Combined Evidence of Coverage and Disclosure Form

Effective January 1, 2026

Insurance and Benefits Trust of PORAC
Basic Prudent Buyer Universal Plan

Preferred Provider Organization (PPO)

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

COMBINED EVIDENCE OF COVERAGE
AND DISCLOSURE FORM

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

Many words used in this booklet are explained in the "Definitions" section starting on page 123. When reading through this booklet, check that section to be sure that you understand what these words mean. Each time these words are used they are capitalized.

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

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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Benefit Changes

- No benefit changes have been made to your Plan, which is the INSURANCE OF BENEFITS TRUST OF PORAC PRUDENT BUYER UNIVERSAL PLAN.

Eligibility/Enrollment Requirements

To be eligible as an Active Employee for this Plan you must satisfy all the eligible criteria:

1. You must be a member of the Peace Officers Research Association of California;
2. Payment of your Active Employee Contribution/Premium must have been made in a timely manner set by the IBT of PORAC. (See section entitled "ENROLLMENT PROVISIONS" on page 94); and
3. Not eligible for a CalPERS medical plan.

To be eligible as a Retired Employee for this Plan you must satisfy all the eligible criteria:

1. You must be a Retired Associate Member or a member of the Peace Officers Research Association of California;
2. Payment of your Retired Employee Contribution/Premium must have been made in a timely manner set by the IBT of PORAC. (See section entitled "ENROLLMENT PROVISIONS" on page 94); and
3. Not eligible for a CalPERS medical plan.

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

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

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

PRUDENT BUYER PLAN
SUMMARY OF BENEFITS: INTRODUCTION

The benefits described under the INSURANCE OF BENEFITS TRUST OF PORAC PRUDENT BUYER UNIVERSAL PLAN ("Plan")-SUMMARY OF BENEFITS are provided for covered charges incurred for treatment of a covered illness, injury or condition. A charge 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.

THE BENEFITS OF THIS PLAN ARE PROVIDED ONLY FOR THOSE SERVICES THAT ARE CONSIDERED MEDICALLY NECESSARY AS DEFINED IN THIS EVIDENCE OF COVERAGE. THE FACT THAT A PHYSICIAN PRESCRIBES OR ORDERS A SERVICE DOES NOT, IN ITSELF, MEAN THAT THE SERVICE IS MEDICALLY NECESSARY OR THAT THE SERVICE IS COVERED. CONSULT THIS BOOKLET OR TELEPHONE USING THE NUMBER SHOWN ON YOUR IDENTIFICATION CARD IF YOU HAVE ANY QUESTIONS REGARDING WHETHER SERVICES ARE COVERED.

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

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

Mental Health Parity and Addiction Equity Act. The Mental Health Parity and Addiction Equity Act provides for parity in the application of aggregate treatment limitations (day or visit limits) on mental health and substance abuse benefits with day or visit limits on medical and surgical benefits. In general, group health plans offering mental health and substance abuse benefits cannot set day/visit limits on mental health or substance abuse benefits that are lower than any such day or visit limits for medical and surgical benefits. A plan that does not impose day or visit limits on medical and surgical benefits may not impose such day or visit limits on mental health and substance abuse benefits offered under the Plan.

The Mental Health Parity and Addiction Equity Act also provides for parity in the application of nonquantitative treatment limitations (NQTL). An example of a nonquantitative treatment limitation is a precertification requirement.

Also, the plan may not impose Deductibles, Copayment, Coinsurance, and out of pocket expenses on mental health and substance abuse benefits that are more restrictive than Deductibles, Copayment, Coinsurance and out of pocket expenses applicable to other medical and surgical benefits.

Medical Necessity criteria and other plan documents showing comparative criteria, as well as the processes, strategies, evidentiary standards, and other factors used to apply an NQTL are available upon request.

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 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 Nurse Line 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.

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

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

Important Note About Maximum Allowed Amount And Your Co-Payment: The Maximum Allowed Amount for Non-Prudent Buyer Plan Providers can be significantly lower than what the provider customarily charges. (Detailed information on how benefits are determined is found under DETERMINATION OF THE MAXIMUM ALLOWED AMOUNT.) You must pay all of this excess amount in addition to your Co-Payment.

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

PORAC PRUDENT BUYER PLAN: SUMMARY OF BENEFITS

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED.

This SUMMARY OF BENEFITS section is provided as a brief summary of the benefits provided under this plan. You need to refer to this entire Evidence of Coverage booklet for complete information about the benefits, conditions, limitations and exclusions of your plan.

