

Combined Evidence of Coverage and Disclosure Form

Effective January 1, 2026

Supplement to Original Medicare Plan with Major Medical Benefits



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)

SUPPLEMENT TO ORIGINAL MEDICARE PLAN

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

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

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

This Supplement to Original Medicare Plan is provided by 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.

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED. IF YOU HAVE SPECIAL HEALTH CARE NEEDS, YOU SHOULD CAREFULLY READ THOSE SECTIONS THAT APPLY TO THOSE NEEDS.

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

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

1-800-655-6397

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ADMINISTRATIVE AND BENEFIT CHANGES

Effective January 1, 2026, the following changes have been made to your

plan. **Administrative Changes**

No administrative changes have been made to your plan.

Benefit Changes

No benefit changes have been made to your plan.

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

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

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

SUMMARY OF PLAN BENEFITS

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

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

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

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

DEFINITIONS

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

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

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

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

Anniversary Date is the first day of each contract term.

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

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

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

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

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

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

DEFINITIONS

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

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

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

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

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

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

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

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

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

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

Emergency or Emergency Medical Condition means a medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity including severe pain such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- Placing the patient's health or the health of another person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or

DEFINITIONS

- Serious dysfunction of any bodily organ or part.

Emergency includes being in active labor when there is inadequate time for a safe transfer to another *hospital* prior to delivery, or when such a transfer would pose a threat to the health and safety of the *member* or unborn child.

An *emergency medical condition* includes a *psychiatric emergency medical condition*, which is a mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either of the following: a) an immediate danger to himself or herself or to others, or b) immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental disorder.

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

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

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

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

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

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

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

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

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

DEFINITIONS

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

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

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

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

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

NOTE: In some cases we will accept Medicare's determination of medical necessity.

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

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

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

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

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

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

DEFINITIONS

A **Physician** means:

1. A doctor of medicine (M.D.) or a doctor of osteopathy (D.O.) who is licensed to practice medicine or osteopathy where the care is provided, or
2. One of the following providers, but only when the provider is licensed to practice where the care is provided, is rendering a service within the scope of that license and such license is required to render that service, and is providing a service for which benefits are specified in the Evidence of Coverage:
 - A dentist (D.D.S. or D.M.D.)
 - An optometrist (O.D.)
 - A dispensing optician
 - A podiatrist or chiropodist (D.P.M., D.S.P. or D.S.C.)
 - A licensed clinical psychologist
 - A chiropractor (D.C.)
 - An acupuncturist (A.C.) (but only for acupuncture and for no other services)
 - A certified registered nurse anesthetist (C.R.N.A.)
 - A licensed clinical social worker (C.S.W. or L.C.S.W.)
 - A marriage and family therapist (M.F.T.)
 - A physical therapist (P.T. or R.P.T.)*
 - A speech pathologist*
 - An audiologist*
 - An occupational therapist (O.T.R.)*
 - A respiratory care practitioner (R.C.P.)*
 - A nurse midwife
 - A nurse practitioner
 - A physician assistant
 - A psychiatric-mental health nurse (a registered nurse having a masters degree in psychiatric-mental health nursing who meets the qualifications for registration and is in fact registered as a psychiatric-mental health nurse with the California Board of Registered Nurses)*
 - Any agency licensed by the state to provide services for the treatment of Mental Disorders or substance abuse, when 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.

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

DEFINITIONS

Reasonable Charge. A Reasonable Charge is one which we consider not to be excessive, based on the circumstances of the care provided. Such circumstances include: level of skill, experience involved, the prevailing or common cost of similar services or supplies and any other factors which determine value. The Member is responsible for paying billed amounts over the Reasonable Charge, in addition to any plan deductible and co-payment amounts, amounts over stated benefit maximums, and any non-covered expense.

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

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

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

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

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

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

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

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

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

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

Subscriber 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.

DEFINITIONS

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

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

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

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

ENROLLMENT PROVISIONS

ELIGIBILITY FOR ENROLLMENT

- All Employees, Annuitants and Family Members who are enrolled under Medicare Parts A and B may enroll hereunder. 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.

- 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

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

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

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 participation policies free of charge.

COMMENCEMENT OF COVERAGE

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

TERMINATION AND RELATED PROVISIONS

TERMINATION OF AGREEMENT

This Plan may be terminated by the Board, the Insurance and Benefits Trust of PORAC or Anthem according to the provisions set forth in the Memorandum of Agreement or 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 and the continuation benefits provided under **TERMINAL BENEFITS** in this section of the Evidence of Coverage:

- By the Board's termination of the Memorandum of Agreement;
- By our termination of the Agreement;
- By voluntary cancellation by the Employee, Annuitant or Family Member in accordance with Section 599.505 of the Regulations. In the event of such voluntary cancellation, the Member shall cease to be covered hereunder without notice from the Plan or us at midnight of the day on which such cancellation becomes effective in accordance with Section 599.505 of the Regulations; or
- If an Employee, Annuitant or Family Member ceases to be eligible for coverage in accordance with Section 599.506 of the Regulations.

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

REENROLLMENT

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

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	Supplement to Original Medicare Rate	Medicare Prescription Drug Rate	Gross Rate *
Self Only	2081	\$346.26	\$250.74	\$597.00
Self and One Dependent	2082	\$766.76	\$555.24	\$1,322.00
Self and Two or More Dependents	2083	\$1,038.78	\$752.22	\$1,791.00

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

STATE EMPLOYEES AND ANNUITANTS

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

PUBLIC AGENCY EMPLOYEES AND ANNUITANTS

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

RATE CHANGE

The plan rates may be changed as of January 1, 2026, following at least sixty (60) days' written notice to the Board prior to such change.

