission of legible copies of all applicable receipts in order to obtain reimbursement.

Urgent Care

Services and supplies received to prevent serious deterioration of your health or, in the case of pregnancy, the health of the unborn child, resulting from an unforeseen illness, medical condition, or complication of an existing condition, including pregnancy, for which treatment cannot be delayed. Urgent care services are not Emergency Services. Services for urgent care are typically provided by an Urgent Care Center or other facility such as a physician's office. Urgent care can be obtained from Participating Providers or Non-Participating Providers.

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BENEFITS FOR PERVASIVE DEVELOPMENTAL DISORDER OR AUTISM

This plan provides coverage for behavioral health treatment for Pervasive Developmental Disorder or autism. This coverage is provided according to the terms and conditions of this plan that apply to all other medical conditions, except as specifically stated in this section.

Behavioral health treatment services covered under this plan are subject to the same deductibles, coinsurance, and copayments that apply to services provided for other covered medical conditions. Services provided by Qualified Autism Service Providers, Qualified Autism Service Professionals, and Qualified Autism Service Paraprofessionals (see the “Definitions” below) will be covered under plan benefits for office visits to Physicians, whether services are provided in the provider’s office or in the patient’s home. Services provided in a facility, such as the outpatient department of a Hospital, will be covered under plan benefits that apply to such facilities.

You must obtain pre-service review for all behavioral health treatment services for the treatment of Pervasive Developmental Disorder or autism in order for these services to be covered by this plan (see UTILIZATION REVIEW PROGRAM for details).

The meanings of key terms used in this section are shown below. Whenever any of the key terms shown below appear in this section, the first letter of each word will be capitalized. When you see these capitalized words, you should refer to this “Definitions” provision.

DEFINITIONS

Pervasive Developmental Disorder, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, includes Autistic Disorder, Rett’s Disorder, Childhood Disintegrative Disorder, Asperger’s Disorder, and Pervasive Developmental Disorder Not Otherwise Specified.

Applied Behavior Analysis (ABA) means the design, implementation, and evaluation of systematic instructional and environmental modifications to promote positive social behaviors and reduce or ameliorate behaviors which interfere with learning and social interaction.

Intensive Behavioral Intervention means any form of Applied Behavioral Analysis that is comprehensive, designed to address all domains of functioning, and provided in multiple settings, depending on the individual’s needs and progress. Interventions can be delivered in a one-to-one ratio or small group format, as appropriate.

Qualified Autism Service Provider is either of the following:

- A person who is certified by a national entity, such as the Behavior Analyst Certification Board, with a certification that is accredited by the National Commission for Certifying Agencies, and who designs, supervises, or provides treatment for Pervasive Developmental Disorder or autism, provided the services are within the experience and competence of the person, who is nationally certified; or
- A person licensed as a physician and surgeon (M.D. or D.O.), physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist pursuant to state law, who designs, supervises, or provides treatment for Pervasive Developmental Disorder or autism, provided the services are within the experience and competence of the licensee.

The network of Participating Providers may be limited to licensed Qualified Autism Service Providers who contract with a Blue Cross and/or Blue Shield Plan and who may supervise and employ Qualified Autism Service Professionals or Qualified Autism Service Paraprofessionals who provide and administer Behavioral Health Treatment.

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Qualified Autism Service Professional is a provider who meets all of the following requirements:

- Provides behavioral health treatment, which may include clinical case management and case supervision under the direction and supervision of a Qualified Autism Service Provider
- Is employed and supervised by a Qualified Autism Service Provider,
- Provides treatment according to a treatment plan developed and approved by the Qualified Autism Service Provider,
- Is a behavioral service provider who meets the education and experience qualifications described in Section 54342 of Title 17 of the California Code of Regulations for an associate behavior analyst, behavior analyst, behavior management assistant, behavior management consultant, or behavior management program as defined in state regulation or who meets equivalent criteria in the state in which he or she practices if not providing services in California, and
- Has training and experience in providing services for Pervasive Developmental Disorder or autism pursuant to Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the Government Code, and
- Is employed by the Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers responsible for the autism treatment plan.

Qualified Autism Service Paraprofessional is an unlicensed and uncertified individual who meets all of the following requirements:

- Is supervised by a Qualified Autism Service Provider or Qualified Autism Service Professional at a level of clinical supervision that meets professionally recognized standards of practice,
- Provides treatment and implements services pursuant to a treatment plan developed and approved by the Qualified Autism Service Provider,
- Meets the criteria set forth in any applicable state regulations adopted pursuant to state law concerning the use of paraprofessionals in group practice provider behavioral intervention services,
- Meets the education and training qualifications described in Section 54342 of Title 17 of the California Code of Regulations,
- Has adequate education, training, and experience, as certified by a Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers, and
- Is employed by the Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers responsible for the autism treatment plan.

YOUR MEDICAL BENEFITS

BEHAVIORAL HEALTH TREATMENT SERVICES COVERED

The behavioral health treatment services covered by this plan for the treatment of Pervasive Developmental Disorder or autism are limited to those professional services and treatment programs, including Applied Behavior Analysis and evidence-based behavior intervention programs, that develop or restore, to the maximum extent practicable, the functioning of an individual with Pervasive Developmental Disorder or autism and that meet all of the following requirements:

- The treatment must be prescribed by a licensed physician and surgeon (an M.D. or D.O.) or developed by a licensed clinical psychologist,
- The treatment must be provided under a treatment plan prescribed by a Qualified Autism Service Provider and administered by one of the following: (a) Qualified Autism Service Provider, (b) Qualified Autism Service Professional supervised and employed by the Qualified Autism Service Provider, or (c) Qualified Autism Service Paraprofessional supervised and employed by a Qualified Autism Service provider, and
- The treatment plan must have measurable goals over a specific timeline and be developed and approved by the Qualified Autism Service Provider for the specific patient being treated. The treatment plan must be reviewed no less than once every six months by the Qualified Autism Service Provider and modified whenever appropriate, and must be consistent with applicable state law that imposes requirements on the provision of Applied Behavioral Analysis services and Intensive Behavioral Intervention services to certain persons pursuant to which the Qualified Autism Service Provider does all of the following:
 - ◆ Describes the patient's behavioral health impairments to be treated,
 - ◆ Designs an intervention plan that includes the service type, number of hours, and parent participation needed to achieve the intervention plan's goal and objectives, and the frequency at which the patient's progress is evaluated and reported,
 - ◆ Provides intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating Pervasive Developmental Disorder or autism,
 - ◆ Discontinues Intensive Behavioral Intervention services when the treatment goals and objectives are achieved or no longer appropriate, and
 - ◆ The treatment plan is not used for purposes of providing or for the reimbursement of respite care, day care, or educational services, and is not used to reimburse a parent for participating in the treatment program. No coverage will be provided for any of these services or costs. The treatment plan must be made available to us upon request.

YOUR MEDICAL BENEFITS

MEDICAL CARE THAT IS NOT COVERED

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

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

1. **Acupuncture.** Acupuncture treatment except as specifically stated in the "Acupuncture" provision of MEDICAL CARE THAT IS COVERED. Acupressure, or massage to control pain, treat illness or promote health by applying pressure to one or more specific areas of the body based on dermatomes or acupuncture points.
2. **After Coverage Ends.** Services received after the Member's coverage ends, except as specifically stated under TERMINAL BENEFITS.
3. **Before Coverage Begins.** Services received before the Member's Effective Date, or during a continuous period of hospitalization which began before the Member's Effective Date. However, in the case of a person covered under this plan by reason of transfer from another CalPERS plan, the exclusion for hospitalization beginning prior to the Member's Effective Date shall apply only during the first 90 days of enrollment under this plan unless the prior carrier provides coverage for the condition causing the Hospital confinement beyond the 90th day following the Member's Effective Date under this plan.
4. **Caffeine Addiction.** Caffeine addiction.
5. **Clinical Trials.** Any investigational drugs or devices, non-health services required for you to receive the treatment, the costs of managing the research, or costs that would not be a covered service under this plan for non-Investigative treatments, except as specifically stated in the Clinical Trials provision of MEDICAL CARE THAT IS COVERED.
6. **Commercial Weight Loss Programs.** Weight loss programs, whether or not they are pursued under medical or physician supervision, unless specifically listed as covered in this plan. This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs. This exclusion does not apply to Medically Necessary treatments for morbid obesity or dietary evaluations and counseling, and behavioral modification programs for the treatment of anorexia nervosa or bulimia nervosa. Surgical treatment for morbid obesity will be covered as stated in the Bariatric Surgery provision of MEDICAL CARE THAT IS COVERED.
7. **Contraceptive Devices.** Contraceptive devices, except for Prescription oral contraceptives as specifically stated under PRESCRIPTION DRUG BENEFITS or as specifically stated in the Contraceptives provision of MEDICAL CARE THAT IS COVERED.
8. **Cosmetic Services.** Cosmetic Surgery or other services performed to alter or reshape normal (including aged) structures or tissues of the body to improve appearance.
9. **Custodial Care or Rest Cures.** Inpatient room and board charges in connection with a Hospital Stay primarily for environmental change, physical therapy or treatment of chronic pain. Custodial Care or rest cures. Services provided by a rest home, a home for the aged, a nursing home or any similar facility. Services provided by a Skilled Nursing Facility, except as specifically stated in THE Skilled Nursing Facility provision under MEDICAL CARE THAT IS COVERED.

YOUR MEDICAL BENEFITS

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

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

This exclusion does not apply to the following:

- Services which we are required by law to cover;
- Services specified as covered in this Evidence of Coverage;
- Dental services to prepare the mouth for radiation therapy to treat head and/or neck cancer.

11. **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.

12. **Drugs Given to you by a Medical Provider.** The following exclusions apply to Drugs you receive from a medical provider:

- **Delivery Charges.** Charges for the delivery of Prescription Drugs.
- **Clinically-Equivalent Alternatives.** Certain Prescription Drugs may not be covered if you could use a clinically equivalent Drug, unless required by law. “Clinically equivalent” means Drugs that for most Members, will give you similar results for a disease or condition. If you have questions about whether a certain *drug* is covered and which Drugs fall into this group, please call the number on the back of your ID card.

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

- **Compound Drugs.** Compound Drugs unless all of the ingredients are FDA-approved in the form in which they are used in the Compound Drug and as designated in the FDA’s Orange Book: *Approved Drug Products with Therapeutic Equivalence Evaluations*, require a prescription to dispense, and the Compound Drug is not essentially the same as an FDA-approved product from a Drug manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants.
- **Drugs Contrary to Approved Medical and Professional Standards.** Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.
- **Drugs Over Quantity or Age Limits.** Drugs which are over any quantity or age limits set by the Plan or us.
- **Drugs Over the Quantity Prescribed or Refills After One Year.** Drugs in amounts over the quantity prescribed or for any refill given more than one year after the date of the original Prescription.

YOUR MEDICAL BENEFITS

- **Drugs Prescribed by Providers Lacking Qualifications, Registrations and/or Certifications.** Prescription Drugs prescribed by a provider that does not have the necessary qualifications, registrations and/or certifications as determined by us.
- **Drugs That Do Not Need a Prescription.** Drugs that do not need a Prescription by federal law (including Drugs that need a Prescription by state law, but not by federal law), except for injectable insulin. This exclusion does not apply to over-the-counter Drugs that we must cover under state law, or federal law when recommended by the U.S. Preventive Services Task Force, and prescribed by a Physician.
- **Lost or Stolen Drugs.** Refills of lost or stolen Drugs.
- **Non-Approved Drugs.** Drugs not approved by the FDA.

13. **Educational or Academic Services.** Services, supplies or room and board for teaching, vocational, or self-training purposes. This includes, but is not limited to boarding schools and/or the room and board and educational components of a residential program where the primary focus of the program is educational in nature rather than treatment based.

This exclusion does not apply to the Medically Necessary treatment of pervasive developmental disorder or autism, to the extent stated in the section BENEFITS FOR PERVASIVE DEVELOPMENTAL DISORDER OR AUTISM.

14. **Excess Amounts.** Any amounts in excess of the Maximum Allowed Amount.
15. **Experimental or Investigational.** Experimental or Investigational procedures or medications. But, if you are denied benefits because it is determined that the requested treatment is Experimental or Investigational, you may request an independent medical review as described in YOUR RIGHT TO APPEALS.
16. **Family Members.** Services prescribed, ordered, referred by or given by a member of your immediate family, including your *spouse*, *child*, brother, sister, parent, in-law or self.
17. **Foot Orthotics.** Foot orthotics, orthopedic shoes or footwear or support items unless used for a systemic illness affecting the lower limbs, such as severe diabetes.
18. **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.
19. **Gene Therapy.** Gene therapy as well as any Drugs, procedures, health care services related to it that introduce or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material.

YOUR MEDICAL BENEFITS

20. **Government Treatment.** 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 law or state law. Services provided by VA Hospitals and military treatment facilities will be considered for payment according to current legislation. We will not cover payment for these services if you are not required to pay for them or they are given to you for free. You are not required to seek any such services prior to receiving Medically Necessary health care services that are covered by this plan.
21. **Hearing Aids or Tests.** Hearing aids, including bone-anchored hearing aids, except as specifically stated under the Hearing Aid Benefits provision of MEDICAL CARE THAT IS COVERED. Routine hearing tests except as specifically provided under the Preventive Care Services provision of MEDICAL CARE THAT IS COVERED. This exclusion does not apply to cochlear implants.
22. **Hospital Services Billed Separately.** Services rendered by hospital resident physicians or interns that are billed separately. This includes separately billed charges for services rendered by employees of hospitals, labs or other institutions, and charges included in other duplicate billings.
23. **Hyperhidrosis Treatment.** Medical and surgical treatment of excessive sweating (hyperhidrosis).
24. **Infertility Treatment.** Services or supplies furnished in connection with the diagnosis and treatment of infertility, except as specifically stated in the "Infertility Treatment" provision of MEDICAL CARE THAT IS COVERED.
25. **In-vitro Fertilization.** Services or supplies for in-vitro fertilization (IVF) for purposes of pre-implant genetic diagnosis (PGD) of embryos, regardless of whether they are provided in connection with infertility treatment.
26. **Medical Equipment, Devices and Supplies.** This Plan does not cover the following
 - Replacement or repair of purchased or rental equipment because of misuse, abuse, or loss/theft.
 - Surgical supports, corsets, or articles of clothing unless needed to recover from surgery or injury.
 - Enhancements to standard equipment and devices that is not Medically Necessary.
 - Supplies, equipment and appliances that include comfort, luxury, or convenience items or features that exceed what is Medically Necessary in your situation
 - Disposable supplies for use in the home such as bandages, gauze, tape, antiseptics, dressings, ace-type bandages, and any other supplies, dressings, appliances or devices that are not specifically listed as covered under the "Durable Medical Equipment" provision of YOUR MEDICAL BENEFITS - MEDICAL CARE THAT IS COVERED.

This exclusion does not apply to Medically Necessary treatment as specifically stated in "Durable Medical Equipment" provision of MEDICAL CARE THAT IS COVERED.

27. **Medicare.** For which benefits are payable under Medicare Parts A and/or B, or would have been payable if you had applied for Parts A and/or B, except as listed in this booklet or as required by federal law, as described in the section titled "BENEFITS FOR MEDICARE ELIGIBLE MEMBERS: Coordinating Benefits With Medicare". If you do not enroll in Medicare Part B when you are eligible, you may have large out-of-pocket costs. Please refer to [Medicare.gov](https://www.medicare.gov) for more details on when you should enroll and when you are allowed to delay enrollment without penalties.
28. **Mobile/Wearable Devices.** Consumer wearable / personal mobile devices such as a smart phone, smart watch, or other personal tracking devices), including any software or applications.