CALENDAR YEAR DEDUCTIBLE	Prudent Buyer Plan Providers & Related Health Providers	Non-Prudent Buyer Plan Providers
Individual	$300	$600
Family	$900	$1,800

Type of Services	**Description of Services**	**What You Pay**	
		Prudent Buyer Plan Providers	Non-Prudent Buyer Plan Providers*
Hospital Services Inpatient	Semi-private room/board, special care units and all medically necessary ancillary services and supplies	20%	20%*
Hospital Services Outpatient	Surgical room fee, radiation and chemotherapy treatment and renal dialysis	20%	20%*
	Non-emergency use of the emergency room	50%	50%*
Physician Care	Office visits	$10 Co-Pay for a Prudent Buyer Plan provider who is not a Specialist $35 Co-Pay for a Prudent Buyer Plan provider who is a Specialist (No deductible) Note: This Co-Pay applies to the charge for the Physician visit only.	20%*
	Home and hospital visits obstetrical care surgery	20%	20%*
	Allergy testing, serum injections and medication dispensed or administered by a Physician	20%	20%*

*The Member's payment for **Non-Prudent Buyer Plan Provider** services is based on a **strictly limited schedule of allowances**, and Members must pay charges in excess of those scheduled amounts. Please refer to the section entitled DETERMINATION OF THE MAXIMUM ALLOWED AMOUNT beginning on page 20 for complete benefit information.

PORAC PRUDENT BUYER PLAN: SUMMARY OF BENEFITS

Type of Services	Description of Services	What You Pay	
		Prudent Buyer Plan Providers	Non-Prudent Buyer Plan Providers*
Physician Care	Preventive Care Services	No charge (No deductible)	No charge* (No deductible)
	Body Scan (for Subscriber only) up to the Maximum Allowed Amount for all services provided by Body Scan International (BSI), as long as BSI remains a Prudent Buyer Plan Provider limited to one scan every 36 months	No charge (No deductible) (as long as BSI is used)	Not Covered
	Home and hospital visits obstetrical care surgery	$35 Co-Pay	20%*
Maternity Services	Room and board, delivery room special care units, nursery care	20%	20%*
	Alternative birth center	20%	20%*
	Certified nurse midwife services	20%	20%*
Family Planning	Voluntary sterilization	20%	20%*
Infertility Services	Infertility studies and treatment, up to a $5,000 lifetime maximum payment	50%	50%*
Diagnostic Radiology & Laboratory Services	Outpatient X-ray & lab services	20%	20%*
Advanced Imaging Procedures	Advanced imaging procedures	20%	20%*
Acupuncture/Chiropractic	20 visit limit apples to any combination of these services per calendar year		20%*
	Acupuncture, Chiropractic	20%	20%*

*The Member's payment for **Non-Prudent Buyer Plan Provider** services is based on a **strictly limited schedule of allowances**, and Members must pay charges in excess of those scheduled amounts. Please refer to the section entitled DETERMINATION OF THE MAXIMUM ALLOWED AMOUNT beginning on page 20 for complete benefit information.

PORAC PRUDENT BUYER PLAN: SUMMARY OF BENEFITS

Type of Services	Description of Services	What You Pay	
		Prudent Buyer Plan Providers	Non-Prudent Buyer Plan Providers*
Durable Medical Equipment	Rental or purchase when certified by a Physician and required for the care of an illness or injury	20%	20%
Hearing Aid Benefits	Hearing exams in conjunction with the purchase of a hearing aid	20% (No deductible)	20%* (No deductible)
	Hearing aids, limited to one hearing aid, per ear, in any 36 month period	20% (No deductible)	20% (No deductible)
Emergency Care	Initial treatment of a sudden or severe illness or accidental injury (including hospital and professional services & supplies)	20%	20%
Ambulance	Ground or air ambulance transportation Emergency air ambulance transportation will be paid at the Qualifying Payment Amount.	20%	20%
Home Health Care	100 visits per Calendar Year	20%	20%
Skilled Nursing Facility Care	100 days per Calendar Year	20%	20%
Hospice Care	Hospice care	20%	20%
Bariatric Surgery	Authorized bariatric surgery, only at Blue Distinction Centers for Specialty Care (BDCSC)	20% when provided by a BDCSC	20% when provided by a BDCSC
	Bariatric surgery travel expense in connection with an authorized bariatric surgery	No charge (No deductible)	No charge (No deductible)
Unrelated Donor Search	Up to $30,000 per transplant for covered bone marrow/stem cell transplants	20%	20%

*The Member's payment for **Non-Prudent Buyer Plan Provider** services is based on a **strictly limited schedule of allowances**, and Members must pay charges in excess of those scheduled amounts. Please refer to the section entitled DETERMINATION OF THE MAXIMUM ALLOWED AMOUNT beginning on page 20 for complete benefit information.