SUPPLEMENTAL SERVICES AND BENEFITS

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

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

BENEFITS TO SUPPLEMENT ORIGINAL MEDICARE PLAN PART A (HOSPITAL)

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

Inpatient Hospital Benefits

- We pay the Medicare Part A Deductible for the first 60 days of Inpatient Hospital services each Benefit Period.
*
- We pay the Medicare Part A Co-payment for the 61st through the 90th day of Inpatient Hospital services each Benefit Period. *
- We pay the Medicare Part A Co-payment when the Member elects to use the lifetime reserve of 60 additional Inpatient Hospital days. *
- We pay up to the Reasonable Charge for the first three units of unreplaced whole blood, packaged red blood cells or any other blood derivative received during a covered Stay.

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

Skilled Nursing Facility Benefits

We pay the Medicare Part A Co-payment for the 21st through the 100th day of Skilled Nursing Facility care each Benefit Period.

Hospice Benefit

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

SUPPLEMENTAL SERVICES AND BENEFITS

BENEFITS TO SUPPLEMENT ORIGINAL MEDICARE PLAN PART B (MEDICAL)

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

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

Professional and Other Medical Services

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

Covered services are:

- Services of a Physician, including, but not limited to, chiropractic services and occupational therapist services when such services supplement benefits provided by Medicare.
- Services of an anesthesiologist or anesthesiologist (M.D. or C.R.N.A.).
- Services of a Physician during a covered Hospice Care Program.
- Services of a Home Health Agency while the Member is confined at home.
- Professional services of a licensed physical therapist.
- Outpatient diagnostic x-ray and laboratory services, including allergy testing.
- Radiation therapy, including use of x-ray, radium, cobalt and other radioactive substances.
- Medical supplies, rental or purchase of appliances and Durable Medical Equipment required for treatment of an illness or injury.
- Ambulance services of a licensed ambulance company for transportation to or from the nearest Participating Hospital or Skilled Nursing Facility.
- Outpatient blood and blood plasma beginning with the fourth unit during any one Year.
- Diabetes instruction programs.

SUPPLEMENTAL SERVICES AND BENEFITS

Outpatient Hospital Services

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

Covered services are:

- Hospital services for outpatient medical care.
- Hospital or Ambulatory Surgical Center services for outpatient surgical treatment.
- Radiation therapy, chemotherapy and hemodialysis treatment.

BENEFITS FOR SERVICES NOT COVERED BY ORIGINAL MEDICARE

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

INPATIENT HOSPITAL BENEFITS BEYOND ORIGINAL MEDICARE

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

Co-Payment

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

Maximum Benefit

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

Covered Services

- Accommodations in a room of two or more beds, or the prevailing charge for two-bed room accommodations in that Hospital if a private room is used. However, if the Member's Physician certifies that a private room is needed because of the Member's medical condition, private room accommodations are covered.
- Services in Special Care Units.
- Operating and special treatment rooms.
- Supplies and ancillary services including laboratory, cardiology, pathology, and radiology. Professional component fees for these services will be covered only if a separate charge for professional interpretation is determined by us to be Medically Necessary.
- Physical therapy, radiation therapy, chemotherapy and hemodialysis treatment.
- Drugs and medicines approved for general use by the federal Food and Drug Administration which are supplied by the Hospital for use during the Member's Stay.
- Blood transfusions, including the first three units of unreplaced blood, blood products or blood processing.

Conditions of Service

- Services must be those which are regularly provided and billed by a Hospital.
- Services are provided only for the number of days required to treat the Member's illness, injury or condition.

BENEFITS FOR SERVICES NOT COVERED BY ORIGINAL MEDICARE

- If a Member is hospitalized in California, payment for covered expense as stated above is provided only if care is received in a Contracting Hospital. If care is received in a Non-Contracting Hospital, we first deduct a penalty of twenty-five percent (25%) from the amount of the Hospital's charges we would otherwise consider to be covered expense. The Member is responsible for paying this penalty amount in addition to any amount in excess of covered expense. An exception to this penalty will be made for an Emergency. Call the PORAC member services toll-free number to locate a Contracting Hospital.
- If a Member is hospitalized outside California, the Contracting Hospital benefits described above are provided. The out-of-California Hospital can bill the local Blue Cross and/or Blue Shield Plan for claims processing and reimbursement through the BlueCard Program.
- Treatment of Mental Disorders is not covered.

SKILLED NURSING FACILITY BENEFITS BEYOND ORIGINAL MEDICARE

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

Co-Payment

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

Maximum Benefit

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

Covered Services

- Accommodations in a room of two or more beds, or the prevailing charge for two-bed room accommodations in that facility if a private room is used.
- Special treatment rooms.
- Laboratory exams.
- Physical, occupational, respiratory and speech therapy. Oxygen and other gas therapy.
- Drugs and medicines approved for general use by the federal Food and Drug Administration which are used in the facility.
- Blood transfusions, including the first three units of unreplaced blood.

BENEFITS FOR SERVICES NOT COVERED BY ORIGINAL MEDICARE

Conditions of Service

- The Member must be referred to the Skilled Nursing Facility by a Physician.
- Services must be those which are regularly provided and billed by a Skilled Nursing Facility.
- The services must be consistent with the illness, injury, degree of disability and medical needs of the Member. Benefits are provided only for the number of days required to treat the Member's illness or injury.
- The Member must remain under the active medical supervision of a Physician. The Physician must be treating the illness or injury for which the Member is confined in the Skilled Nursing Facility.
- In order to receive these Skilled Nursing Facility benefits, the Member must be admitted within fourteen (14) days following the date the Member was discharged from a Hospital Stay of three (3) or more days and be confined for the same illness, injury or condition. If the Member is readmitted to a Skilled Nursing Facility within fourteen (14) days of discharge from a previous Stay and care is required for the same illness, injury or condition for which the Member was previously confined, it is considered the same Benefit Period. These Skilled Nursing Facility benefits renew with each new Benefit Period.