YOUR MEDICAL BENEFITS

29. **Natural childbirth classes.** Charges incurred for registration and classes that prepare new and expectant parents for a natural birthing experience.
30. **Non-Approved Facility.** Services from a provider that does not meet the definition of facility.
31. **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 us. This exclusion does not apply to the Medically Necessary treatment of pervasive developmental disorder or autism, to the extent stated in the section BENEFITS FOR PERVASIVE DEVELOPMENTAL DISORDER OR AUTISM.
32. **Not Medically Necessary.** Services or supplies that are not Medically Necessary as defined.
33. **Orthodontic Care.** Braces, other orthodontic appliances or orthodontic services, except as specifically stated in the Reconstructive Surgery or Dental Care provisions of MEDICAL CARE THAT IS COVERED.
34. **Outpatient Drugs.** Outpatient drugs prescribed for self-administration by the Member, except as specifically stated under PRESCRIPTION DRUG BENEFITS.
35. **Outpatient Speech Therapy.** Outpatient speech therapy except as specifically stated in Speech Therapy under MEDICAL CARE THAT IS COVERED. This exclusion also does not apply to the Medically Necessary treatment of Severe Mental Disorders, or to the Medically Necessary treatment of pervasive developmental disorder or autism, to the extent stated in the section BENEFITS FOR PERVASIVE DEVELOPMENTAL DISORDER OR AUTISM.
36. **Personal Items and Services.** Air purifiers, air conditioners, humidifiers, exercise equipment and supplies for comfort, hygiene or beautification, health club memberships, health spas, charges from a physical fitness instructor or personal trainer, or other charges for activities, equipment or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. Nutritional and /or dietary supplements and counseling (other than for the treatment of phenylketonuria), except as provided in this plan or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written prescription or dispensing by a licensed pharmacist. Formulas and food products approved by the FDA and prescribed by a Physician for the treatment of phenylketonuria are covered under this plan.
37. **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.
38. **Refractive Eye Surgery.** Any eye surgery solely for the purpose of correcting refractive defects of the eye such as nearsightedness (myopia) or astigmatism.
39. **Relatives.** Professional services received from a person who lives in the Member's home or who is related to the Member by blood or marriage, except as specifically stated in Home Infusion Therapy under MEDICAL CARE THAT IS COVERED.
40. **Residential accommodations.** Residential accommodations to treat medical or behavioral health conditions, except when provided in a Hospital, Hospice, Skilled Nursing Facility or Residential Treatment Center.

YOUR MEDICAL BENEFITS

This exclusion includes procedures, equipment, services, supplies or charges for the following but not limited to:

- Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
 - Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
 - Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, or outward bound programs, even if psychotherapy is included.
41. **Routine Physicals and Immunizations.** Physical exams and immunizations required for travel, enrollment in any insurance program, as a condition of employment, for licensing, sports programs, or for other purposes, which are not required by law under Preventive Care Services under MEDICAL CARE THAT IS COVERED.
 42. **Speech Disorders.** Services primarily for correction of speech disorders, including but not limited to stuttering or stammering.
 43. **Sterilization Reversal.** Sterilization reversal.
 44. **Surrogate Mother Services.** For any services or supplies provided to a person not covered under the plan in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).
 45. **Telephone, Facsimile Machine and Electronic Mail Consultations.** Consultations provided using telephone, facsimile machine or electronic mail.
 46. **Transportation and Travel Expense.** Expense incurred for transportation, except as specifically stated in the Ambulance, Transplant Travel Expense and Bariatric Surgery Travel Expense provisions of MEDICAL CARE THAT IS COVERED. Mileage reimbursement except as specifically stated in the Transplant Travel Expense and Bariatric Surgery Travel Expense provisions of MEDICAL CARE THAT IS COVERED and approved by us. Charges incurred in the purchase or modification of a motor vehicle. Charges incurred for child care, telephone calls, laundry, postage, or entertainment. Frequent flyer miles; coupons, vouchers or travel tickets; prepayments of deposits.
 47. **Unlisted Services.** Services not specifically listed in this booklet as covered services.
 48. **Varicose Vein Treatment.** Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) when services are rendered for cosmetic purposes.
 49. **Vision Services or Supplies.** Optometric services, eye exercises including orthoptics, routine eye exams and routine eye refractions, except when provided under the Preventive Care Services provision of MEDICAL CARE THAT IS COVERED. Eyeglasses or contact lenses, except as specifically stated in Additional Services and Supplies under MEDICAL CARE THAT IS COVERED.
 50. **Waived Cost-Shares Non-Participating Plan 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.
 51. **Wilderness.** Wilderness or other outdoor camps and/or programs

YOUR MEDICAL BENEFITS

52. **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 of recovery and reimbursement under California Labor Code Section 4903, and as described in the THIRD PARTY LIABILITY provision.

UTILIZATION REVIEW PROGRAMS

This Plan includes the process of utilization review to decide when services are Medically Necessary or Experimental / Investigative as those terms are defined in this booklet. Utilization review aids the delivery of cost-effective health care by reviewing the use of treatments and, when proper, level of care and/or the setting or place of service that they are performed.

REVIEWING WHERE SERVICES ARE PROVIDED

A service must be Medically Necessary to be a covered service. When level of care, setting or place of service is part of the review, services that can be safely given to you in a lower level of care or lower cost setting / place of care, will not be Medically Necessary if they are given in a higher level of care, or higher cost setting / place of care. This means that a request for a service may be denied because it is not Medically Necessary for the service to be provided where it is being requested. When this happens the service can be requested again in another place and will be reviewed again for medical necessity. At times a different provider or facility may need to be used in order for the service to be considered Medically Necessary. Examples include, but are not limited to:

- A service may be denied on an inpatient basis at a Hospital but may be approvable if provided on an outpatient basis at a Hospital.
- A service may be denied on an outpatient basis at a Hospital but may be approvable at a free standing imaging center, infusion center, ambulatory surgery center, or in a Physician's office.
- A service may be denied at a Skilled Nursing Facility but may be approvable in a home setting.

Utilization review criteria will be based on many sources including medical policy and clinical guidelines. It may be decided that a treatment that was asked for is not Medically Necessary if a clinically equivalent treatment that is more cost-effective is available and appropriate. . "Clinically equivalent" means treatments that for most *members*, will give you similar results for a disease or condition.

If you have any questions about the utilization review process, the medical policies or clinical guidelines, you may call the Member Services phone number on the back of your Identification Card.

Coverage for or payment of the service or treatment reviewed is not guaranteed. For benefits to be covered, on the date you get service:

1. You must be eligible for benefits;
2. The service or supply must be a covered service under your Plan;
3. The service cannot be subject to an exclusion under your Plan (please see MEDICAL CARE THAT IS NOT COVERED for more information); and
4. You must not have exceeded any applicable limits under your Plan.

TYPES OF REVIEWS

- **Pre-service Review** – A review of a service, treatment or admission for a benefit coverage determination which is done before the service or treatment begins or admission date.
 - **Precertification** – A required pre-service review for a benefit coverage determination for a service or treatment. Certain services require precertification in order for you to get benefits. The benefit coverage review

will include a review to decide whether the service meets the definition of medical necessity or is Experimental / Investigative as those terms are defined in this booklet.

For admissions following an Emergency, you, your authorized representative or Physician must tell us within 24 hours of the admission or as soon as possible within a reasonable period of time.

For childbirth admissions, precertification is not needed for the first 48 hours for a vaginal delivery or 96 hours for a cesarean section. Admissions longer than 48/96 hours require precertification.

For inpatient Hospital stays for mastectomy surgery, including the length of Hospital stays associated with mastectomy, precertification is not needed.

- **Continued Stay / Concurrent Review** – A utilization review of a service, treatment or admission for a benefit coverage determination which must be done during an ongoing stay in a facility or course of treatment.
 - Both pre-service and continued stay / concurrent reviews may be considered urgent when, in the view of the treating provider or any Physician with knowledge of your medical condition, without such care or treatment, your life or health or your ability to regain maximum function could be seriously threatened or you could be subjected to severe pain that cannot be adequately managed without such care or treatment. Urgent reviews are conducted under a shorter timeframe than standard reviews.
- **Post-service Review** – A review of a service, treatment or admission for a benefit coverage that is conducted after the service has been provided. Post-service reviews are performed when a service, treatment or admission did not need a precertification, or when a needed precertification was not obtained. Post-service reviews are done for a service, treatment or admission in which we have a related clinical coverage guideline and are typically initiated by us.

The appropriate utilization reviews must be performed in accordance with this plan. Services that are not reviewed prior to or during service delivery will be reviewed retrospectively when the bill is submitted for benefit payment. When pre-service review is performed and the admission, procedure or service is determined to be Medically Necessary and appropriate, benefits will be provided for the following. If review results in the determination that part or all of the services were not Medically Necessary and appropriate, benefits will not be paid for those services.

Services for which precertification is required (i.e., services that need to be reviewed by us to determine whether they are Medically Necessary) include, but are not limited to, the following:

- All scheduled, non-Emergency Inpatient Hospital Stays and Residential Treatment Center admissions.

Exceptions: Pre-service review is not required for Inpatient Hospital Stays for the following services:

- ◆ Maternity care of 48 hours or less following a normal delivery or 96 hours or less following a cesarean section, and
 - ◆ Mastectomy and lymph node dissection.
- Specific non-Emergency outpatient services, including diagnostic treatment, genetic tests and other outpatient services provided at a Hospital or Ambulatory Surgical Center.

UTILIZATION REVIEW PROGRAMS

- Surgical procedures, wherever performed.
- Transplant Services as follows:
 - a. For bone, skin or cornea transplants, if the Physicians on the surgical team and the facility in which the transplant is to take place are approved by us for the transplant requested.
 - b. For transplantation of heart, liver, lung, combination heart-lung, kidney, pancreas, simultaneous pancreas-kidney or bone marrow/stem cell and similar procedures if the providers of the related preoperative and postoperative services are approved and the transplant will be performed at a Centers of Medical Excellence (CME) or Blue Distinction Centers for Specialty Care (BDCSC) facility.
- Air ambulance in a non-medical Emergency.
- Visits for physical therapy, physical medicine and occupational therapy beyond those described under the “Physical Therapy – Physical Medicine” provision of YOUR MEDICAL BENEFITS – MEDICAL CARE THAT IS COVERED. A specified number of additional visits may be authorized after your initial visit. While there is no limit on the number of covered visits for Medically Necessary physical therapy, physical medicine, and occupational therapy, additional visits in excess of the stated number of visits must be authorized in advance.
- Specific Durable Medical Equipment.
- Admissions to a Skilled Nursing Facility if you require daily skilled nursing or rehabilitation, as certified by your attending Physician.
- Bariatric surgical services, such as gastric bypass and other surgical procedures for weight loss if:
 - The services are to be performed for the treatment of morbid obesity; and
 - The Physicians on the surgical team and the facility in which the surgical procedure is to take place are approved for the surgical procedure requested; and
 - The bariatric surgical procedure will be performed at a Blue Distinction Centers for Specialty Care.
- Advanced imaging procedures, including, but not limited to: Magnetic Resonance Imaging (MRI), Computer Axial Tomography (CAT scans), Positron Emission Tomography (PET scan), Magnetic Resonance Spectroscopy (MRS scan), Magnetic Resonance Angiogram (MRA scan), Echocardiography and Nuclear Cardiac Imaging. The Member may call member services toll-free at 1-800-655-6397 to find out if an imaging procedure requires pre-service review.
- Behavioral health treatment for pervasive developmental disorder or autism, as specified in the section BENEFITS FOR PERVASIVE DEVELOPMENTAL DISORDER OR AUTISM.
- All interventional spine pain, elective hip, knee, and shoulder arthroscopic/open sports medicine, and outpatient spine surgery procedures must be authorized in advance.
- Transgender services, including transgender travel expense, as specified under the “Transgender Services” provision of YOUR MEDICAL BENEFITS – MEDICAL CARE THAT IS COVERED. You must be diagnosed with gender identity disorder or gender dysphoria by a Physician.

For a list of current procedures requiring precertification, please call the toll-free number for Member Services printed on your Identification Card.

UTILIZATION REVIEW PROGRAMS

WHO IS RESPONSIBLE FOR PRECERTIFICATION?

Typically, Participating Providers know which services need precertification and will get any precertification when needed. Your Physician and other Participating Providers have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the ordering provider, Hospital or attending Physician (“requesting provider”) will get in touch with us to ask for a precertification. However, you may request a precertification or you may choose an authorized representative to act on your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older. The table below outlines who is responsible for precertification and under what circumstances.

Provider Network Status	Responsibility to Get Precertification	Comments
Participating Providers	Provider	<ul style="list-style-type: none">• The provider must get precertification when required.
Non-Participating Providers	Member	<ul style="list-style-type: none">• Member must get precertification when required. (Call Member Services.)• Member may be financially responsible for charges or costs related to the service and/or setting in whole or in part if the service and/or setting is found to not be Medically Necessary.

UTILIZATION REVIEW PROGRAMS

Provider Network Status	Responsibility to Get Precertification	Comments
Blue Card Provider	Member (Except for Inpatient Admissions)	<ul style="list-style-type: none"> • Member must get precertification when required. (Call Member Services.) • Member may be financially responsible for charges or costs related to the service and/or setting in whole or in part if the service and or setting is found to not be Medically Necessary. • Blue Card Providers must obtain pre-certification for all Inpatient Admissions.
<p>NOTE: For an Emergency admission, precertification is not required. However, you, your authorized representative or Physician must tell us within 24 hours of the admission or as soon as possible within a reasonable period of time.</p>		

UTILIZATION REVIEW PROGRAMS

HOW DECISIONS ARE MADE

We use our clinical coverage guidelines, such as medical policy, clinical guidelines, and other applicable policies and procedures to help make our Medical Necessity decisions. Medical policies and clinical guidelines reflect the standards of practice and medical interventions identified as proper medical practice. We reserve the right to review and update these clinical coverage guidelines from time to time.

You are entitled to ask for and get, free of charge, reasonable access to any records concerning your request. To ask for this information, call the precertification phone number on the back of your identification card.

If you are not satisfied with our decision under this section of your benefits, please refer to the YOUR RIGHT TO APPEALS section to see what rights may be available to you.

DECISION AND NOTICE REQUIREMENTS

We will review requests for medical necessity according to the timeframes listed below. The timeframes and requirements listed are based on state and federal laws. Where state laws are stricter than federal laws, we will follow state laws. If you live in and/or get services in a state other than the state where your Plan was issued other state-specific requirements may apply. You may call the phone number on the back of your identification card for more details.

Request Category	Timeframe Requirement for Decision
Urgent Pre-Service Review	72 hours from the receipt of the request
Non-Urgent Pre-Service Review	15 business days from the receipt of the request
Continued Stay / Concurrent Review when hospitalized at the time of the request and no previous authorization exists	72 hours from the receipt of the request
Urgent Continued Stay / Concurrent Review when request is received at least 24 hours before the end of the previous authorization	24 hours from the receipt of the request
Urgent Continued Stay / Concurrent Review when request is received less than 24 hours before the end of the previous authorization	72 hours from the receipt of the request
Non-Urgent Continued Stay / Concurrent Review	15 business days from the receipt of the request
Post-Service Review	30 calendar days from the receipt of the request

UTILIZATION REVIEW PROGRAMS

If more information is needed to make our decision, we will tell the requesting Physician of the specific information needed to finish the review. If we do not get the specific information we need by the required timeframe identified in the written notice, we will make a decision based upon the information we have.

We will notify you and your Physician of our decision as required by state and federal law. Notice may be given by one or more of the following methods: verbal, written, and/or electronic.

Revoking or modifying a Precertification Review decision. We will determine **in advance** whether certain services (including procedures and admissions) are Medically Necessary and are the appropriate length of stay, if applicable. These review decisions may be revoked or modified prior to the service being rendered for reasons including but not limited to the following:

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

For a copy of the medical necessity review process, please contact member services at the telephone number on the back of your Member ID card.

QUESTIONS ABOUT OR DISAGREEMENTS WITH UTILIZATION REVIEW DETERMINATIONS

- A. If the Member or the Member's Physician disagrees with a decision or questions how it was reached, the Member or the Member's Physician may request reconsideration. Requests for reconsideration (either by telephone or in writing) must be directed to the reviewer making the determination. The address and the telephone number of the reviewer are included on the Member's written notice of determination. Written requests must include medical information that supports the medical necessity of the services.
- B. If the Member, the Member's representative or the Member's Physician acting on the Member's behalf find the reconsidered decision still unsatisfactory, a request for an appeal of the reconsidered decision may be submitted in writing to us.
- C. In the event that the appeal decision still is unsatisfactory, the Member's remedy may be binding arbitration as stated elsewhere in this Evidence of Coverage.

EXCEPTIONS TO THE UTILIZATION REVIEW PROGRAM

From time to time, we may waive, enhance, modify, or discontinue certain medical management processes (including utilization management, case management, and disease management) if, in our discretion, such a change furthers the provision of cost effective, value based and quality services. In addition, we may select certain qualifying health care providers to participate in a program or a provider arrangement that exempts them from certain procedural or medical management processes that would otherwise apply. We may also exempt claims from medical review if certain conditions apply.

If we exempt a process, health care provider, or claim from the standards that would otherwise apply, we are in no way obligated to do so in the future, or to do so for any other health care provider, claim, or Member. We may stop or modify any such exemption with or without advance notice.

UTILIZATION REVIEW PROGRAMS

We also may identify certain providers to review for potential fraud, waste, abuse or other inappropriate activity if the claims data suggests there may be inappropriate billing practices. If a provider is selected under this program, then we may use one or more clinical utilization management guidelines in the review of claims submitted by this provider, even if those guidelines are not used for all providers delivering services to this plan's Members.

You may determine whether a health care provider participates in certain programs or a provider arrangement by checking our online provider directory on the website at www.anthemcom/ca or by calling the member services telephone number listed on your ID card.

HEALTH PLAN INDIVIDUAL CASE MANAGEMENT

The health plan individual case management program enables us to assist the Member to obtain medically appropriate care in a more economical, cost effective and coordinated manner during prolonged periods of intensive medical care. Through a case manager, we discuss possible options for an alternative plan of treatment which may include services not covered under this plan. It is not the Member's right to receive individual case management, nor do we have an obligation to provide it; we provide these services at its sole and absolute discretion.

How Health Plan Individual Case Management Works

Our personal case management program (Case Management) helps coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions. Our programs coordinate benefits and educate Members who agree to take part in the Case Management program to help meet their health-related needs.

Our Case Management programs are confidential and voluntary, and are made available at no extra cost to the Member. These programs are provided by, or on behalf of and at the request of, the Member's health plan case management staff. These Case Management programs are separate from any covered services the Member is receiving.

If you meet program criteria and agree to take part, we will help you meet your identified health care needs. This is reached through contact and team work with you and/or your chosen authorized representative, treating Physicians, and other providers.

In addition, we may assist in coordinating care with existing community-based programs and services to meet your needs. This may include giving you information about external agencies and community-based programs and services.

Alternative Treatment Plan. In certain cases of severe or chronic illness or injury, we may provide benefits for alternate care that is not listed as a covered service. We may also extend services beyond the benefit maximums of this Plan. We will make our decision case-by-case, if in our discretion the alternate or extended benefit is in the best interest of the member and us and the member or member's authorized representative agree to the alternate or extended benefit in writing. A decision to provide extended benefits or approve alternate care in one case does not obligate us to provide the same benefits again to you or to any other member. We reserve the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, we will notify the Member or the Member's authorized representative in writing.

PREScription DRUG BENEFITS

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

PARTICIPATING PHARMACIES

When the Member presents his or her plastic Identification Card to a Participating Pharmacy to have a Prescription filled, the Member will only pay the applicable copayment amount for each covered Prescription and each refill. The Member may call the number on the back of the ID Card for assistance in locating a Participating Pharmacy.

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

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

**Prescription Drug Program
Attn: Commercial Claims
P.O. Box 2872
Clinton, IA 52733-2872**

Participating Pharmacies usually have claims forms, but, if the Participating Pharmacy does not have claim forms, claim forms and member services are available by calling the number on the back of your ID Card. Mail your claim, with the appropriate portion completed by the pharmacist, to the Pharmacy Benefits Manager within 90 days of the date of purchase. If it is not reasonably possible to submit the claim within that time frame, an extension of up to 12 months will be allowed.

Important Note: If we determine that you may be using Prescription Drugs in a harmful or abusive manner, or with harmful frequency, your selection of Participating Pharmacies may be limited. If this happens, we may require you to select a single Participating Pharmacy that will provide and coordinate all future pharmacy services. Benefits will only be paid if you use the single Participating Pharmacy. We will contact you if we determine that use of a single Participating Pharmacy is needed and give you options as to which Participating Pharmacy you may use. If you do not select one of the Participating Pharmacies we offer within 31 days, we will select a single Participating Pharmacy for you. If you disagree with our decision, you may ask us to reconsider it as described in YOUR RIGHT TO APPEALS.

In addition, if we determine that you may be using Controlled Substance Prescription Drugs in a harmful or abusive manner, or with harmful frequency, your selection of Participating Providers for Controlled Substance Prescriptions may be limited. If this happens, we may require you to select a single Participating Provider that will provide and coordinate all Controlled Substance Prescriptions. Benefits for Controlled Substance Prescriptions will only be paid if

PRESCRIPTION DRUG BENEFITS

you use the single Participating Provider. We will contact you if it is determined that use of a single Participating Provider is needed and give you options as to which Participating Provider you may use. If you do not select one of the Participating Providers that is offered within 31 days, we will select a single Participating Provider for you. If you disagree with the decision, you may file complaint.

NON-PARTICIPATING PHARMACIES

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

**Prescription Drug Program
Attn: Commercial Claims
P.O. Box 2872
Clinton, IA 52733-2872**

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

Claim forms and member services are available by calling the number on the back of your ID Card. The Member must mail the claim form with the appropriate portion completed by the pharmacist to the Pharmacy Benefits Manager within 90 days of the date of purchase. If it is not reasonably possible to submit the claim within that timeframe, an extension of up to 12 months will be allowed. The Member will be reimbursed according to the procedures described under the REIMBURSEMENT provision of this section.

HOME DELIVERY PROGRAM

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

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

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

To obtain order forms or verify whether the Drug is available through the home delivery program, contact us at the number on the back of your ID Card.

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

PRESCRIPTION DRUG BENEFITS

SPECIALTY DRUG PROGRAM

Certain specified Specialty Drugs must be obtained through the specialty drug program unless the Member is given an exception from the specialty drug program (see PRESCRIPTION DRUG CONDITIONS OF SERVICE on pages 64-66 of this section). These specified Specialty Drugs that must be obtained through the Specialty Drug Program are limited to up to a 30-day supply. The Specialty Drug Program will deliver the Member's medication by mail or common carrier (You cannot pick up your medication at our office).

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

The Member or Member's Physician may order the Member's Specialty Drug by calling the number on the back of your ID Card. When the Member calls the Specialty Drug Program, a dedicated care coordinator will guide the Member through the process up to and including actual delivery of the Member's Specialty Drug to the Member. (If you order your Specialty Drug by telephone, you will need to use a credit card or debit card to pay for it.) The Member may also submit a Prescription for a Specialty Drug with the appropriate payment for the amount of the purchase (You can pay by check, money order, credit card or debit card), and a properly completed order form to the Specialty Drug Program. The Member will only have to pay the cost of the applicable copayment as shown under COPAYMENTS AT A RETAIL PHARMACY or COPAYMENTS THROUGHT THE HOME DELIVERY PROGRAM of this section.

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

The Member or Member's Physician may obtain order forms or a list of Specialty Drugs that must be obtained through the specialty drug program by contacting Member Services at the number listed on their ID card.

Specified Specialty Drugs must be obtained through the Specialty Drug Program. If the Member does not get Specialty Drugs through the specialty drug program, and the Member does not have an exception, the Member will not receive any benefits under this plan for such Drugs.

PREVENTIVE PRESCRIPTION DRUGS AND OTHER ITEMS

The Member's prescription drug benefits include certain preventive drugs, medications, and other items as listed below that may be covered under this plan as Preventive Care Services. In order to be covered as a Preventive Care Service, these items must be prescribed by a Physician and obtained from a Participating Pharmacy or through the home delivery program. This includes items that can be obtained over the counter for which a Physician's prescription is not required by law.

When these items are covered as Preventive Care Services, the Calendar Year Deductible, if any, will not apply and no Co-Payment will apply. In addition, any separate deductible that applies to Prescription Drugs will not apply.

- All FDA-approved contraceptives for women, including oral contraceptives, diaphragms, patches, and over-the-counter contraceptives. In order to be covered as a Preventive Care Service, in addition to the requirements stated above, contraceptive Prescription Drugs must be Generic oral contraceptives or Brand Name Drugs.

Note: For FDA-approved, Self-administered Hormonal Contraceptives, up to a 12-month supply is covered when dispensed or furnished at one time by a provider or pharmacist, or at a location licensed or otherwise authorized to dispense Drugs or supplies.

PRESCRIPTION DRUG BENEFITS

- Vaccinations prescribed by a Physician and obtained from a Participating Pharmacy.
- Tobacco cessation Drugs, medications, and other items for Members age 18 and older as recommended by the United States Preventive Services Task Force including:
 - Prescription Drugs to eliminate or reduce dependency on, or addiction to, tobacco and tobacco products.
 - FDA-approved smoking cessation products including over-the-counter (OTC) nicotine gum, lozenges and patches when obtained with a Physician's prescription.
- Aspirin to reduce the risk of heart attack or stroke, for men ages 45-79 and women ages 55-79.
- Aspirin after 12 weeks of gestation in pregnant women who are at high risk for preeclampsia.
- Generic low to moderate dose statins for Members that are 40-75 years and have one or more risk factors for cardiovascular disease.
- Folic acid supplementation for women age 55 years and younger (folic acid supplement or a multivitamin).
- Medications for risk reduction of primary breast cancer in women (such as tamoxifen or raloxifene) for women who are at increased risk for breast cancer and at low risk for adverse medication effects.
- Bowel preparations when prescribed for a preventive colon screening.
- Fluoride supplements for children from birth through 6 years old (drops or tablets).
- Dental fluoride varnish to prevent tooth decay of primary teeth for children from birth to 5 years old.

COPAYMENTS AT A RETAIL PHARMACY

- A. The Member is responsible for a **\$25.00** copayment for each Brand Name Prescription Drug or refill listed on the Prescription Drug Formulary, plus the difference in Prescription Drug Covered Expense between the cost of the Brand Name Drug and its Generic Drug equivalent, unless a Generic Drug equivalent is not available or a Brand Name Drug is Medically Necessary. When no Generic Drug equivalent is available, or when a Physician prescribes a Brand Name Drug and indicates that it is Medically Necessary on the Prescription form, the Member will only be responsible for the \$25.00 copayment.
- B. The Member is responsible for a **\$45.00** copayment for each Brand Name Prescription Drug or refill **not** listed on the Prescription Drug Formulary, plus the difference in Prescription Drug Covered Expense between the cost of the Brand Name Drug and its Generic Drug equivalent, unless a Generic Drug equivalent is not available or a Brand Name Drug is Medically Necessary. When no Generic Drug equivalent is available, or when a Physician prescribes a Brand Name Drug and indicates that it is Medically Necessary on the Prescription form, the Member will only be responsible for the \$45.00 copayment.
- C. The Member is responsible for a **\$45.00** copayment for each Compound Medication dispensed by a Participating Pharmacy. (You are responsible for the full cost of Compound Medications filled by Non-Participating Pharmacies.)
- D. The Member is responsible for a **\$10.00** copayment for each Generic Prescription Drug or refill.
- E. The copayments specified in A., B., C. and D. above will apply to each 34-day supply. See page 65 for more information.

PRESCRIPTION DRUG BENEFITS

COPAYMENTS THROUGH THE HOME DELIVERY PROGRAM

- A. The Member is responsible for a **\$40.00** copayment for each Brand Name Prescription Drug or refill listed on the Prescription Drug Formulary, plus the difference in Prescription Drug Covered Expense between the cost of the Brand Name Drug and its Generic Drug equivalent, unless a Generic Drug equivalent is not available or a Brand Name Drug is Medically Necessary. When no Generic Drug equivalent is available, or when a Physician prescribes a Brand Name Drug and indicates that it is Medically Necessary on the Prescription form, the Member will only be responsible for the \$40.00 copayment.
- B. The Member is responsible for a **\$75.00** copayment for each Brand Name Prescription Drug or refill **not** listed on the Prescription Drug Formulary, plus the difference in Prescription Drug Covered Expense between the cost of the Brand Name Drug and its Generic Drug equivalent, unless a Generic Drug equivalent is not available or a Brand Name Drug is Medically Necessary. When no Generic Drug equivalent is available, or when a Physician prescribes a Brand Name Drug and indicates that it is Medically Necessary on the Prescription form, the Member will only be responsible for the \$75.00 copayment.
- C. The Member is responsible for a **\$20.00** copayment for each Generic Prescription Drug or refill.
- D. The copayments specified in A., B. and C. above will apply to each 90-day supply. See page 65 for more information.

REIMBURSEMENT

- A. When the Member has a Prescription filled at a Participating Pharmacy or through the Specialty Drug Program, the Member pays only the applicable copayment amount.
- B. When the Member has a Prescription filled at a Non-Participating Pharmacy, the Member will be reimbursed for covered expense incurred according to the following:
 - 1. The Pharmacy Benefits Manager determines the amount of Prescription Drug Covered Expense; then,
 - 2. The Pharmacy Benefits Manager subtracts the Member's applicable copayment from the Prescription Drug Covered Expense.

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

PRESCRIPTION DRUG OUT-OF-POCKET AMOUNTS

If a Member pays Prescription Drug copayments equal to the Prescription Drug out-of-pocket amount per Member during a Calendar Year, the Member will no longer be required to make copayments for any Prescription Drug Covered Expense the Member incurs during the remainder of that Calendar Year.

PRESCRIPTION DRUG BENEFITS

DETERMINATION OF COVERED EXPENSE

Prescription Drug Covered Expense will always be the lesser of the billed charge or the Prescription Drug Maximum Allowed Amount. Expense is incurred on the date the Member receives the Drug for which the charge is made.

PRESCRIPTION DRUG CONDITIONS OF SERVICE

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

- A. It must be prescribed by a licensed prescriber and be dispensed within one year of being prescribed, subject to federal and state laws.
- B. It must be approved for general use by the federal Food and Drug Administration (FDA).
- C. It must be for the direct care and treatment of the Member's illness, injury or condition. Dietary supplements, health aids or Drugs for cosmetic purposes are not included. However the following items are covered:
 - a. Formulas prescribed by a Physician for the treatment of phenylketonuria.
 - b. Vaccinations provided at a Participating Pharmacy as specified under PREVENTIVE PRESCRIPTION DRUGS AND OTHER ITEMS, subject to all terms of this plan that apply to those benefits.
 - c. Vitamins, supplements, and health aids as specified under PREVENTIVE PRESCRIPTION DRUGS AND OTHER ITEMS, subject to all terms of this plan that apply to those benefits.
- D. It must be dispensed from a licensed retail Pharmacy, a Home Health Agency, through the home delivery program, or through the specialty drug program.
- E. **An approved Compound Medication must be dispensed by a Participating Pharmacy.** Call the number on the back of your ID Card to find out where to take the Member's Prescription for an approved Compound Medication to be filled. (You can also find a listing of Participating Pharmacies online at www.anthem.com/ca.) **Some Compound Medications must be approved before the Member can get them** (See PRESCRIPTION DRUG FORMULARY on pages 70 to 72 of this section). **The Member will have to pay the full cost of any Compound Medication the Member gets from a Non-Participating Pharmacy.**
- F. **A specified Specialty Drug must be obtained by using the specialty drug program.** See SPECIALTY DRUG PROGRAM on page 61 of this section for information on how to get the Member's Drugs by using the specialty drug program. **The Member will have to pay the full cost of any Specialty Drug the Member gets from a retail Pharmacy that should have been obtained from the specialty drug program. If a Member orders a Specialty Drug that must be obtained using the specialty drug program through the home delivery program, it will be forwarded to the specialty drug program for processing and will be processed according to specialty drug program rules.**

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

- a. The first two month's supply of a specified Specialty Drug which is available through a retail Participating Pharmacy;
- b. Drugs which, due to medical necessity, must be obtained immediately;
- c. A Member who is unable to pay for delivery of their medication (i.e., no credit card); or
- d. A Member for whom, according to the Coordination of Benefit rules, this plan is not the primary plan.