SPECIAL DUTY NURSING SERVICES BENEFITS

Deductible and Co-Payment

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

Maximum Benefit

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

Conditions of Service

- Services must be provided by a registered nurse (R.N.) or a licensed vocational nurse (L.V.N.).
- Services must be provided while the Member is hospitalized as a registered bed patient in a Participating Hospital or Contracting Hospital.
- Special duty nursing services must be ordered by the Member's attending Physician (M.D. or D.O.).

BENEFITS FOR SERVICES NOT COVERED BY ORIGINAL MEDICARE

VISION CARE BENEFITS

Co-Payment

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

Maximum Benefits

We will pay 80% of covered expense for:

- one eye examination each Year;
- the initial set of frames and lenses up to a maximum payment of **\$40.00**; thereafter
- one set of lenses each Year up to a maximum payment of **\$20.00**, and one set of replacement frames up to a maximum payment of **\$20.00** when the correction is such that a new set of frames is required; or
- contact lenses, if provided at the Member's option, up to the combined total allowance for frames and lenses as specified above.

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

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

Covered Services and Supplies

- Normal eye examination for refractive error including refraction, examination of the inner eye, measurement of eye tension, routine testing for visual field and muscle balance. If a normal examination reveals the need, a complete visual field examination, including pupil dilation or muscle balance, will be allowed. A follow up visit for muscle balance will also be covered if Medically Necessary.
- When an eye examination indicates the need for a correction to insure proper visual health and welfare, frames and lenses or contact lenses.

BENEFITS FOR SERVICES NOT COVERED BY ORIGINAL MEDICARE

HEARING AID BENEFITS

Co-Payment

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

Maximum Benefits

We will pay 80% of covered expense for:

- one hearing aid per ear during any **36** month period. Benefits are further limited to a maximum payment of **\$450** for each hearing aid.
- examinations in conjunction with the purchase of a hearing aid, up to our maximum payment of **\$50** for each visit.

Covered Services and Supplies

- Hearing aids, including replacements, only when purchased as a result of a written recommendation by a Physician certified as either an otologist, an otolaryngologist or a state certified audiologist.
- Audiological evaluations and audio-metric examinations to measure the extent of hearing loss and determine the most appropriate make and model of hearing aid.

MAJOR MEDICAL BENEFITS

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

MAJOR MEDICAL BENEFITS DEDUCTIBLE

- Each Member must initially meet a Major Medical Benefits deductible amount of **\$100.00** for covered expense incurred during any Year. Any billed amount exceeding a Customary and Reasonable Charge or Reasonable Charge is not applied toward the Major Medical Benefits deductible. Enrolled Members of a family must meet a total of \$200.00 in Major Medical Benefits deductible during any Year (not to exceed \$100 for one Member). Once that amount has been reached, no further Major Medical Benefits deductible is required for all Members of that family for the rest of that Year. Any amounts applied toward the Major Medical Benefits deductible as well as those in excess of covered expense will be the Member's responsibility to pay.
- Covered expense incurred during the last quarter of a Year (i.e., the months of October, November and December) and applied toward the Major Medical Benefits deductible for that Year is also applied toward the Major Medical Benefits deductible for the next following Year.
- For a Member who enrolls under the Agreement during the last quarter of a Year, any covered expense incurred by that Member which was applied toward a prior carrier's deductible during the last quarter of that same Year is also applied toward that Member's Major Medical Benefits deductible under this plan for the next following Year.

MAJOR MEDICAL BENEFITS CO-PAYMENTS

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

First Level of Co-Payments*

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

- fifty percent (50%) of the covered expense the Member incurs for outpatient psychotherapy and psychological testing, including outpatient biofeedback procedures for treatment of a Mental Disorder.
- twenty percent (20%) of the covered expense the Member incurs for all services and supplies other than outpatient psychotherapy and psychological testing.

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

MAJOR MEDICAL BENEFITS

Second Level of Co-Payments*

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

- fifty percent (50%) of the covered expense that Member incurs for outpatient psychotherapy and psychological testing, including outpatient biofeedback procedures for treatment of a Mental Disorder.
- no co-payment for covered expense that Member incurs for all services and supplies other than outpatient psychotherapy and psychological testing.

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

MAJOR MEDICAL BENEFITS MAXIMUMS

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

- Benefits paid for Inpatient or outpatient Physician's visits covered under **Mental Disorders** are limited as follows:
 1. outpatient psychotherapy and psychological testing are limited to a plan maximum payment of **\$20.00** for each visit.
 2. Inpatient Physician visits are limited to a plan maximum payment of **\$40.00** for each visit.
- Benefits paid for services covered under **Speech Therapy** are limited to a plan maximum payment of **\$5,000.00** during each Member's lifetime.

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

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

MAJOR MEDICAL BENEFITS

MAJOR MEDICAL BENEFITS COVERED SERVICES AND SUPPLIES

Hospital

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

Professional Services

- Services of a Physician. Acupuncture and chiropractic services are included. Education for pediatric asthma, including education to enable the child to properly use nebulizers, inhaler spacers and peak flow meters, is covered under the plan's benefit for office visits to a Physician.
- Services of an anesthesiologist or anesthesiologist (M.D. or C.R.N.A.).
- Services of a registered nurse (R.N.) or a licensed vocational nurse (L.V.N.).