PREScription DRUG BENEFITS

How to obtain an exception to the specialty drug program. If the Member believes that he or she should not be required to get his or her medication through the specialty drug program, for any of the reasons listed above, except item d, the Member must complete an Exception to Specialty Drug Program form to request an exception and send this form to the Pharmacy Benefits Manager. If the Member needs a copy of the form, he or she may call the number on the back of their ID Card to request one. If we have given the Member an exception, it will be good for a limited period of time based on the reason for the exception. When the exception period ends, if the Member believes that he or she should still not be required to get his or her medication through the specialty drug program, the Member must again request an exception. If we deny the Member's request for an exception, it will be in writing and will tell the Member why the exception was not approved.

Urgent or emergency need of a Specialty Drug subject to the specialty drug program. If the Member is out of a Specialty Drug which must be obtained through the specialty drug program, we will authorize an override of the specialty drug program requirement for 72 hours, or until the next business day following a holiday or weekend, to allow the Member to get an emergency supply of medication if his or her Physician decides that it is appropriate and Medically Necessary. The Member may have to pay the applicable copayment, shown under COPAYMENTS AT A RETAIL PHARMACY or COPAYMENTS THROUGH THE HOME DELIVERY PROGRAM of this section, for the 72-hour supply of his or her Drug.

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

- G. It must not be used while the Member is confined in a Hospital, Skilled Nursing Facility, rest home, sanitarium, convalescent hospital or similar facility. Also, it must not be dispensed in or administered by a Hospital, Skilled Nursing Facility, rest home, sanitarium, convalescent hospital, or similar facility. Other drugs that may be prescribed by the Member's Physician while the Member is confined in a rest home, sanitarium, convalescent hospital or similar facility, may be purchased at a Pharmacy by the Member, or a friend, relative or care giver on your behalf, and are covered under this Prescription Drug benefit.
- H. For a retail Pharmacy, the Prescription must not exceed the greater of a 34-day supply.

Drugs federally-classified as Schedule II which are FDA-approved and that require a triplicate prescription form must not exceed a 60-day supply.

FDA-approved smoking cessation products and over-the-counter nicotine replacement products are limited as specified under PREVENTIVE PRESCRIPTION DRUGS AND OTHER ITEMS.

Note: For FDA-approved, Self-administered Hormonal Contraceptives, up to a 12-month supply is covered when dispensed or furnished at one time by a provider or pharmacist, or at a location licensed or otherwise authorized to dispense Drugs or supplies. For specialty drug program, the Prescription must not exceed a 30-day supply.

- J. For the home delivery program, the Prescription must not exceed the greater of a 90-day supply.

Note: For FDA-approved, Self-administered Hormonal Contraceptives, up to a 12-month supply is covered when dispensed or furnished at one time by a provider or pharmacist, or at a location licensed or otherwise authorized to dispense Drugs or supplies.

PREScription DRUG BENEFITS

- K. Drugs for the treatment of impotence and/or sexual dysfunction are limited to six tablets/units for a 30-day period and are available at retail Pharmacies only. Documented evidence of contributing medical condition must be submitted to us for review.
- L. Certain Drugs have specific quantity supply limits based on our analysis of Prescription dispensing trends and the FDA dosing recommendations.
- M. The drug will be covered under PRESCRIPTION DRUG BENEFITS only if it is not covered under another benefit of your plan.
- N. Be prescribed by a licensed Physician with an active Drug Enforcement Administration (DEA) license, if the Drug is considered a Controlled Substance.

PREScription DRUG SERVICES AND SUPPLIES THAT ARE COVERED

- A. Outpatient Drugs and medications which the law restricts to sale by Prescription, except as specifically stated in this section. Formulas prescribed by a Physician for the treatment of phenylketonuria. These formulas are subject to the copayment for Brand Name Drugs.
- B. Insulin and diabetic supplies (i.e. test strips and lancets); niacin for lowering cholesterol.
- C. Syringes and/or needles when dispensed for use with insulin, antibiotics and other self-injectable Drugs or medications.
- D. Drugs with FDA labeling for self-administration.
- E. AIDS vaccine (when approved by the federal Food and Drug Administration and that is recommended by the US Public Health Service).
- F. Prescription Drugs prescribed for the treatment of male or female Infertility including, but not limited to, Clomid, Pergonal and Metrodin. Drugs used primarily for the purpose of treating Infertility that are Medically Necessary for treatment of another covered condition.
- G. All compound Prescription Drugs when a commercially available dosage form of a Medically Necessary medication is not available, all the ingredients of the compound Drug are FDA approved in the form in which they are used in the Compound Medication, and as designated in the FDA's Orange Book: *Approved Drug Products with Therapeutic Equivalence Evaluations*, require a prescription to dispense, and are not essentially the same as an FDA approved product from a Drug manufacturer. Non-FDA approved non-proprietary, multisource ingredients that are vehicles essential for compound administration may be covered.
- H. Prescription Drugs for treatment of impotence and/or sexual dysfunction are limited to organic (non-psychological) causes.
- I. Inhaler spacers and peak flow meters for the treatment of pediatric asthma. These items are subject to the copayment for Brand Name Drugs.
- J. Prescription Drugs, vaccinations (including administration), vitamins, supplements, and certain over-the-counter items as specified under PREVENTIVE PRESCRIPTION DRUGS AND OTHER ITEMS, subject to all terms of this plan that apply to those benefits.

PRESCRIPTION DRUG BENEFITS

PRESCRIPTION DRUG SERVICES AND SUPPLIES THAT ARE NOT COVERED

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

- A. Immunizing agents, biological sera, blood, blood products or blood plasma. While not covered under PRESCRIPTION DRUG BENEFITS, these items are covered under the Blood and Preventive Care Services provisions of MEDICAL CARE THAT IS COVERED, subject to all terms of this plan that apply to those benefits.
- B. Hypodermic syringes and/or needles, except when dispensed for use with insulin, antibiotics or other self-injectable Drugs or medications. While not covered under PRESCRIPTION DRUG BENEFITS, these items are covered under the Home Health Care, Home Infusion Therapy and Hospice Care provisions of MEDICAL CARE THAT IS COVERED, subject to all terms of this plan that apply to those benefits.
- C. Drugs and medications used to induce spontaneous and non-spontaneous abortions. While not covered under PRESCRIPTION DRUG BENEFITS, FDA approved medications that may only be dispensed by or under direct supervision of a Physician, such as Drugs and medications used to induce non-spontaneous abortions, are covered as specifically stated in the Pregnancy, Maternity Care and Family Planning provision of MEDICAL CARE THAT IS COVERED, subject to all terms of this plan that apply to the benefit.
- D. Drugs and medications, even if written as a Prescription, dispensed or administered in an outpatient setting, including, but not limited to, outpatient Hospital facilities and Physicians' offices. While not covered under PRESCRIPTION DRUG BENEFITS, these items are covered as specified under the Home Health Care, Home Infusion Therapy, Hospice Care and Hospital - Outpatient provisions of MEDICAL CARE THAT IS COVERED, subject to all terms of this plan that apply to those benefits.
- E. Professional charges in connection with administering, injecting or dispensing of Drugs. While not covered under PRESCRIPTION DRUG BENEFITS, these items are covered as specified under the Home Infusion Therapy and Professional Services provisions of MEDICAL CARE THAT IS COVERED, subject to all terms of this plan that apply to those benefits.
- F. A non-Prescription patent or proprietary medicine. Drugs and medications which may be obtained without a Physician's written Prescription, except insulin or niacin, for cholesterol reduction.

Note: Vitamins, supplements, and certain over-the-counter items as specified under PREVENTIVE PRESCRIPTION DRUGS AND OTHER ITEMS are covered under this plan only when obtained with a Physician's Prescription, subject to all terms of this plan that apply to those benefits.

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

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- H. Durable Medical Equipment, devices, appliances and supplies, even if prescribed by a Physician, except Prescription contraceptives as specified under PREVENTIVE PRESCRIPTION DRUGS AND OTHER ITEMS. While not covered under PRESCRIPTION DRUG BENEFITS, these items are covered as specified under the Additional Services and Supplies and Hearing Aid Benefits provisions of MEDICAL CARE THAT IS COVERED, subject to all terms of this plan that apply to those benefits.
- I. Services or supplies for which the Member is not charged.
- J. Oxygen. While not covered under PRESCRIPTION DRUG BENEFITS, this item is covered as specified under the Home Health Care, Hospice Care, Hospital and Skilled Nursing Facility provisions of MEDICAL CARE THAT IS COVERED, subject to all terms of this plan that apply to those benefits.
- K. Cosmetics and health or beauty aids. However, health aids that are Medically Necessary and meet the requirements for Durable Medical Equipment as specified under the Additional Services and Supplies provision of MEDICAL CARE THAT IS COVERED are covered, subject to all terms of this plan that apply to that benefit.
- L. Any Drug labeled "Caution, Limited By Federal Law to Investigational Use" or non-FDA approved Investigational Drugs. Any Drug or medication prescribed for Experimental indications. If you are denied a Drug because we determine that the Drug is Experimental or Investigational, you may ask that the denial be reviewed. See the YOUR RIGHT TO APPEALS section for information on how to ask for a review of your Drug denial.
- M. Any expense incurred for a Drug or medication in excess of the Prescription Drug Maximum Allowed Amount.
- N. Any Drug which has not been approved for general use by the FDA. This does not apply to Drugs that are Medically Necessary for a covered condition.
- O. Drugs used primarily for cosmetic purposes (e.g., Retin-A for wrinkles). However, this exclusion will not apply to the use of this type of Drug for Medically Necessary treatment of a medical condition other than one that is cosmetic.
- P. Anorexiant and Drugs used for weight loss except when used to treat morbid obesity (i.e., diet pills and appetite suppressants).
- Q. Drugs obtained outside the United States, unless such drugs are furnished in connection with urgent care or an Emergency.
- R. Allergy desensitization products or allergy serum. While not covered under PRESCRIPTION DRUG BENEFITS, such Drugs are covered as specified under the Hospital, Skilled Nursing Facility, and Professional Services provisions of MEDICAL CARE THAT IS COVERED, subject to all terms of this plan that apply to those benefits.
- S. Infusion Drugs, except Drugs that are self-administered subcutaneously. While not covered under PRESCRIPTION DRUG BENEFITS, these Drugs are covered as specified under the Home Infusion Therapy and Professional Services provisions of MEDICAL CARE THAT IS COVERED, subject to all terms of this plan that apply to those benefits.
- T. Herbal, nutritional and dietary supplements, except as described in this Plan or what must be covered by law. This exclusion includes, but is not limited to, nutritional formulas and dietary supplements that you can buy over the counter and those you can get without a written Prescription or from a licensed pharmacist. However, formulas prescribed by a Physician for the treatment of phenylketonuria that are obtained from a Pharmacy are covered as specified under PRESCRIPTION DRUG SERVICES AND SUPPLIES THAT ARE COVERED. Special food products that are not available from a Pharmacy are covered as specified under the Nonprescription Medical

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Formulas provision of MEDICAL CARE THAT IS COVERED, subject to all terms of this plan that apply to that benefit. Also, vitamins, supplements, and certain over-the-counter items as specified under PREVENTIVE PRESCRIPTION DRUGS AND OTHER ITEMS are covered under this plan only when obtained with a Physician's Prescription, subject to all terms of this plan that apply to those benefits.

- U. Prescription Drugs with a non-Prescription (over-the-counter) chemical and dose equivalent except insulin, even if written as a Prescription. This exclusion does not apply if an over-the-counter equivalent was tried and was ineffective.
- V. Onychomycosis (toenail fungus) Drugs except to treat patients who are immuno-compromised or diabetic.
- W. All compound Prescription Drugs when a commercially available dosage form of a Medically Necessary medication is not available, all the ingredients of the compound drug are FDA approved in the form in which they are used in the Compound Medication and as designated in the FDA's Orange Book: *Approved Drug Products with Therapeutic Equivalence Evaluations*, require a prescription to dispense and are not essentially the same as an FDA approved product from a *drug* manufacturer. Non-FDA approved non-proprietary, multisource ingredients that are vehicles essential for compound administration may be covered. **The Member will have to pay the full cost of the Compound Medications the Member gets from a Non-Participating Pharmacy.** If the Member is denied a Compound Medication because he/she obtained it from a Non-Participating Pharmacy, the Member may file a grievance with us by following the procedures described in the section entitled YOUR RIGHT TO APPEALS.
- X. Specialty Drugs that must be obtained from the specialty drug program but which are obtained from a retail Pharmacy or through the home delivery program are not covered by this plan. Unless the Member qualifies for an exception, these Drugs are not covered by this plan (see PRESCRIPTION DRUG CONDITIONS OF SERVICE). **The Member will have to pay the full cost of the Specialty Drugs the Member gets from a retail Pharmacy that the Member should have gotten through the specialty drug program.**

If the Member orders a Specialty Drug through the home delivery program, it will be forwarded to the specialty drug program for processing and will be processed according to the specialty drug program rules.
- Y. Charges for pharmacy services not related to conditions, diagnoses, and/or recommended medications described in your medical records.
- Z. Certain Prescription Drugs may not be covered if you could use a clinically equivalent Drug, unless required by law. "Clinically equivalent" means Drugs that for most Members, will give you similar results for a disease or condition. If you have questions about whether a certain Drug is covered and which Drugs fall into this group, please call the number on the back of your Identification Card.

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

- AA. Drugs which are over any quantity or age limits set by the Plan or us.
- BB. Prescription Drugs prescribed by a provider that does not have the necessary qualifications, registrations and/or certifications.

PRESCRIPTION DRUG BENEFITS

- CC. Drugs prescribed, ordered, referred by or given by a member of your immediate family, including your Spouse, Child, brother, sister, parent, in-law or self.
- DD. Services we conclude are not Medically Necessary. This includes services that do not meet medical policy, clinical coverage, or benefit policy guidelines.
- EE. Any investigative drugs or devices, non-health services required for you to receive the treatment, the costs of managing the research, or costs that would not be a covered service under this plan for non-investigative treatments.
- FF. Prescription drugs related to the medical and surgical treatment of excessive sweating (hyperhidrosis).

PRESCRIPTION DRUG PROGRAM UTILIZATION REVIEW

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

PRESCRIPTION DRUG FORMULARY

The presence of a Drug on the plan's Prescription Drug Formulary list does not guarantee that you will be prescribed that Drug by your Physician. This list of outpatient Prescription Drugs is developed by a committee of Physicians and pharmacists to determine which medications are sound, therapeutic and cost effective choices. These medications, which include both Generic and Brand Name Drugs, are listed in the Prescription Drug Formulary. The Formulary is updated quarterly to ensure that the list includes Drugs that are safe and effective. Note: The Formulary Drugs may change from time to time.

Some Drugs may require prior authorization. If you have a question regarding whether a particular Drug is on our Formulary Drug list or requires prior authorization, please call member services at the number on the back of your ID Card. Information about the Drugs on our Formulary Drug list is also available on the website at www.anthem.com/ca.

Exception request for a drug not on the prescription drug formulary (non-formulary exceptions).

Your Prescription Drug benefit covers those Drugs listed on our Prescription Drug Formulary. This Prescription Drug Formulary contains a limited number of Prescription Drugs, and may be different than the Prescription Drug Formulary for other products. **In cases where your Physician prescribes a medication that is not on the Prescription Drug Formulary, it may be necessary to obtain a non-formulary exception in order for the Prescription Drug to be a covered benefit. Your Physician must complete a non-formulary exception form and return it to us.**

When we receive a non-formulary exception request, we will make a coverage decision within a certain period of time, depending on whether exigent circumstances exist.

Exigent circumstances exist if you are suffering from a health condition that may seriously jeopardize your life, health, or ability to regain maximum function, or if you are undergoing a current course of treatment using a drug not covered by the Plan. In this case, we will make a coverage decision within 24 hours of receiving your request. If we approve the coverage of the Drug, coverage of the Drug will be provided for the duration of the exigency. If we deny coverage of the Drug, you have the right to request an external review by an IRO. The IRO will make a coverage decision within 24 hours of receiving your request. If the IRO approves the coverage of the Drug, coverage of the Drug will be provided for the duration of the exigency.

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When exigent circumstances do not exist, we will make a coverage decision within 72 hours of receiving your request. If we approve the coverage of the Drug, coverage of the Drug will be provided for the duration of the Prescription, including refills. If we deny coverage of the Drug, you have the right to request an external review by an Independent Review Organization (IRO). The IRO will make a coverage decision within 72 hours of receiving your request. If the IRO approves the coverage of the Drug, coverage of the Drug will be provided for the duration of the Prescription.

Requesting a non-formulary exception or having an IRO review your request for a non-formulary exception does not affect your right to submit an appeal. Please see the section entitled YOUR RIGHT TO APPEALS for details.

Coverage of a Drug approved as a result of your request or your Physician's request for an exception will only be provided if you are a Member enrolled under the Plan.

Prior Authorization. Physicians must obtain prior authorization in order for you to get benefits for certain Prescription Drugs. At times, your Physician will initiate a prior authorization on your behalf before your Pharmacy fills your prescription. At other times, the Pharmacy may make you or your Physician aware that a prior authorization or other information is needed. In order to determine if the Prescription Drug is eligible for coverage, we have established criteria.

The criteria, which are called drug edits, may include requirements regarding one or more of the following:

- Specific clinical criteria and/or recommendations made by state or federal agencies (including, but not limited to, requirements regarding age, test result requirements, presence of a specific condition or disease, quantity, dose and/or frequency of administration);
- Specific provider qualifications including, but not limited to, REMS certification (Risk, Evaluation and Mitigation Strategies) as recommended by the FDA;
- Step therapy requiring one Drug, Drug regimen, or treatment be used prior to use of another Drug, Drug regimen, or treatment for safety and/or cost-effectiveness when clinically similar results may be anticipated;
- Use of a Prescription Drug Formulary which is a list of FDA-approved Drugs that have been reviewed and recommended for use based on their quality and cost effectiveness.
- You or your Physician can get the list of the Prescription Drug that require prior authorization by calling the phone number on the back of your identification card. The list will be reviewed and updated from time to time. Including a Prescription Drug or related item on the list does not guarantee coverage under your Plan. Your Physician may check with us to verify Prescription Drug, to find out which Prescription Drugs are covered under this section and if any drug edits apply.

In order for the Member to get a Drug that requires prior authorization, the Member's Physician must send a written request to us for the Drug using the required uniform prior authorization request form. If you're requesting an exception to the step therapy process, your *physician* must use the same form. The request, for either prior authorization or step therapy exceptions, can be sent to us by mail, facsimile, or it may be submitted electronically. The Physician may call us toll-free at the number on the back of your ID Card to request a copy of the form.

Upon receiving the completed uniform prior authorization request form. We will review the request and respond within the following time periods:

- 72 hours for non-urgent requests, and

PREScription DRUG BENEFITS

- 24 hours if exigent circumstances exist. Exigent circumstances exist if you are suffering from a health condition that may seriously jeopardize your life, health, or ability to regain maximum function, or if you are undergoing a current course of treatment using a Drug not covered by the Plan.

While we are reviewing the request, a 72-hour Emergency supply of medication may be dispensed to the Member if the Member's Physician or pharmacist determines that it is appropriate and Medically Necessary. The Member may have to pay the applicable copayment, shown in SUMMARY OF BENEFITS section on page 5 and under COPAYMENTS AT A RETAIL PHARMACY on page 62 of this section, for the 72-hour supply of the Drug. If the request for the Specialty Pharmacy Drug is approved after the Member has received a 72-hour supply, the Member will receive the remainder of the 30-day supply of the Drug with no additional copayment.

If you have any questions regarding whether a Drug is on the Prescription Drug Formulary or requires prior authorization, please call the number on the back of your ID Card. Information about the Drugs on our Formulary Drug list is also available on the website at www.anthem.com/ca.

If we deny a request for prior authorization of a Drug that is not part of our Formulary Drug list, you or your prescribing Physician may appeal our decision by calling us at the number on the back of your ID Card. If you are not satisfied with the resolution of your inquiry, you may file a grievance with us by following the procedures described in the section entitled YOUR RIGHT TO APPEALS.

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

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

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

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

SERVICES COVERED BY OTHER BENEFITS

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

COORDINATION OF BENEFITS

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

SUBROGATION AND REIMBURSEMENT

These provisions apply when the Plan pays benefits as a result of injuries or illnesses you sustained and you have a right to a Recovery or have received a Recovery from any source. A "Recovery" includes, but is not limited to, monies received from any person or party, any person's or party's liability insurance, uninsured/underinsured motorist proceeds, worker's compensation insurance or fund, "no-fault" insurance and/or automobile medical payments coverage, whether by lawsuit, settlement or otherwise. Regardless of how you or your representative or any agreements characterize the money you receive as a Recovery, it shall be subject to these provisions.

Subrogation

The Plan has the right to recover payments it makes on your behalf from any party responsible for compensating you for your illnesses or injuries. The following apply:

- The Plan has first priority from any Recovery for the full amount of benefits it has paid regardless of whether you are fully compensated, and regardless of whether the payments you receive make you whole for your losses, illnesses and/or injuries.
- You and your legal representative must do whatever is necessary to enable the Plan to exercise the Plan's rights and do nothing to prejudice those rights. For example, you must complete a questionnaire regarding the incident caused by the responsible party and a Lien and Subrogation Agreement. Completion of the Agreement is a condition of eligibility for benefits under the Plan. Failure to sign the Agreement or breach of such Agreement will be grounds for denying benefits or recovery under the Plan whether or not those benefits relate to the incident involving the responsible party.
- In the event that you or your legal representative fails to do whatever is necessary to enable the Plan to exercise its subrogation rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.
- The Plan has the right to take whatever legal action it sees fit against any person, party or entity to recover the benefits paid under the Plan.
- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full the Plan's subrogation claim and any claim held by you, the Plan's subrogation claim shall be first satisfied before any part of a Recovery is applied to your claim, your attorney fees, other expenses or costs.
- The Plan is not responsible for any attorney fees, attorney liens, other expenses or costs you incur. The "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the Plan.

Reimbursement

If you obtain a Recovery and the Plan has not been repaid for the benefits the Plan paid on your behalf, the Plan shall have a right to be repaid from the Recovery in the amount of the benefits paid on your behalf and the following provisions will apply:

- You must reimburse the Plan from any Recovery to the extent of benefits the Plan paid on your behalf regardless of whether the payments you receive make you whole for your losses, illnesses and/or injuries.
- Notwithstanding any allocation or designation of your Recovery (e.g., pain and suffering) made in a settlement agreement or court order, the Plan shall have a right of full recovery, in first priority, against any Recovery. Further, the Plan's rights will not be reduced due to your negligence.
- You and your legal representative must hold in trust for the Plan the proceeds of the gross Recovery (*i.e.*, the total amount of your Recovery before attorney fees, other expenses or costs) to be paid to the Plan immediately upon your receipt of the Recovery. You and your legal representative acknowledge that the portion of the Recovery to which the Plan's equitable lien applies is a Plan asset
- Any Recovery you obtain must not be dissipated or disbursed until such time as the Plan has been repaid in accordance with these provisions.
- You must reimburse the Plan, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the Plan.
- If you fail to repay the Plan, the Plan shall be entitled to deduct any of the unsatisfied portion of the amount of benefits the Plan has paid or the amount of your Recovery whichever is less, from any future benefit under the Plan if:
 1. The amount the Plan paid on your behalf is not repaid or otherwise recovered by the Plan; or
 2. You fail to cooperate.
- In the event that you fail to disclose the amount of your settlement to the Plan, the Plan shall be entitled to deduct the amount of the Plan's lien from any future benefit under the Plan.
- The Plan shall also be entitled to recover any of the unsatisfied portion of the amount the Plan has paid or the amount of your Recovery, whichever is less, directly from the Providers to whom the Plan has made payments on your behalf. In such a circumstance, it may then be your obligation to pay the Provider the full billed amount, and the Plan will not have any obligation to pay the Provider or reimburse you.
- The Plan is entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate you or make you whole.

Your Duties

- You must promptly notify the Plan of how, when and where an accident or incident resulting in personal injury or illness to you occurred and all information regarding the parties involved and any other information requested by the Plan.
- You must cooperate with the Plan in the investigation, settlement and protection of the Plan's rights. In the event that you or your legal representative fail to do whatever is necessary to enable the Plan to exercise its subrogation

or reimbursement rights, the Plan shall be entitled to deduct the amount the Plan paid from any future benefits under the Plan.

- You must not do anything to prejudice the Plan's rights.
- You must send the Plan copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to you.
- You must promptly notify the Plan if you retain an attorney or if a lawsuit is filed on your behalf.
- You must immediately notify the Plan if a trial is commenced, if a settlement occurs or if potentially dispositive motions are filed in a case.

The Insurance and Benefits Trust of PORAC (IBT of PORAC), which is the plan administrator has sole discretion to interpret the terms of the Subrogation and Reimbursement provision of this Plan in its entirety and reserves the right to make changes as it deems necessary.

If the covered person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative, shall be subject to this provision. Likewise, if the covered person's relatives, heirs, and/or assignees make any Recovery because of injuries sustained by the covered person, that Recovery shall be subject to this provision.

The Plan is entitled to recover its attorney's fees and costs incurred in enforcing this provision.

The Plan shall be secondary in coverage to any medical payments provision, no-fault automobile insurance policy or personal injury protection policy regardless of any election made by you to the contrary. The Plan shall also be secondary to any excess insurance policy, including, but not limited to, school and/or athletic policies.

The Plan has the right to assert, in full, a lien for costs of health benefits paid on behalf of a plan Member against any settlement with, or arbitration award or judgment against, a third party. The Plan will be entitled to collect on its full 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.

THIRD PARTY LIABILITY

If you receive medical services covered by the Plan for injuries caused by the act or omission of another person (a "third party"), you agree to:

1. promptly assign your rights to reimbursement from any source for the costs of such covered services; and
2. reimburse the Plan, who is entitled to a first right to reimbursement from full and partial recoveries, to the extent of benefits provided, immediately upon collection of damages by you for such injury from any source, including any applicable automobile uninsured or underinsured motorist coverage, whether by action of law, settlement, or otherwise; and
3. provide the Plan with a lien, to the extent of benefits provided by the Plan, upon your claim against or because of the third party. The lien may be filed with the third party, the third party's agent, the insurance company, or the court; and
4. the release of all information, medical or otherwise, which may be relevant to the identification of and collection from parties responsible for your illness or injury; and

5. notify us and the Plan of any claim filed against a third party for recovery of the cost of medical services obtained for injuries caused by the third party; and
6. cooperate with CalPERS, us and the IBT of PORAC in protecting the lien rights of the Plan against any recovery from the third party, which includes, but is not limited to, providing timely and periodic updates regarding the status of any claims or actions brought against the third party or any related claim; and
7. obtain written consent from IBT of PORAC prior to settling any claim with the third party that would release the third party from the lien or limit the rights of the Plan to recovery.

Pursuant to Government Code section 22947, a Member (or his/her attorney) must immediately notify the Plan, via certified mail, of the existence of any claim or action against a third party for injuries allegedly caused by the third party. Notices of third party claims and actions must be sent to:

Insurance and Benefits Trust of PORAC
2960 Advantage Way
Sacramento, CA 95834

The Plan has the right to assert, in full, a lien for costs of health benefits paid on behalf of a plan Member against any settlement with, or arbitration award or judgment against, a third party. The Plan will be entitled to collect on its full 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.

Compliance with these requirements is a condition of eligibility for benefits under this Plan for you and your dependents. Failure to comply with these requirements will be grounds for denying benefits or recovery under the Plan.

WORKERS' COMPENSATION INSURANCE

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

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

BENEFITS FOR MEDICARE ELIGIBLE MEMBERS

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

Any benefits provided under both this *plan* and Medicare will be provided according to Medicare Secondary Payer legislation, regulations, and Centers for Medicare & Medicaid Services guidelines, subject to federal court decisions. Federal law controls whenever there is a conflict among state law, terms of this *plan*, and federal law.

If you are entitled to Medicare and covered under this *plan* as an active employee, or as a dependent of an active employee, this *plan* will generally pay first and Medicare will pay second.

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

When Medicare is the primary payer for a Member, covered charges for covered services is determined as stated under Exception in the section YOUR MEDICAL BENEFITS - MAXIMUM ALLOWED AMOUNT.

If you have questions about your eligibility for a Basic or Supplement Plan, please contact CalPERS at **888 CalPERS** (or **888-225-7377**).

COORDINATING BENEFITS WITH MEDICARE

In general, when Medicare is the primary payor according to federal law, Medicare must provide benefits first to any services that are covered both by Medicare and under this Plan. For any given claim, the combination of benefits provided by Medicare and under this Plan will not exceed the Maximum Allowed Amount for the covered services.

Except when federal law requires us to be the primary payer, the benefits under this Plan for Members age 65 and older, or for Members who are otherwise eligible for Medicare (such as due to a disability or receiving treatment for end-stage renal disease), will not duplicate any benefit for which Members are entitled under Medicare, including Medicare Part B. Where Medicare is the responsible primary payer, all sums payable by Medicare for services provided to you shall be reimbursed by or on your behalf to us, to the extent we have made primary payment for such services. For the purposes of the calculation of benefits, if you are eligible for Medicare but have not enrolled, we will calculate benefits as if you had enrolled. **You should enroll in Medicare as soon as possible to avoid potential liability.**

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

ENROLLMENT PROVISIONS

ELIGIBILITY FOR ENROLLMENT

- A. Eligibility and enrollment is restricted to members of the Peace Officers Research Association of California (PORAC) and their eligible Family Members, who meet the requirements to participate in this Plan as established by the Insurance and Benefits Trust of PORAC (IBT of PORAC).

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

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

ENROLLMENT PROVISIONS

CONDITIONS OF ENROLLMENT

- A. Each Employee eligible to become a Subscriber according to the provisions stated under ENROLLMENT PROVISIONS, and who files an application for membership for himself or herself and his or her eligible Family Members on forms provided by the Employer with the Employer during an Open Enrollment Period or period of initial eligibility, as specified in the Act, shall have fulfilled the Conditions of Enrollment.
- B. If an Employee fails to enroll himself or herself or his or her eligible Family Members during an Open Enrollment Period or the period of initial eligibility as specified in the Act, the Employee may apply for enrollment for himself or herself and any eligible Family Members in accordance with the Act. Contact your Employer or CalPERS by calling **888 CalPERS** (or **888-225-7377**) for further information.