Additional Services and Supplies

- The following ambulance services:
 1. Base charge, mileage and non-reusable supplies of a licensed ambulance company for ground service to transport a Member to and from a Hospital.
 2. Emergency services or transportation services that are provided to the Member by a licensed ambulance company as a result of a "911" emergency response system* request for assistance if the Member believes he or she has an Emergency medical condition requiring such assistance.
 3. Base charge, mileage and non-reusable supplies of a licensed air ambulance company to transport the Member from the area where the Member is first disabled to the nearest Hospital where appropriate treatment is provided if, and only if, such services are Medically Necessary, as determined by us, and ground ambulance service is inadequate.
 4. Monitoring, electrocardiogram (EKG or EEG), cardiac defibrillation, cardiopulmonary resuscitation (CPR) and administration of oxygen and intravenous (IV) solutions in connection with ambulance service. An appropriately licensed person must render the services.

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

- Outpatient diagnostic radiology and laboratory services, including allergy testing.
- Radiation therapy, chemotherapy and hemodialysis treatment.
- Surgical implants.
- Artificial limbs or eyes. This includes services of an orthotist and prosthetist in connection with evaluation or fitting of an orthotic or prosthetic device when services are billed as part of the charge for the artificial limbs or eyes.

MAJOR MEDICAL BENEFITS

- Rental or purchase of dialysis equipment. Dialysis supplies. Therapeutic shoes and inserts for the prevention and treatment of diabetes-related foot complications. Nebulizers, including face masks and tubing, when required for the Medically Necessary treatment of pediatric asthma. Rental or purchase of other Durable Medical Equipment and supplies which are:
 1. Ordered by a Physician, and
 2. Of no further use when medical need ends (but not disposable), and
 3. Usable only by the patient, and
 4. Not primarily for the Member's comfort or hygiene, and
 5. Not for environmental control, and
 6. Not for exercise, and
 7. Manufactured specifically for medical use.

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

- Routine and diagnostic mammograms, mastectomy and lymph node dissection, complications from a mastectomy including lymphedema, reconstructive surgery performed to restore and achieve symmetry following a Medically Necessary mastectomy, and breast prostheses following mastectomy.
- Contraceptive services and supplies, limited to injectable Drugs and implants for birth control administered in a Physician's office if Medically Necessary. IUDs and diaphragms dispensed by a Physician, and the services of a Physician in connection with the prescribing, fitting, and insertion of intrauterine contraceptive devices or diaphragms.
- Diabetes instruction program which: (1) is designed to teach a Member who is a patient and covered Members of the patient's family about the disease process and the daily management of diabetic therapy; (2) includes self-management training, education, and medical nutrition therapy to enable the Member to properly use the equipment, supplies, and medications necessary to manage the disease; and (3) is supervised by a Physician.
- Blood transfusions, including blood processing and the cost of unreplaced blood and blood products.
- Biofeedback for treatment of a condition other than a Mental Disorder. Benefits for biofeedback for treatment of a Mental Disorder are provided under **Mental Disorders**.

Dental Injury

Benefits are payable at the levels of payment shown under **CO-PAYMENTS** for services of a Physician (M.D.) or dentist (D.D.S. or D.M.D.) solely to treat an Accidental Injury to natural teeth. Coverage shall be limited to only such services that are Medically Necessary to repair the damage done by Accidental Injury and /or restore function lost as a direct result of the Accidental Injury. Damage to natural teeth due to chewing or biting is not Accidental Injury.

MAJOR MEDICAL BENEFITS

Important: If you decide to receive dental services that are not covered under this plan, a dentist may charge you his or her usual and customary rate for those services. Prior to providing you with dental services that are not a covered benefit, the dentist should provide a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about the dental services that are covered under this plan, please call the 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.

Mental Disorders

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

- Services and supplies, including biofeedback procedures furnished by a Hospital and a Physician for treatment of Mental Disorders while confined in a Hospital as a registered bed patient. Charges of a Hospital for room and board in excess of the semi-private (two-bed) room rate will not be considered covered expense. Benefits for Inpatient Physician visits are limited to a plan maximum payment of **\$40.00** for each visit.
- Psychiatric services of a Physician and biofeedback procedures for treatment of Mental Disorders while not confined in a Hospital as a registered bed patient. Benefits for outpatient psychotherapy and psychological testing are limited to a plan maximum payment of **\$20.00** for each visit. Such treatment shall be limited to conditions which are subject to significant improvement through acute short term treatment.

Speech Therapy

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

Home Infusion Therapy

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

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

MAJOR MEDICAL BENEFITS

SPECIAL BENEFIT INFORMATION

- The benefits of this Evidence of Coverage are provided for pregnancy, maternity care, abortion and sterilizations.
- All benefits provided elsewhere in this Evidence of Coverage are provided for an organ transplant if:
 1. The transplant is of a cornea, kidney or bone marrow; and
 2. The recipient of such transplant is a Member.

HOSPITAL – MEDICAL BENEFITS OUTSIDE OF THE UNITED STATES

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

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

PLAN EXCLUSIONS AND LIMITATIONS

GENERAL EXCLUSIONS AND LIMITATIONS

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

Benefits of this Plan are not provided for or in connection with the following items. (The titles given to these exclusions and limitations are for ease of reference only; they are not meant to be an integral part of the exclusions and limitations and do not modify their meaning.)

1. **After Coverage Ends.** Services received after the Member's coverage ends, except as specifically stated under TERMINAL BENEFITS.
2. **Before Coverage Begins.** Services received before the Member's Effective Date, or during a continuous period of hospitalization which began before the Member's Effective Date. However, in the case of a person covered under this plan by reason of transfer from another CalPERS plan, the exclusion for hospitalization beginning prior to the Member's Effective Date shall apply only during the first 90 days of enrollment under this plan unless the prior carrier provides coverage for the condition causing the Hospital confinement beyond the 90th day following the Member's Effective Date under this plan.
3. **Cosmetic Services.** Cosmetic surgery or other services performed to alter or reshape normal (including aged) structures or tissues of the body to improve appearance.
4. **Custodial Care or Rest Cures.** Inpatient room and board charges in connection with a Hospital Stay primarily for environmental change, physical therapy or treatment of chronic pain, except when such services supplement benefits under Original Medicare. Custodial Care or rest cures, except as specifically stated in Home Infusion Therapy under MAJOR MEDICAL BENEFITS. Services provided by a rest home, a home for the aged, a nursing home or any similar facility. Services provided by a Skilled Nursing Facility, except as specifically stated in Skilled Nursing Facility Benefits under SUPPLEMENTAL SERVICES AND BENEFITS.
5. **Dental Services or Supplies.** Cosmetic dental surgery or other dental services for beautification. Dental plates, bridges, crowns, caps or other dental prostheses, dental implants, dental services, extraction of teeth or treatment to the teeth or gums, except for surgery of the jaw or related structures, setting fractures of the jaw or facial bones, or services that would be covered when provided by a Physician.

This exclusion also does not apply to general anesthesia and associated facility charges when your clinical status or underlying medical condition requires that dental procedures be rendered in a Hospital or ambulatory surgical center. This applies only if you are developmentally disabled or your health is compromised and general anesthesia is Medically Necessary. Charges for the dental procedure itself, including professional fees of a dentist, are not covered.

PLAN EXCLUSIONS AND LIMITATIONS

6. **Diagnostic Hospital Stays.** Inpatient room and board charges in connection with a Hospital Stay primarily for diagnostic tests which could have been performed safely on an outpatient basis, except when such services supplement benefits under Original Medicare.
7. **Excess Amounts.** Any amounts in excess of:
 - Allowable Charges as determined by Medicare, for benefits provided under the sections entitled BENEFITS TO SUPPLEMENT ORIGINAL MEDICARE PLAN PART A (HOSPITAL) and BENEFITS TO SUPPLEMENT ORIGINAL MEDICARE PLAN PART B (MEDICAL) ; and
 - The negotiated rate, for professional Part B services of a participating provider who does not accept Medicare assignment; and
 - Reasonable Charges, as we determine, for benefits provided under the sections entitled INPATIENT HOSPITAL BENEFITS BEYOND ORIGINAL MEDICARE and HOSPITAL – MEDICAL BENEFITS OUTSIDE OF THE UNITED STATES; and
 - Any maximums for all covered services as stated in the provision MAJOR MEDICAL BENEFITS MAXIMUMS.
8. **Experimental or Investigational.** Experimental or Investigational procedures or medications. But, if you are denied benefits because it is determined that the requested treatment is Experimental or Investigative, you may request an independent medical review as described in YOUR RIGHT TO APPEALS.
9. **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.
10. **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.
11. **Government Services.** Any services actually given to you by a local, state or federal government agency, or by a public school system or school district, except when payment under this plan is expressly required by federal or state law. This limitation does not apply to services provided by Medi-Cal. Services provided by VA Hospitals and military treatment facilities will be considered for payment according to current legislation. The plan will not cover payment for these services if you are not required to pay for them or they are given to you for free.

PLAN EXCLUSIONS AND LIMITATIONS

12. **Hearing Aids or Tests.** Hearing aids or routine hearing tests, except as specifically stated under the section entitled BENEFITS FOR SERVICES NOT COVERED BY ORIGINAL MEDICARE.
13. **Learning Disorders.** Hyperkinetic syndromes and/or attention deficit disorders, learning disabilities, behavior problems, mental retardation or autistic disease of childhood.
14. **Medicare Services.** We will not provide the benefits under this plan that duplicate any benefits to which a Member would be entitled under Medicare.
15. **Mental Disorders or Chemical Dependency.** Services for conditions attributable to a Mental Disorder, except as specifically stated under SUPPLEMENTAL SERVICES AND BENEFITS and MAJOR MEDICAL BENEFITS or except when services for such conditions supplement benefits under Original Medicare. Chemical dependency, except when services for these conditions supplement benefits under Original Medicare.
16. **Nicotine or Caffeine Addiction.** Services for smoking cessation or reduction, nicotine use or addiction; caffeine addiction.
17. **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.
18. **Not Medically Necessary.** Services or supplies that are not Medically Necessary as defined.
19. **Organ Transplants.** Any charges made in connection with an organ transplant, except that this exclusion shall not apply when:
 - a. the transplant is of a cornea, kidney or bone marrow, and
 - b. The recipient of such transplant is a Member.
20. **Orthodontic Care.** Braces, other orthodontic appliances or orthodontic services.
21. **Outpatient Prescription Drugs and Medications.** Outpatient Prescription Drugs or medications, insulin, and niacin for lowering cholesterol, except as specifically stated in the Home Infusion Therapy provision under MAJOR MEDICAL BENEFITS. Non-prescription, over-the-counter patent or proprietary drugs or medicines. Cosmetics, dietary supplements, health or beauty aids.
22. **Outpatient Speech Therapy.** Outpatient speech therapy, except as specifically stated under MAJOR MEDICAL BENEFITS.
23. **Outside United States.** Services and benefits rendered outside the United States and its territories, except as provided under HOSPITAL - MEDICAL BENEFITS OUTSIDE OF THE UNITED STATES.
24. **Personal Items and Services.** Air purifiers, air conditioners, humidifiers, exercise equipment and supplies for comfort, hygiene or beautification. Educational services, nutritional counseling or food supplements. Consultations provided by telephone or facsimile machine.
25. **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.