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

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
2960 Advantage Way
Sacramento, Ca 95834
800-655-6397 (office)
916-999-8892 (fax)

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

COMMENCEMENT OF COVERAGE

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

TERMINATION AND RELATED PROVISIONS

TERMINATION OF THE AGREEMENT

This plan may be terminated by the Board, the Insurance and Benefits Trust of PORAC, or us according to the provisions set forth in the 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, the continuation benefits provided under CONTINUATION OF GROUP COVERAGE and TERMINAL BENEFITS:

1. By the Board's termination of the Memorandum of Agreement.
2. By our termination of the Agreement.
3. By voluntary cancellation by the Subscriber or Family Member in accordance with Section 599.505 of the Act. In the event of such voluntary cancellation, the Member shall cease to be covered hereunder without notice from the Employer, Plan or us at midnight of the day on which such cancellation becomes effective in accordance with Section 599.505 of the Regulations.
4. If a Subscriber or Family Member ceases to be eligible for coverage in accordance with Section 599.506 of the Act.

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

OPEN ENROLLMENT

Members who have voluntarily cancelled enrollment with us may apply for reenrollment during the Open Enrollment Period.

CONTINUATION OF GROUP COVERAGE

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

A. Eligibility for Continuation - Qualifying Events

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

For Subscriber and Family Members . . .

1. The Subscriber's termination 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.
7. The Subscriber's entitlement to Medicare.

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. For qualifying events 4 and 7, a Family Member will be notified of the continuation right. Anyone choosing to continue coverage must so notify the Board within 60 days of the date they receive notice of their continuation right.

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

The member must inform the Board of qualifying events 5 or 6 above within 60 days of such event if the Family Member wishes to continue coverage. If the 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.

CONTINUATION OF GROUP COVERAGE

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

Once the continuation of coverage under the Plan is elected, written notice of his/her rights to continuation of coverage shall be sent to each covered Subscriber. In addition to the notice, an Evidence of Coverage booklet shall be sent to each enrolled Subscriber at the address on enrollment document(s) and shall be deemed notice to such Subscriber 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 "premium", must be paid each month during the COBRA continuation period to keep the continuation in force. The premium for continuation coverage may not exceed 102 percent of the prepayment fees specified for coverage under the Plan 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 the COBRA Administrator the premium for continuation coverage not later than the following dates:

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

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

CONTINUATION OF GROUP COVERAGE

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, the COBRA Administrator shall charge 150 percent of the Subscriber's premium prior to the disability. The COBRA Administrator must receive timely payment of the premium charge each month in order to maintain the coverage in force.

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

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

4. Subsequent Qualifying Events

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

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

5. When Continuation Coverage Begins

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

C. When The Continuation Ends

This continuation will end on the earliest of:

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

CONTINUATION OF GROUP COVERAGE

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

- a. 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, or 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 end of 36 months from the date the Subscriber became entitled to Medicare, if the qualifying event was the Subscriber's entitlement to Medicare.
4. The date the Plan terminates.
5. The end of the last period for which the final premium charge was paid.
6. The date after the date of election of COBRA, the Member first becomes eligible for Medicare.
7. The date after the date of election of COBRA, the Member first becomes covered under any other group health plan.

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 Maximum Allowed Amount incurred.

Subject to the Plan remaining in effect, a retired Subscriber whose coverage began due to a Chapter 11 bankruptcy may continue coverage for the remainder of his 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 4, 5, 6, or 7 above.

CONTINUATION OF GROUP COVERAGE

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

TERMINAL BENEFITS

Any benefits available under this section are subject to all the other terms and conditions of this Plan.

If you are Totally Disabled on the Employer's termination date, and you are not eligible for regular coverage under another similar health plan, benefits will continue for treatment of the disabling condition(s). Benefits will continue until the earliest of:

1. The date you cease to be Totally Disabled;
2. The end of a period of 12 months in a row that follows the Employer termination date;
3. The date you become eligible for regular coverage under another health plan; or
4. The payment of any benefit maximum.

Benefits will be limited to coverage for treatment of the condition or conditions causing Total Disability and in no event will include benefits for any dental condition.

MONTHLY RATES

Type of Enrollment	Enrollment Code	Gross Rate
Self Only	1501	\$899.00
Self and One Dependent	1502	\$1,899.00
Self and Two or More Dependents	1503	\$2,223.00

State Employees and Annuitants

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

Public Agency Employees and Annuitants

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

Rate Change

The plan rates may be changed as of January 1, 2023, following at least sixty (60) days' written notice to the Board prior to such change.

GENERAL PROVISIONS

Identification Cards

We shall issue to the Subscriber an identification card to which the Subscriber and Family Members are entitled. Possession of an identification card confers no right to services or other benefits of the Agreement. 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 therefore at prevailing rates.

Medical Necessity

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

Expense in Excess of Benefits

We are not liable for any expense the Member incurs in excess of the benefits of this Plan.

Inter-Plan Arrangements

Out-of-Area Services

Overview. We have a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you access healthcare services outside the geographic area we serve (the "Anthem Service Area"), the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When you receive care outside of the Anthem Service Area, you will receive it from one of two kinds of providers. Most providers ("participating providers") contract with the local Blue Cross and/or Blue Shield Plan in that geographic area ("Host Blue"). Some providers ("non-participating providers") do not contract with the Host Blue. We explain below how we pay both kinds of providers.

GENERAL PROVISIONS

Inter-Plan Arrangements Eligibility – Claim Types

Most claim types are eligible to be processed through Inter-Plan Arrangements, as described above. Examples of claims that are not included are Prescription Drugs that you obtain from a Pharmacy and most dental or vision benefits.

A. BlueCard[®] Program

Under the BlueCard[®] Program, when you receive covered services within the geographic area served by a Host Blue, we will still fulfill our contractual obligations. But, the Host Blue is responsible for: (a) contracting with its providers; and (b) handling its interactions with those providers.

When you receive covered services outside the Anthem Service Area and the claim is processed through the BlueCard Program, the amount you pay is calculated based on the lower of:

- The billed charges for covered services; or
- The negotiated price that the Host Blue makes available to us.

Often, this “negotiated price” will be a simple discount that reflects an actual price that the Host Blue pays to the provider. Sometimes, it is an estimated price that takes into account special arrangements with that provider. Sometimes, such an arrangement may be an average price, based on a discount that results in expected average savings for services provided by similar types of providers. Estimated and average pricing arrangements may also involve types of settlements, incentive payments and/or other credits or charges.

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price we used for your claim because they will not be applied after a claim has already been paid.

B. Negotiated (non–BlueCard Program) Arrangements

With respect to one or more Host Blues, instead of using the BlueCard Program, we may process your claims for covered services through Negotiated Arrangements for National Accounts.

The amount you pay for covered services under this arrangement will be calculated based on the lower of either billed charges for covered services or the negotiated price (refer to the description of negotiated price under Section A. BlueCard Program) made available to us by the Host Blue.

C. Special Cases: Value-Based Programs

BlueCard[®] Program

If you receive covered services under a Value-Based Program inside a Host Blue’s Service Area, you will not be responsible for paying any of the provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to us through average pricing or fee schedule adjustments. Additional information is available upon request.

Value-Based Programs: Negotiated (non–BlueCard Program) Arrangements

If we have entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to the *group* on your behalf, we will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as noted above for the BlueCard Program.

GENERAL PROVISIONS

D. Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

Federal or state laws or regulations may require a surcharge, tax or other fee. If applicable, we will include any such surcharge, tax or other fee as part of the claim charge passed on to you.

E. Non-participating Providers Outside Our Service Area

1. Allowed Amounts and Member Liability Calculation

When covered services are provided outside of Anthem's Service Area by non-participating providers, we may determine benefits and make payment based on pricing from either the Host Blue or the pricing arrangements required by applicable state or federal law. In these situations, the amount you pay for such services as deductible or copayment will be based on that allowed amount. Also, you may be responsible for the difference between the amount that the non-participating provider bills and the payment we will make for the covered services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network Emergency Services.

2. Exceptions

In certain situations, we may use other pricing methods, such as billed charges or the pricing we would use if the healthcare services had been obtained within the Anthem Service Area, or a special negotiated price to determine the amount we will pay for services provided by non-participating providers. In these situations, you may be liable for the difference between the amount that the non-participating provider bills and the payment we make for the covered services as set forth in this paragraph.

F. Blue Cross Blue Shield Global Core Program

If you plan to travel outside the United States, call Member Services to find out your Blue Cross Blue Shield Global Core benefits. Benefits for services received outside of the United States may be different from services received in the United States. Remember to take an up to date health ID card with you.

When you are traveling abroad and need medical care, you can call the Blue Cross Blue Shield Global Core Service Center any time. They are available 24 hours a day, seven days a week. The toll free number is 800-810-2583. Or you can call them collect at 804-673-1177.

If you need inpatient hospital care, you or someone on your behalf, should contact us for preauthorization. Keep in mind, if you need Emergency medical care, go to the nearest hospital. There is no need to call before you receive care.

Please refer to the "Utilization Review Program" section in this booklet for further information. You can learn how to get pre-authorization when you need to be admitted to the hospital for Emergency or non-emergency care.

How Claims are Paid with Blue Cross Blue Shield Global Core

In most cases, when you arrange inpatient hospital care with Blue Cross Blue Shield Global Core, claims will be filed for you. The only amounts that you may need to pay up front are any copayment or deductible amounts that may apply.

You will typically need to pay for the following services up front:

- Physician services;
- Inpatient hospital care not arranged through Blue Cross Blue Shield Global Core; and

GENERAL PROVISIONS

- Outpatient services.

You will need to file a claim form for any payments made up front.

When you need Blue Cross Blue Shield Global Core claim forms you can get international claims forms in the following ways:

- Call the Blue Cross Blue Shield Global Core Service Center at the numbers above; or
- Online at www.bcbsglobalcore.com.

You will find the address for mailing the claim on the form.

Payment of Benefits

You authorize us, in our own discretion and on behalf of the Plan, to make payments directly to providers for covered services. In no event, however, shall the plan's right to make payments directly to a provider be deemed to suggest that any provider is a beneficiary with independent claims and appeal rights under the plan. We also reserve the right, in our own discretion, to make payments directly to you as opposed to any provider for covered service. In the event that payment is made directly to you, you have the responsibility to apply this payment to the claim from the non-Participating Provider. Payments and notice regarding the receipt and/or adjudication of claims may also be sent to an alternate recipient (which is defined herein as any child of a subscriber who is recognized under a "Qualified Medical Child Support Order" as having a right to enrollment under the employer's plan), or that person's custodial parent or designated representative. Any payments made by us (whether to any provider for covered service or you) will discharge the Plan's obligation to pay for covered services. You cannot assign your right to receive payment to anyone, except as required by a "Qualified Medical Child Support Order" as defined by, and if subject to, ERISA or any applicable Federal law. Once a provider performs a covered service, we will not honor a request to withhold payment of the claims submitted.

The coverage, rights, and benefits under the plan are not assignable by any member without the written consent of the plan, except as provided above. This prohibition against assignment includes rights to receive payment, claim benefits under the plan and/or law, sue or otherwise begin legal action, or request plan documents or any other information that a participant or beneficiary may request under ERISA. Any assignment made without written consent from the plan will be void and unenforceable.

Claims Procedures

Properly completed claim forms itemizing the services received and clearly and accurately describing the services or supplies received and the charges must be sent to PORAC by the Member or the provider of service. These claim forms must be received by PORAC within 90 days of the date services are received. If it is not reasonably possible to submit the claim within that timeframe, an extension of up to 12 months will be allowed. We are not liable for the benefits of the Plan if claims are not filed within this time period. Claim forms must be used; cancelled checks or receipts are not acceptable. To obtain a claim form you or someone on your behalf may call the member services phone number shown on your ID Card.

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

Insurance and Benefits Trust of PORAC
2960 Advantage Way
Sacramento, CA 95834-3725

GENERAL PROVISIONS

If you have any questions regarding your claim, please call the statewide service telephone number on the back of your ID Card.

Care Coordination

We pay Participating Providers in various ways to provide covered services to you. For example, sometimes we may pay Participating Providers a separate amount for each covered service they provide. We may also pay them one amount for all covered services related to treatment of a medical condition. Other times, we may pay a periodic, fixed pre-determined amount to cover the costs of covered services. In addition, we may pay Participating Providers financial incentives or other amounts to help improve quality of care and/or promote the delivery of health care services in a cost-efficient manner, or compensate Participating Providers for coordination of your care. In some instances, Participating Providers may be required to make payment to us because they did not meet certain standards. You do not share in any payments made by Participating Providers to us under these programs.

Right of Recovery

Whenever payment has been made in error, we will have the right to make appropriate adjustment to claims, recover such payment from you or, if applicable, the provider, in accordance with applicable laws and regulations. In the event we recover a payment made in error from the provider, except in cases of fraud or misrepresentation on the part of the provider, we will only recover such payment from the provider within 365 days of the date we made the payment on a claim submitted by the provider. We reserves the right to deduct or offset any amounts paid in error from any pending or future claim.

Under certain circumstances, if we pay your healthcare provider amounts that are your responsibility, such as deductibles, Co-Payments or co-insurance, we may collect such amounts directly from you. You agree that we have the right to recover such amounts from you.

We have oversight responsibility for compliance with provider and vendor and subcontractor contracts. We may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a provider, vendor, or subcontractor resulting from these audits if the return of the overpayment is not feasible.

We have established recovery policies to determine which recoveries are to be pursued, when to incur costs and expenses, and whether to settle or compromise recovery amounts. We will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. We may not provide you with notice of overpayments made by us or you if the recovery method makes providing such notice administratively burdensome.

We reserve the right to deduct or offset, including cross plan offsetting on participating provider claims and on non-participating providers claims where the non-participating providers agrees to cross plan offsetting, any amounts paid in error from any pending or future claim.

Free Choice of Hospital and Physician

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

GENERAL PROVISIONS

Workers' Compensation Insurance

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

Non-Regulation of Providers

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

Area of Service

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

Benefits Non-Transferable

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

Independent Contractors

All providers are independent contractors. We is not liable for any claim or demand of damages connected with any injury resulting from any treatment.

Clerical Error

A clerical error will never disturb or affect your coverage, as long as your coverage is valid under the rules of the Plan. This rule applies to any clerical error, regardless of whether it was the fault of the Plan or us.

Your Right to Appeals

We shall offer a single mandatory level of appeal and an additional voluntary second level of appeal.

Right to Receive and Release Information

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

Member Cooperation

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

You will be expected to complete and submit to us all such authorizations, consents, releases, assignments and other documents that may be needed in order to obtain or assure reimbursement under Medicare, Workers' Compensation or any other governmental program. If you fail to cooperate, you will be responsible for any charge for services.

GENERAL PROVISIONS

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

Protection of Coverage

We do not have the right to cancel your coverage under this plan while:

- A. This Plan is still in effect, and
- B. You are eligible, and
- C. Your premiums are paid according to the terms of the Plan.

Providing of Care

We are not responsible for providing any type of hospital, medical or similar care.

Terms of Coverage

- 1. In order for you to be entitled to benefits under the *plan*, your coverage under the Plan must be in effect on the date the expense giving rise to a claim for benefits is incurred.
- 2. The benefits to which you may be entitled will depend on the terms of coverage in effect on the date the expense giving rise to a claim for benefits is incurred. An expense is incurred on the date you receive the service or supply for which the charge is made.
- 3. The Plan is subject to amendment, modification or termination according to the provisions of the Plan without your consent or concurrence.

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.