PLAN EXCLUSIONS AND LIMITATIONS

26. **Refractive Eye Surgery.** Any eye surgery solely for the purpose of correcting refractive defects of the eye such as near-sightedness (myopia) or astigmatism.
27. **Relatives.** Professional services received from a person who lives in the Member's home or who is related to the Member by blood or marriage, except as specifically stated in Home Infusion Therapy under MAJOR MEDICAL BENEFITS.
28. **Routine Exams or Tests.** Routine physical exams or tests which do not directly treat an actual illness, injury or condition, including those required by employment or government authority.
29. **Services Not Covered By Medicare.** Services not covered by Medicare unless specifically listed as benefits in this Evidence of Coverage.
30. **Speech Disorders.** Services primarily for correction of speech disorders, including but not limited to stuttering or stammering.
31. **Sterilization Reversal and Artificial Insemination.** Sterilization reversal. Artificial insemination, in vitro fertilization and gamete intrafallopian transfer including any medical or surgical treatment performed in connection with such procedures. Prescription Drugs for the purpose of birth control. Contraceptive devices, except as specifically stated under MAJOR MEDICAL BENEFITS.
32. **Vision Services or Supplies.** Optometric services, eye exercises including orthoptics, routine eye exams and routine eye refractions, except as specifically stated in Vision Care Benefits under BENEFITS FOR SERVICES NOT COVERED BY ORIGINAL MEDICARE. Eyeglasses or contact lenses, except as specifically stated in Vision Care Benefits under BENEFITS FOR SERVICES NOT COVERED BY ORIGINAL MEDICARE.
33. **Waived Cost-Shares Non-Participating Provider.** For any service for which you are responsible under the terms of this plan to pay a co-payment or deductible, and the co-payment or deductible is waived by a Non-Participating Plan Provider.
34. **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.

PLAN EXCLUSIONS AND LIMITATIONS

COORDINATION OF BENEFITS

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

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:

PLAN EXCLUSIONS AND LIMITATIONS

- 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.

PLAN EXCLUSIONS AND LIMITATIONS

- 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.

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, 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 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 and the IBT of PORAC in protecting the lien rights of the Plan against any recovery from the third party; 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.

PLAN EXCLUSIONS AND LIMITATIONS

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 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 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.

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 this 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.

MEDICARE NON-DUPLICATION OF BENEFITS

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

CONTINUATION OF GROUP COVERAGE (COBRA)

A. Eligibility for Continuation - Qualifying Events

Under the Act and Regulations, all CalPERS employers are subject to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Under COBRA, Subscribers or Family Members may choose to continue coverage under the 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.

B. Requirements for Continuation

1. Notice

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

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

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

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

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

CONTINUATION OF GROUP COVERAGE (COBRA)

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

2. Family Members Acquired During Continuation

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

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

3. Cost of Coverage

The benefits of continuation coverage are identical to the benefits in this Evidence of Coverage. The cost for this continuation coverage, called the "subscription charge", must be paid each month during the COBRA continuation period to keep the continuation coverage in force. The subscription charge for continuation coverage may not exceed 102 percent of the prepayment fees specified for coverage under the 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 subscription charge for continuation coverage not later than the following dates:

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

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

CONTINUATION OF GROUP COVERAGE (COBRA)

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 subscription charge prior to the disability. The COBRA Administrator must receive timely payment of the subscription charge each month in order to maintain the coverage in force.

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

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

4. Subsequent Qualifying Events

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

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

5. When Continuation Coverage Begins

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

C. When The Continuation Ends

This continuation will end on the earliest of:

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

CONTINUATION OF GROUP COVERAGE (COBRA)

Exception: A qualified beneficiary whose coverage is continued may extend that continuation coverage for up to an additional 11 months, provided that the disabled Member has been determined by the Social Security Administration to be totally and permanently disabled according to the statutory requirements of either Title II or Title XVI of the Social Security Act. The extension applies to all covered Members as well as the disabled Member. The disabled Member must furnish proof of the Social Security Administration's determination to his/her Employer during the first 18 months of COBRA continuation, but no later than 60 days after the later of the following events:

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

The period of continuation will in no event continue beyond (1) the period of disability, or (2) a maximum of 29 months after the date the Subscriber's coverage terminated due to the loss of employment, whichever occurs first.

2. The end of 36 months from the date the Member's coverage terminates, if the qualifying event was the death of the Subscriber; divorce, legal separation, the Spouse vacates the residence shared with the Subscriber; or the end of dependent child status. For a Member whose continuation coverage began under a prior plan, this term will be dated from the time the Member's coverage terminated under that prior plan due to the qualifying event.
3. The date the Plan terminates.
4. The end of the last period for which the final subscription charge was paid.
5. The date after the date of election of COBRA, the Member first becomes eligible for Medicare.
6. The date after the date of election of COBRA, the Member first becomes covered under any other group health plan, except that if the Member's coverage under a group health plan contains any exclusion or limitation relating to a pre-existing condition, the Member's coverage will remain effective until the exclusions or limitations of the group health plan for pre-existing conditions no longer apply to the Member.

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

Subject to the 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 3, 4 or 6 above.

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

GENERAL PROVISIONS

Identification Cards

In addition to the card issued to the Subscriber and/or Family Member by Medicare, 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 this plan. To be entitled to services or benefits, the holder of the card must, in fact, be a Member on whose behalf applicable prepayment fees under the Agreement have actually been paid. Any person receiving services or other benefits to which he or she is not then entitled pursuant to the provisions of the Agreement is chargeable therefor at prevailing rates.