Continuity of Care after Termination of Provider

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

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

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

1. An acute condition. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the acute condition.
2. A serious chronic condition. A serious chronic condition is a medical condition caused by a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by us in consultation with you and the terminated provider and consistent with good professional practice. Completion of covered services shall not exceed twelve (12) months from the date the provider's contract terminates.
3. A pregnancy. A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of covered services shall be provided for the duration of the pregnancy.
4. A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one (1) year or less. Completion of covered services shall be provided for the duration of the terminal illness.
5. The care of a newborn child between birth and age thirty-six (36) months. Completion of covered services shall not exceed twelve (12) months from the date the provider's contract terminates.
6. Performance of a surgery or other procedure that we have authorized as part of a documented course of treatment and that has been recommended and documented by the provider to occur within 180 days of the time you enroll in this plan.

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

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

Confidentiality and Release of Information

Applicable state and federal law requires us to undertake efforts to safeguard your medical information.

For informational purposes only, please be advised that a statement describing our policies and procedures regarding the protection, use and disclosure of your medical information is available and can be furnished to you upon request by contacting our Member Services department.

GENERAL PROVISIONS

Obligations that arise under state and federal law and policies and procedures relating to privacy that are referenced but not included in this booklet are not part of the contract between the parties and do not give rise to contractual obligations.

Voluntary Clinical Quality Programs. We may offer additional opportunities to assist you in obtaining certain covered preventive or other care (e.g., well child check-ups or certain laboratory screening tests) that you have not received in the recommended timeframe. These opportunities are called voluntary clinical quality programs. They are designed to encourage you to get certain care when you need it and are separate from covered services under your plan. These programs are not guaranteed and could be discontinued at any time. We will give you the choice and if you choose to participate in one of these programs, and obtain the recommended care within the program's timeframe, you may receive incentives such as gift cards or retailer coupons, which we encourage you to use for health and wellness related activities or items. Under other clinical quality programs, you may receive a home test kit that allows you to collect the specimen for certain covered laboratory tests at home and mail it to the laboratory for processing. You may also be offered a home visit appointment to collect such specimens and complete biometric screenings. You may need to pay any cost shares that normally apply to such covered laboratory tests (e.g., those applicable to the laboratory processing fee) but will not need to pay for the home test kit or the home visit. If you have any questions about whether receipt of a gift card or retailer coupon results in taxable income to you, we recommend that you consult your tax advisor.

Voluntary Wellness Incentive Programs. We may offer health or fitness related program options for purchase by PORAC to help you achieve your best health. These programs are not covered services under your plan, but are separate components, which are not guaranteed under this plan and could be discontinued at any time. If PORAC has selected one of these options to make available to all employees, you may receive incentives such as gift cards by participating in or completing such voluntary wellness promotion programs as health assessments, weight management or tobacco cessation coaching. Under other options PORAC may select, you may receive such incentives by achieving specified standards based on health factors under wellness programs that comply with applicable law. If you think you might be unable to meet the standard, you might qualify for an opportunity to earn the same reward by different means. You may contact member services number on your ID card and we will work with you (and, if you wish, your Physician) to find a wellness program with the same reward that is right for you in light of your health status. If you receive a gift card as a wellness reward and use it for purposes other than for qualified medical expenses, this may result in taxable income to you. For additional guidance, please consult your tax advisor.

Protecting your privacy

Where to find our Notice of Privacy Practices

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

We may collect, use and share your Protected Health Information (PHI) for the following reasons and others as allowed or required by law, including the HIPAA Privacy Rule:

For payment: We use and share PHI to manage your account or benefits; or to pay claims for health care you get through your plan.

GENERAL PROVISIONS

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

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

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

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

Health Insurance Portability and Accountability Act (HIPAA) Information

CalPERS and its Plan Administrators comply with the federal Health Insurance Portability and Accountability Act (HIPAA) and the privacy regulations that have been adopted under it. Your privacy rights under HIPAA are detailed in CalPERS' Notice of Privacy Practices (NOPP) which is mailed annually to each subscriber as part of the annual open enrollment mailing. In addition, the current NOPP is always available on CalPERS' website at www.calpers.ca.gov. If you have any questions regarding your rights under HIPAA, please contact the CalPERS HIPAA coordinator at **888 CalPERS** (or **888-225-7377**). If you are outside of the United States, you should contact the operator in the country you are in to assist you in making the call.

IBT of PORAC's Notice of Privacy Practices

By visiting the IBT of PORAC's website (<http://ibtofporac.org>), you can download its Notice of Privacy Practices to your computer. You can also request a paper copy of any of this Notice by contacting the IBT of PORAC Office by phone at (800) 655-6397. You may also request a copy by writing to the IBT of PORAC Office at: Insurance and Benefits Trust of PORAC, 2960 Advantage Way, Sacramento, CA 95384. Please identify you are a participant in this IBT of PORAC Health Plan along with your address, phone number and any email address.

GENERAL INFORMATION

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

CalPERS Member Services

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

Direct Payment of Dues

If you arrange for direct payment of dues, send your payment, together with Form HBD 21 to PORAC, 2960 Advantage Way, Sacramento, CA 95384. Be sure to include your identification number with your payment. For further details, see the CalPERS Health Program Guide.

YOUR RIGHT TO APPEALS

For purposes of these Appeal provisions, “claim for benefits” means a request for benefits under the Plan. The term includes both pre-service and post-service claims.

- A pre-service claim is a claim for benefits under the Plan for which you have not received the benefit or for which you may need to obtain approval in advance.
- A post-service claim is any other claim for benefits under the *plan* for which you have received the service.

If your claim is denied or if your coverage is rescinded:

- you will be provided with a written notice of the denial or rescission; and
- you are entitled to a full and fair review of the denial or rescission.

The procedure we will follow will satisfy following the minimum requirements for a full and fair review under applicable federal regulations.

Notice of Adverse Benefit Determination

If your claim is denied, our notice of the adverse benefit determination (denial) will include:

- information sufficient to identify the claim involved;
- the specific reason(s) for the denial;
- a reference to the specific Plan provision(s) on which our determination is based;
- a description of any additional material or information needed to perfect your claim;
- an explanation of why the additional material or information is needed;
- a description of the Plan’s review procedures and the time limits that apply to them, if you appeal and the claim denial is upheld;
- information about any internal rule, guideline, protocol, or other similar criterion relied upon in making the claim determination and about your right to request a copy of it free of charge, along with a discussion of the claims denial decision; and
- information about the scientific or clinical judgment for any determination based on medical necessity or experimental treatment, or about your right to request this explanation free of charge, along with a discussion of the claims denial decision; and
- the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman who may assist you.

YOUR RIGHT TO APPEALS

For claims involving urgent/concurrent care:

- Our notice will also include a description of the applicable urgent/concurrent review process; and
- We may notify you or your authorized representative within 72 hours orally and then furnish a written notification.

Appeals

You have the right to appeal an adverse benefit determination (claim denial or rescission of coverage). You or your authorized representative must file your appeal within 180 calendar days after you are notified of the denial or rescission. You will have the opportunity to submit written comments, documents, records, and other information supporting your claim. Our review of your claim will take into account all information you submit, regardless of whether it was submitted or considered in the initial benefit determination.

- We shall offer a single mandatory level of appeal and an additional voluntary second level of appeal which may be a panel review, independent review, or other process consistent with the entity reviewing the appeal. The time frame allowed for us to complete its review is dependent upon the type of review involved (e.g. pre-service, concurrent, post-service, urgent, etc.).

For pre-service claims involving urgent/concurrent care, you may obtain an expedited appeal. You or your authorized representative may request it orally or in writing. All necessary information, including our decision, can be sent by telephone, facsimile or other similar method. To file an appeal for a claim involving urgent/concurrent care, you or your authorized representative must contact us at the phone number listed on your ID card and provide at least the following information:

- the identity of the claimant;
- the date (s) of the medical service;
- the specific medical condition or symptom;
- the provider's name;
- the service or supply for which approval of benefits was sought; and
- any reasons why the appeal should be processed on a more expedited basis.

All other requests for appeals should be submitted in writing by the Member or the Member's authorized representative, except where the acceptance of oral appeals is otherwise required by the nature of the appeal (e.g. urgent care). You or your authorized representative must submit a request for review to:

Insurance and Benefits Trust of the Peace Officers Research Association of California (IBT of PORAC)
2960 Advantage Way
Sacramento, CA, 95834

You must include Your Member Identification Number when submitting an appeal.

Upon request, we will provide, without charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim. "Relevant" means that the document, record, or other information:

YOUR RIGHT TO APPEALS

- was relied on in making the benefit determination; or
- was submitted, considered, or produced in the course of making the benefit determination; or
- demonstrates compliance with processes and safeguards to ensure that claim determinations are made in accordance with the terms of the *plan*, applied consistently for similarly-situated claimants; or
- is a statement of the Plan's policy or guidance about the treatment or benefit relative to your diagnosis.

We will also provide you, free of charge, with any new or additional evidence considered, relied upon, or generated in connection with your claim. In addition, before you receive an adverse benefit determination on review based on a new or additional rationale, we will provide you, free of charge, with the rationale.

For Out of State Appeals You have to file Provider appeals with the Host Plan. This means Providers must file appeals with the same plan to which the claim was filed.

How Your Appeal will be Decided

When we consider your appeal, we will not rely upon the initial benefit determination or, for voluntary second-level appeals, to the earlier appeal determination. The review will be conducted by an appropriate reviewer who did not make the initial determination and who does not work for the person who made the initial determination. A voluntary second-level review will be conducted by an appropriate reviewer who did not make the initial determination or the first-level appeal determination and who does not work for the person who made the initial determination or first-level appeal determination.

If the denial was based in whole or in part on a medical judgment, including whether the treatment is experimental, investigational, or not Medically Necessary, the reviewer will consult with a health care professional who has the appropriate training and experience in the medical field involved in making the judgment. This health care professional will not be one who was consulted in making an earlier determination or who works for one who was consulted in making an earlier determination.

Notification of the Outcome of the Appeal

If you appeal a claim involving urgent/concurrent care, we will notify you of the outcome of the appeal as soon as possible, but not later than 72 hours after receipt of your request for appeal.

If you appeal any other pre-service claim, we will notify you of the outcome of the appeal within 30 days after receipt of your request for appeal.

If you appeal a post-service claim, we will notify you of the outcome of the appeal within 60 days after receipt of your request for appeal.

Appeal Denial

- If your appeal is denied, that denial will be considered an adverse benefit determination. The notification from us will include all of the information set forth in the above subsection entitled "Notice of Adverse Benefit Determination."

YOUR RIGHT TO APPEALS

Voluntary Second Level Appeals

If you are dissatisfied with the Plan's mandatory first level appeal decision, a voluntary second level appeal may be available. If you would like to initiate a second level appeal, please write to the address listed above. Voluntary appeals must be submitted within 60 calendar days of the denial of the first level appeal. You are not required to complete a voluntary second level appeal prior to submitting a request for an independent External Review.

External Review

If the outcome of the mandatory first level appeal is adverse to you and it was based on medical judgment, or if it pertained to a rescission of coverage, you may be eligible for an independent External Review pursuant to federal law.

You must submit your request for External Review to us within four (4) months of the notice of your final internal adverse determination.

A request for an External Review must be in writing unless we determine that it is not reasonable to require a written statement. You do not have to re-send the information that you submitted for internal appeal. However, you are encouraged to submit any additional information that you think is important for review.

For pre-service claims involving urgent/concurrent care, you may proceed with an Expedited External Review without filing an internal appeal or while simultaneously pursuing an expedited appeal through our internal appeal process. You or your authorized representative may request it orally or in writing. All necessary information, including our decision, can be sent between Anthem and you by telephone, facsimile or other similar method. To proceed with an Expedited External Review, you or your authorized representative must contact us at the phone number listed on your ID card and provide at least the following information:

- the identity of the claimant;
- the date (s) of the medical service;
- the specific medical condition or symptom;
- the provider's name;
- the service or supply for which approval of benefits was sought; and
- any reasons why the appeal should be processed on a more expedited basis.

All other requests for External Review should be submitted in writing unless we determine that it is not reasonable to require a written statement. Such requests should be submitted by you or your authorized representative to:

Insurance and Benefits Trust of the Peace Officers Research Association of California (IBT of PORAC)
2960 Advantage Way
Sacramento, CA, 95834

You must include Your Member Identification Number when submitting an appeal.

YOUR RIGHT TO APPEALS

This is not an additional step that you must take in order to fulfill your appeal procedure obligations described above. Your decision to seek External Review will not affect your rights to any other benefits under this health care Plan. There is no charge for you to initiate an independent External Review. The External Review decision is final and binding on all parties except for any relief available through applicable state laws.

Requirement to file Appeal and Exhaust Appeals Procedures with Anthem before requesting Binding Arbitration from IBT of PORAC

You must exhaust Anthem's Claims and Appeals Procedure set out above, except for any voluntary level of appeal, before requesting binding arbitration against the IBT of PORAC.

Contractual Limitation Period. No lawsuit or legal action of any kind related to a benefit decision may be filed by you in small claims court, if applicable, in arbitration or in any other forum, unless it is commenced within three years of the Plan's final decision on the claim or other request for benefits. If the Plan decides an appeal is untimely, the Plan's latest decision on the merits of the underlying claim or benefit request is the final decision date.

Anthem reserves the right to modify the policies, procedures and timeframes in this section upon further clarification from Department of Health and Human Services and Department of Labor.

NOTE: You should use the above appeals procedures for disputes over coverage and/or benefits through Anthem first. If you have exhausted the claims and appeals procedures for coverage and/or benefits with Anthem and are still dissatisfied, you should contact:

Insurance and Benefits Trust of the Peace Officers Research Association of California (IBT of PORAC)
2960 Advantage Way
Sacramento, CA, 95834
800-655-6397 (office)
916-999-8892 (fax)

You must also contact IBT of PORAC if you have questions about eligibility under the Plan or if you would like a copy of the Trust's Eligibility and Participation Policies.

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.

You must make written demand of the IBT of PORAC for arbitration to resolve such disputes or claims. Make written demands to IBT of PORAC, 2960 Advantage Way, Sacramento, CA 95834.

NOTE: Demands for arbitration may only be made if you have exhausted the claims and appeals procedures with Anthem and with IBT of PORAC.

YOUR RIGHT TO APPEALS

Discretion of Board of Trustees of IBT of PORAC and its Delegation of Discretion

The Board of Trustees of the Insurance and Benefits Trust of the Peace Officers Research Association of California (IBT of PORAC) has appointed Anthem to act as the Claims Fiduciary for purposes of reviewing appeals. Anthem has discretionary authority and power to make factual findings, fix omissions, resolve plan ambiguities, construe the terms of the Plan, make benefit determinations, and to resolve other disputes under the Plan.

If you have exhausted the claims and appeals procedures for coverage and/or benefits with Anthem and are still dissatisfied, you should contact the IBT of PORAC at the address above. The Trustees (or a Committee thereof) shall have sole and exclusive discretion and authority to administer, apply, and interpret the Health Plan and all its plan documents. Trustees have discretionary authority and power to decide all matters arising in connection with the Health Plan, including but not limited to: making factual findings, fixing omissions, resolving ambiguities, construing the terms of the Plan, making determinations, and resolving disputes under the Plan. All determinations made by the Trustees (or a Committee thereof) with respect to any matter arising under the Health Plan will be final and binding on all concerned. Any review by any arbitrator or judge, if applicable, of any Trustee decision concerning the Health Plan must be done in deference to the Trustees' decision.

GENERAL DEFINITIONS

GENERAL DEFINITIONS

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

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

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

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

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

Authorized referral occurs when you, because of your medical needs, require the services of a specialist who is a Non-Participating Provider, or require special services or facilities not available at a contracting hospital, but only when the referral has been authorized by us before services are rendered and when the following conditions are met:

- There is no Participating Provider who practices in the appropriate specialty, or there is no contracting hospital which provides the required services, or which has the necessary facilities;
- That meets the adequacy and accessibility requirements of state or federal law; and
- You are referred to a Hospital or Physician that does not have an agreement with us for a covered service by the Physician who is a Participating Provider.