Medical Necessity

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

Expense in Excess of Benefits

We are not liable for any expense you incur in excess of the benefits of this Plan.

Payment to Providers

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

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.

Provider Reimbursement

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

GENERAL PROVISIONS

Claims Procedures

Unless utilizing the Claim-Free Service, properly completed claim forms, the provider's bill and a copy of the Medicare EOMB (if applicable) itemizing the services received and the charges must be sent to PORAC by the Member or the provider of service. These claim forms must be received by PORAC within 24 months of the date services are received. 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.

Claim-Free Service

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

Right of Recovery

When the amount paid by us exceeds the amount for which is liable under this Plan, we have the right to recover the excess amount. This amount may be recovered from the Member, the person to whom payment was made or any other plan.

Free Choice of Hospital and Physician

The Plan in no way interferes with the right of any Member entitled to Hospital benefits to select the 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, benefits payable according to the terms of this Plan will be different for non-participating providers than those benefits payable for participating providers.

Workers' Compensation Insurance

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

Providing of Care

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

Right to Receive Benefit

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

GENERAL PROVISIONS

Non-Regulation of Providers

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

Services Non-Transferable

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

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.

Warranty of Information Provided

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

Member Cooperation

By virtue of the agreement with CalPERS, Members agree to: (a) take action, furnish help and information, and execute instruments required to enforce 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 its rights.

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

Protection of Coverage

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

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

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.

GENERAL PROVISIONS

Confidentiality and Release of Medical Information

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

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

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

Legal Actions. No attempt to recover on the Plan through legal or equity action may be made until at least 60 days after the written proof of loss has been furnished as required by this Plan. No such action may be started later than three years from the time written proof of loss is required to be furnished.

HOW TO SUBMIT CLAIMS

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

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

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

1-800-655-6397

Claim-Free Service

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

HOSPITAL BENEFITS (ORIGINAL MEDICARE PART A BENEFITS)

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

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

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

HOW TO SUBMIT CLAIMS

MEDICAL BENEFITS (ORIGINAL MEDICARE PART B BENEFITS)

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

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

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

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

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

Cancelled checks or receipts are not acceptable.

VISION BENEFITS AND HEARING AID BENEFITS

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

SERVICES RECEIVED OUTSIDE THE UNITED STATES

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

GENERAL INFORMATION

Enrollment Information

Information pertaining to eligibility, enrollment, cancellation or termination of insurance, etc., is found in the informational pamphlet entitled *CalPERS Health Program Guide*. This pamphlet is prepared by CalPERS in Sacramento, California. You may request a copy of this pamphlet online by visiting the CalPERS web site at www.calpers.ca.gov or by calling CalPERS at **888 CalPERS** (or **888-225-7377**).

Remember, it is your responsibility to stay informed about your health plan coverage. If you have any questions, consult your Health Benefits Officer in your agency or the retirement system from which you receive your allowance, or write to CalPERS 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

Information Practices

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

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

Information and Assistance With Medicare

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

- Visit your local Social Security Administration Office or call 1-800-772-1213.
- Medicare at 1-800-MEDICARE (1-800-633-4227) or access the Medicare web site at www.medicare.gov.
- Health Insurance Counseling and Advocacy Program (HICAP) which offers health insurance counseling for California seniors: 1-800-434-0222.

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 mandatory first and second level of appeal. The second level of appeal 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:

Anthem Blue Cross Life and Health Insurance Company
ATTN: Appeals
P.O. Box 4310, Woodland Hills, CA 91365-4310

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:

- was relied on in making the benefit determination; or

YOUR RIGHT TO APPEALS

- 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 the 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. The 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

Second Level Appeals

If you are dissatisfied with the Plan's mandatory first level appeal decision, a second level appeal may be available. If you would like to initiate a second level appeal, please write to the address listed above. Appeals must be submitted within 60 calendar days of the denial of the first level appeal. You are not required to complete a 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 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:

Anthem Blue Cross Life and Health Insurance Company
ATTN: Appeals
P.O. Box 4310, Woodland Hills, CA 91365-4310

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

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

YOUR RIGHT TO APPEALS

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 before requesting Binding Arbitration from IBT of PORAC

You must exhaust the Claims and Appeals Procedure set out above, 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 and IBT of PORAC reserve 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 first. If you have exhausted the claims and appeals procedures for coverage and/or benefits 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.

FOR YOUR INFORMATION

TRIAGE OR SCREENING SERVICES

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

AFTER HOURS CARE

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

ORGAN DONATION

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

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

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

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

www.donatelifecalifornia.org/

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



Get help in your language

Language Assistance Services

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

IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call right away at 1-888-254-2721. (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 customer service telephone number on the back of your ID card.

Spanish

IMPORTANTE: ¿Puede leer esta carta? De lo contrario, podemos hacer que alguien lo ayude a leerla. También puede recibir esta carta escrita en su idioma. Para obtener ayuda gratuita, llame de inmediato al 1-888-254-2721. (TTY/TDD: 711)

Arabic

مهم: هل يمكنك قراءة هذه الرسالة؟ إذا لم تستطع، فيمكننا السّعة بشخص ما ليساعدك على قراءتها. كما يمكنك أي الحصول على المساعدة المجانية، يرجى الاتصال فوراً بالرقم (1-888-254-2721) TTY/TDD:711.