You or your Physician must call the toll-free telephone number printed on your identification card prior to scheduling an admission to, or receiving the services of, a Non-Participating Provider.

Bariatric BDCSC Coverage Area is the area within the 50-mile radius surrounding a designated bariatric *BDCSC*.

Biosimilar (Biosimilars) is a type of biological product that is licensed (approved) by FDA because it is highly similar to an already FDA-approved biological product, known as the biological reference product (reference product), and has been shown to have no clinically meaningful differences from the reference product.

Blue Distinction Centers for Specialty Care (BDCSC) are health care providers designated by us as a selected facility for specified medical services. A provider participating in a BDCSC network has an agreement in effect with us at the time services are rendered or is available through our affiliate companies or our relationship with the Blue Cross and Blue Shield Association. BDCSC agree to accept the Maximum allowed Amount as payment in full for covered services. A Participating Provider in the Blue Cross and/or Blue Shield Plan is not necessarily a BDCSC facility.

GENERAL DEFINITIONS

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

A **Brand Name Prescription Drugs (Brand Name Drugs)** are Prescription Drugs that are classified as Brand Name Drugs or the Pharmacy Benefit Manager has classified as Brand Name Drugs through use of an independent proprietary industry database.

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

A **Compound Medication** is a mixture of Prescription Drugs when a commercially available dosage form of a medically necessary medication is not available, all of the ingredients of the compound drug are FDA-approved in the form in which they are used in the Compound Medication and as designated in the FDA's Orange Book: Approved Drug Products with Therapeutic Equivalence Evaluations, require a prescription to dispense and are not essentially the same as an FDA-approved product from a Drug manufacturer. Non-FDA approved non-proprietary, multisource ingredients that are vehicles essential for compound administration may be covered.

A **Co-Payment (Co-Pay)** is the amount that a Member is required to pay for specific covered services.

Controlled Substances are Drugs and other substances that are considered controlled substances under the Controlled Substances Act (CSA) which are divided into five schedules.

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

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

If Medically Necessary, benefits will be provided for feeding (by tube or gastrostomy) and suctioning.

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

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.

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

GENERAL DEFINITIONS

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.

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

Emergency means a sudden, serious and unexpected acute illness, injury or condition (including without limitation sudden and unexpected severe pain) or a 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 us.

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

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

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

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

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

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

A **Generic Prescription Drugs (Generic Drugs)** are Prescription Drugs that are classified as Generic Drugs or that the PBM has classified as Generic Drugs through use of an independent proprietary industry database. Generic Drugs have the same active ingredients, must meet the same FDA rules for safety, purity and potency, and must be given in the same form (tablet, capsule, cream) as the Brand Name Drug.

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

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

Home Infusion Therapy Provider is a provider licensed according to state and local laws as a pharmacy, and must be either certified as a home health care provider by Medicare, or accredited as a home pharmacy by The Joint Commission (TJC).

GENERAL DEFINITIONS

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 us. 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 (TJC).

For the limited purpose of Inpatient care, the definition of hospital also includes: (1) Psychiatric Health Facilities (only for the acute phase of a Mental or Nervous Disorder or substance abuse), and (2) Residential Treatment Centers.

Infertility is (1) the presence of a condition recognized by a Physician as the cause of infertility, or (2) the inability to conceive a pregnancy or carry a pregnancy to a live birth after a year or more of regular sexual relations without contraception or after 3 cycles of artificial insemination.

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.

Intensive In-Home Behavioral Health Program is a range of therapy services provided in the home to address symptoms and behaviors that, as the result of a Mental or Nervous Disorder or substance abuse, put the Members and others at risk of harm.

Intensive Outpatient Program is a structured, multidisciplinary behavioral health treatment that provides a combination of individual, group and family therapy in a program that operates no less than 3 hours per day, 3 days per week.

Interchangeable Biologic Product is a type of biological product that is licensed (approved) by FDA because it is highly similar to an already FDA-approved biological product, known as the biological reference product (reference product), and has been shown to have no clinically meaningful differences from the reference product. In addition to meeting the biosimilarity standard, it is expected to produce the same clinical result as the reference product in any given patient.

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

Maximum allowed amount is the maximum amount of reimbursement we will allow for covered medical services and supplies under this plan. See YOUR MEDICAL BENEFITS: MAXIMUM ALLOWED AMOUNT.

Medically Necessary procedures, supplies, equipment or services are those considered to be:

1. Appropriate and necessary for the diagnosis or treatment of the medical condition;

GENERAL DEFINITIONS

2. Clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or disease;
3. Provided for the diagnosis or direct care and treatment of the medical condition;
4. Within standards of good medical practice within the organized medical community;
5. Not primarily for your convenience, or for the convenience of your Physician or another provider;
6. Not more costly than an equivalent service, including the same service in an alternative setting, or sequence of services that is medically appropriate and is likely to produce equivalent therapeutic or diagnostic results in regard to the diagnosis or treatment of that patient's illness, injury or condition; and
7. The most appropriate procedure, supply, equipment or service which can safely be provided. The most appropriate procedure, supply, equipment or service must satisfy the following requirements:
 - a. There must be valid scientific evidence demonstrating that the expected health benefits from the procedure, supply, equipment or service are clinically significant and produce a greater likelihood of benefit, without a disproportionately greater risk of harm or complications, for you with the particular medical condition being treated than other possible alternatives; and
 - b. Generally accepted forms of treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable.

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 Plan.

Mental or Nervous 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 or nervous disorders include Severe Mental Disorders as defined in this plan (see definition of "severe mental disorders").

Multi-source brand name drugs are drugs with at least one generic substitute.

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

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

- A Hospital
- A Physician
- An Ambulatory Surgical Center
- A Home Health Agency
- A facility which provides diagnostic imaging services
- A Durable Medical Equipment outlet
- A Skilled Nursing Facility

GENERAL DEFINITIONS

- A clinical laboratory
- A Home Infusion Therapy Provider
- An urgent care center
- A retail health clinic
- A hospice
- A licensed ambulance company
- A licensed qualified autism service provider

They are not Participating Providers. Remember that the Maximum Allowed Amount may only represent a portion of the amount which a non-participating provider charges for services. See YOUR MEDICAL BENEFITS: MAXIMUM ALLOWED AMOUNT on pages 12-15.

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

Other health care provider is one of the following providers:

- A certified registered nurse anesthetist
- A blood bank

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

Out-of-Pocket Expense is the difference between the Maximum Allowed Amount and our payment. You are responsible to pay Out-of-Pocket Expense until your total out-of-pocket payments in a Year equal the Out-of-Pocket Expense Amount shown in the SUMMARY OF BENEFITS section. Out-of-Pocket Expense Amount does **not** include any amounts exceeding the Maximum Allowed Amount for Non-Participating Providers and Other Health Care Providers, and any other charges which are not considered covered. In addition, outpatient prescription drug copayments do **not** accrue towards the Out-of-Pocket Expense Amount. You will need to meet the separate Prescription Drug Out-of-Pocket Amount shown in the SUMMARY OF BENEFITS section.

Partial Hospitalization Program is a structured, multidisciplinary behavioral health treatment that offers nursing care and active individual, group and family treatment in a program that operates no less than 6 hours per day, 5 days per week.

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

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

- A Hospital
- A Physician
- An Ambulatory Surgical Center
- A Home Health Agency
- A facility which provides diagnostic imaging services

GENERAL DEFINITIONS

- A Durable Medical Equipment outlet
- A Skilled Nursing Facility
- A clinical laboratory
- A Home Infusion Therapy Provider
- An urgent care center
- A retail health clinic
- A hospice
- A licensed ambulance company
- A licensed qualified autism service provider

Participating Providers agree to accept the Maximum Allowed Amount as payment for covered services. A directory of Participating Providers is available upon request.

A **Pharmacy** is a licensed retail pharmacy.

Pharmacy and Therapeutics Process is a process in which health care professionals including nurses, pharmacists, and Physicians determine the clinical appropriateness of Drugs and promote access to quality medications. The process also reviews Drugs to determine the most cost effective use of benefits and advise on programs to help improve care. Our programs include, but are not limited to, Drug utilization programs, prior authorization criteria, therapeutic conversion programs, cross-branded initiatives, and Drug profiling initiatives.

A **Pharmacy Benefits Manager (PBM)** a company that manages pharmacy benefits on our behalf. Our PBM has a nationwide network of retail pharmacies, a home delivery pharmacy, and clinical services that include prescription drug list management.

The management and other services the PBM provides include, but are not limited to, managing a network of retail pharmacies and operating a mail service pharmacy. The PBM, in consultation with us, also provides services to promote and assist Members in the appropriate use of pharmacy benefits, such as review for possible excessive use, proper dosage, drug interactions or drug/pregnancy concerns.

Physician means:

1. A doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is licensed to practice medicine or osteopathy where the care is provided; or
2. One of the following providers, but only when the provider is licensed to practice where the care is provided, is rendering a service within the scope of that license and such license is required to render that service, and is providing a service for which benefits are specified in this booklet:
 - 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 licensed educational psychologist for the provision of behavioral health treatment services for the treatment of pervasive developmental disorder or autism only

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- A chiropractor (D.C.)
- An acupuncturist (A.C.)
- A nurse midwife
- A nurse practitioner
- A physician assistant
- A licensed clinical social worker (L.C.S.W.)
- A marriage and family therapist (M.F.T.)
- A licensed professional clinical counselor (L.P.C.C.)*
- 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 Psychiatric Mental Health Nurse (R.N.)*
- Any agency licensed by the state to provide services for the treatment of Mental or Nervous Disorders or substance abuse, when we are 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.

Plan is the set of benefits described in this booklet and in the amendments to this booklet (if any). The Plan is a self-funded health plan established and administered by IBT of PORAC (the plan administrator and sponsor), which contracts with us to provide health coverage hereunder. We also handles the claims and appeals for the Plan.

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

Prescription Drug Covered Expense is the expense the Member incurs for a covered Prescription Drug, but not more than the Prescription Drug Maximum Allowed Amount. Expense is incurred on the date the Member receives the service or supply.

The **Prescription Drug Formulary (Formulary)** is a list which we developed of outpatient Prescription Drugs which may be cost-effective, therapeutic choices. Any Participating Pharmacy can assist you in purchasing Drugs listed on the Formulary. The Member may also get information about covered formulary drugs by calling the number on the back of their ID Card.

The **Prescription Drug Maximum Allowed Amount** is the maximum amount we will allow for any Drug. The amount is determined by us using prescription drug cost information provided to us by the Pharmacy Benefits Manager. The amount is subject to change. The Member may determine the Prescription Drug Maximum Allowed Amount of a particular drug by calling the number on the back of your ID Card.

GENERAL DEFINITIONS

Preventive Care Services include routine examinations, screenings, tests, education, and immunizations administered with the intent of preventing future disease, illness, or injury. Services are considered preventive if the Member has no current symptoms or prior history of a medical condition associated with that screening or service. These services shall meet requirements as determined by federal and state law. Sources for determining which services are recommended include the following:

1. Services with an "A" or "B" rating from the United States Preventive Services Task Force (USPSTF);
2. Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
3. Preventive care and screenings for infants, children, and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
4. Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration.

The Member may call the member services number listed on the Member ID card for additional information about services that are covered by this plan as preventive care services. The Member may also refer to the following websites that are maintained by the U.S. Department of Health & Human Services.

<https://www.healthcare.gov/what-are-my-preventive-care-benefits>

<http://www.ahrq.gov>

<http://www.cdc.gov/vaccines/acip/index.html>

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

Psychiatric Emergency Medical Condition is a Mental or Nervous 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 or Nervous Disorder.

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

1. Qualified to provide short-term Inpatient treatment according to state law;
2. Accredited by The Joint Commission (TJC); and
3. Staffed by an organized medical or professional staff which includes a Physician as medical director.

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

Reconstructive surgery is surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following: (a) improve function; or (b) create a normal appearance, to the extent possible.

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

GENERAL DEFINITIONS

A **Residential Treatment Center** is an Inpatient treatment facility where the patient resides in a modified community environment and follows a comprehensive medical treatment regimen for treatment and rehabilitation as the result of a Mental or Nervous Disorder or substance abuse. The facility must be licensed to provide psychiatric treatment of Mental or Nervous Disorders or rehabilitative treatment of substance abuse according to state and local laws and requires a minimum of one physician visit per week in the facility. The facility must be fully accredited by The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the National Integrated Accreditation for Healthcare Organizations (NIAHO), or the Council on Accreditation (COA).

A **Retail Health Clinic** is a facility that provides limited basic medical care services to Members on a “walk-in” basis. These clinics normally operate in major pharmacies or retail stores.

Self-Administered Hormonal Contraceptives are products with the following routes of administration:

- Oral;
- Transdermal;
- Vaginal;
- Depot Injection.

Severe Mental Disorders include the following psychiatric diagnoses specified in California Insurance Code Section 10144.5: 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).

Single source brand name drugs are drugs with no generic substitute.

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 (TJC) and related facilities, or which is recognized as a Skilled Nursing Facility by the Secretary of Health and Human Services of the United States government pursuant to the Medicare Act.

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

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

GENERAL DEFINITIONS

Specialty Drugs are typically high-cost, injectable, infused, oral or inhaled medications that generally require close supervision and monitoring of their effect on the patient by a medical professional. Certain specified Specialty Drugs may require special handling, such as temperature controlled packaging and overnight delivery, and therefore, certain specified Specialty Drugs will be required to be obtained through the specialty drug program, unless a Member qualifies for an exception.

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 is the person enrolled who is responsible for payment of premiums to the Plan, and whose employment or other status, except family dependency, is the basis for eligibility for enrollment under this Plan. Subscribers must meet the requirements to participate in this Plan as established by the Insurance and Benefits Trust of PORAC (IBT of PORAC).

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.

An **Urgent care center** is a physician's office or a similar facility which meets established ambulatory care criteria and provides medical care outside of a hospital emergency department, usually on an unscheduled, walk-in basis. Urgent care centers are staffed by medical doctors, nurse practitioners and physician assistants primarily for the purpose of treating patients who have an injury or illness that requires immediate care but is not serious enough to warrant a visit to an emergency room.

To find an urgent care center, please call us at the member services number listed on your ID card or you can also search online using the "Provider Finder" function on the website at www.anthem.com/ca. Please call the Urgent Care Center directly for hours of operation and to verify that the center can help with the specific care that is needed.

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

FOR YOUR INFORMATION

SPECIAL NOTICE REGARDING REPRODUCTIVE HEALTH CARE SERVICES

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

FOR YOUR INFORMATION

STATEMENT OF RIGHTS UNDER THE NEWBORNS AND MOTHERS HEALTH PROTECTION ACT

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a delivery by cesarean section. However the plan or issuer may pay for a shorter stay if the attending Physician (e.g., your Physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48 hour (or 96 hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-certification. For information on pre-certification, please call us at the member services telephone number listed on your ID card.

STATEMENT OF RIGHTS UNDER THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

This plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). If you have any questions about this coverage, please call us at the member services telephone number listed on your ID card.



Get help in your language

Notice of Language Assistance

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

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

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

Spanish

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

Arabic

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

Armenian

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

Chinese

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

Farsi

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

Hindi

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

Hmong

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

Japanese

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

Khmer

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

Korean

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

Punjabi

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

Russian

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

Tagalog

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

Thai

ท่านมีสิทธิขอรับบริการสอบถามข้อมูลและความช่วยเหลือในภาษาของท่านฟรี โทรไปที่หมายเลขฝ่ายบริการสมาชิกบนบัตรประจำตัวของท่านเพื่อขอความช่วยเหลือ(TTY/TDD: 711)

Vietnamese

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

It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1-800-537-7697) or online at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

For claims and customer service, contact:

Insurance and Benefits Trust of PORAC

2960 Advantage Way
Sacramento, CA 95834

1-800-655-6397

www.ibtofporac.org/benefits-offered/health-plans/