Armenian

ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Կարողանո՞ւմ եք ընթերցել այս նամակը: Եթե ոչ, մենք կարող ենք տրամադրել ինչ-որ մեկին, ով կօգնի Ձեզ՝ կարդալ այն: Կարող ենք նաև այս նամակը Ձեզ գրավոր տարբերակով տրամադրել: Անվճար օգնություն ստանալու համար կարող եք անհապաղ զանգահարել 1-888-254-2721 հեռախոսահամարով: (TTY/TDD: 711)

Chinese

重要事項: 您能看懂這封信函嗎? 如果您看不懂, 我們能夠找人協助您。您有可能可以獲得以您的語言而寫的本信函。如需免費協助, 請立即撥打1-888-254-2721。(TTY/TDD: 711)

Farsi

مهم: آیا میتوانید این نامه را بخوانید؟ اگر نمیتوانید، میتوانیم شخصی را به شما معرفی کنیم تا در خواندن این نامه شما را کمک کند. همچنین میتوانید این نامه را به صورت مکتوب به زبان خودتان دریافت کنید. برای دریافت کمک رایگان، همین حال با شماره

(TTY/TDD:711) 1-888-254-2721 تماس بگیرید.

Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association.

Hindi

सहायता : क्या आप यह पत्र पढ़ सकते हैं? अगर नहीं, तो हम आपको इसे में मदद करने के लिए ककसी को उपिब्ध करा सकते हैं। आप यह पत्र अपनी भाषा में भी सक्षम हो सकते हैं। ननिशुल्क मदद के लिए, कृपया 1-888-254-2721 पर तुरंत कॉल करें। (TTY/TDD: 711)

Hmong

TSEEM CEEB: Koj puas muaj peev xwm nyeem tau daim ntawv no? Yog hais tias koj nyeem tsis tau, peb muaj peev xwm cia lwm tus pab nyeem rau koj mloog. Tsis tas li ntawd tej zaum koj kuj tseem yuav tau txais daim ntawv no sau ua koj hom lus thiab. Txog rau kev pab dawb, thov hu tam sim no rau tus xov tooj 1-888-254-2721. (TTY/TDD: 711)

Japanese

重要: この書簡を読めますか? もし読めない場合には、内容を理解するための支援を受けることができます。また、この書簡を希望する言語で書いたものを入手することもできます。次の番号にいますぐ電話して、無料支援を受けてください。1-888-254-2721 (TTY/TDD: 711)

Khmer

សំខាន់៖ តើ អ្នកអាចអានលិខិតបាន រឺ ទេ? តើ មិនអាចើត តើ ឯអាចឲ្យនរណា ឃើញ ក្នុងអំឡុងពេល នេះ អ្នក អាច រឺ លល ិខិតតើ ើ លោសតសរសេរភាសាសំខ្មែរ ក្នុងភាសា ខ្មែរ ឬ រឺ លល ត្រឹមត្រូវ លើ រសំព ្រឹម ។ ម្យ៉ាងទៀតលេខ 1-888-254-2721។ (TTY/TDD: 711)

Korean

중요: 이 서신을 읽으실 수 있으십니까? 읽으실 수 없을 경우 도움을 드릴 사람이 있습니다. 귀하가 사용하는 언어로 쓰여진 서신을 받으실 수도 있습니다. 무료 도움을 받으시려면 즉시 1-888-254-2721로 전화하십시오. (TTY/TDD: 711)

Punjabi

ਮਹੱਤਵਪੂਰਨ: ਕੀ ਤੁਸੀਂ ਇਹ ਪੱਤਰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇ ਨਹੀਂ, ਤਾਂ ਅਸੀਂ ਇਸ ਨੂੰ ਪੜ੍ਹਨ ਵੱਚ ਤੁਹਾਡੀ ਮਦਦ ਲਈ ਵਕਸੇ ਨੂੰ ਬੁਲਾ ਸਕਦੇ ਹਾਂ। ਤੁਸੀਂ ਇਹ ਪੱਤਰ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਵਲਵਲਾ ਰੋਇਆ ਵਧੀ ਪਰ ਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਮੁਫਤ ਮਦਦ ਲਈ, ਵਕਰਪ ਕਰਕੇ ਫੌਰਨ 1-888-254-2721 ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD: 711)

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Russian

ВАЖНО. Можете ли вы прочитать данное письмо? Если нет, наш специалист поможет вам в этом. Вы также можете получить данное письмо на вашем языке. Для получения бесплатной помощи звоните по номеру 1-888-254-2721. (TTY/TDD: 711)

Tagalog

MAHALAGA: Nababasa ba ninyo ang liham na ito? Kung hindi, may taong maaaring tumulong sa inyo sa pagbasa nito. Maaari ninyo ring makuha ang liham na ito nang nakasulat sa ginagamit ninyong wika. Para sa libreng tulong, mangyaring tumawag kaagad sa 1-888-254-2721. (TTY/TDD: 711)

Thai

หมายเหตุสาค : ทานสามารถอ่านจดหมายฉบับนี้หรือไม่ หากทานไม่สามารถอ่านจดหมายฉบับนี้
เราสามารถจัดหาเจ้าหน้าที่ช่วยเหลือได้ ทานย อาจให้เจ้าหน้าที่ช่วยเหลือในภาษาของท่าน นอก ด้วย
เจ้าหน้าที่

หากต้องการความช่วยเหลือโดยไม่ ค่าใช้จ่าย โปรดโทรติดต่อหมายเลข 1-888-254-2721 (TTY/TDD: 711)

Vietnamese

QUAN TRỌNG: Quý vị có thể đọc thư này hay không? Nếu không, chúng tôi có thể bố trí người giúp quý vị đọc thư này. Quý vị cũng có thể nhận thư này bằng ngôn ngữ của quý vị. Để được giúp đỡ miễn phí, vui lòng gọi ngay số 1-888-254-2721. (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:

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