PORAC PRUDENT BUYER PLAN: SUMMARY OF BENEFITS

Type of Services	Description of Services	What You Pay	
		Prudent Buyer Plan Providers	Non-Prudent Buyer Plan Providers*
Specified Transplants	Authorized specified transplants, only at Centers of Medical Excellence (CME) or Blue Distinction Centers for Specialty Care (BDCSC)	20%	20%
	Transplant travel expense in connection with an approved specified transplant up to $10,000 per transplant	No charge (No deductible)	No charge (No deductible)
Physical Therapy, Occupational Therapy			20%*
	For all other services	20%	20%*
Speech Therapy	Inpatient or outpatient treatment	20%	20%*
Biofeedback	For all covered conditions	20%	20%*
Other Benefits	--Unreplaced Blood	20%	20%
	--Blood Administration	20%	20%*
Transgender Travel Expense	All authorized travel expense in connection with an authorized transgender surgery or surgeries, up to $10,000 per surgery or series of surgery	No charge (No deductible)	No charge (No deductible)

*The Member's payment for **Non-Prudent Buyer Plan Provider** services is based on a **strictly limited schedule of allowances**, and Members must pay charges in excess of those scheduled amounts. Please refer to the section entitled DETERMINATION OF THE MAXIMUM ALLOWED AMOUNT beginning on page 20 for complete benefit information.

PORAC PRUDENT BUYER PLAN: SUMMARY OF BENEFITS

Type of Services	Description of Services	What You Pay	
		Participating Pharmacy	Non-Participating Pharmacy
Prescription Drug Benefits**	Drugs purchased at a retail pharmacy, (drugs include insulin and authorized diabetic supplies)	$10 copay-generic	$10 copay-generic
		$25 copay-formulary brand name	$25 copay-formulary brand name
		$45 copay-non-formulary brand name	$45 copay-non-formulary brand name
	Drugs purchased through the home delivery program (drugs include insulin and authorized diabetic supplies)	$20 copay-generic	N/A
		$40 copay-formulary brand name	
		$75 copay-non-formulary brand name	N/A

**If non-mandatory brand name drugs are purchased, the Member will be responsible for the copay amount and the total price difference between the brand name and the generic drug. The Calendar Year Deductible does not apply to benefits provided under the PRESCRIPTION DRUG BENEFITS section.

Prescription Drug Out-of-Pocket Amount

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

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

Exception to Prescription Drug Co-Payments: There will be no copayment required for services provided under the PREVENTIVE PRESCRIPTION DRUG AND OTHER ITEMS provision in the section entitled PRESCRIPTION DRUG BENEFITS.

Your copayment for all other Drugs covered under this Plan will not exceed the lesser of any applicable copayment listed above or:

- For a 30-day supply from a retail Pharmacy $250

PLAN PROVIDERS

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

PRUDENT BUYER PLAN PROVIDERS IN CALIFORNIA

Your PORAC Prudent Buyer Plan offers you the freedom to select any provider of your choice. However, when Prudent Buyer Plan Providers are used, you save on out-of-pocket costs. Prudent Buyer Plan Providers have agreed to a rate they will accept as reimbursement for covered services.

BENEFITS FOR NON-PRUDENT BUYER PLAN PROVIDERS CAN BE SIGNIFICANTLY REDUCED WHEN COMPARED TO THOSE PROVIDED BY PRUDENT BUYER PLAN PROVIDERS. For detailed information on how benefits are determined, please refer to the sections entitled DETERMINATION OF THE MAXIMUM ALLOWED AMOUNT on page 20. For Information on how providers are paid please refer to PRUDENT BUYER PLAN BENEFITS - CO-PAYMENTS. These sections contain important information regarding how Non-Prudent Buyer Plan Providers are paid.

There are three ways you can find out if a Provider or Facility is in the Claims Administrator's network. You can also find out where they are located and details about their license or training:

- See your Plan's directory of In-Network Providers at www.anthem.com, which lists the Physicians, Providers, and Facilities that participate in this Plan's network. **Please Note: It is very important that you select your specific Plan to receive an accurate list of In-Network Providers for your Plan.**
- Call Member Services to request a list of Physicians and Providers that participate in this Plan's network, based on specialty and geographic area.
- Check with your Physician or Provider.

Please note that not all In-Network Providers offer all services. For example, when you need outpatient lab services, some Hospital-based labs are not part of our Reference Lab Network. In those cases you will have to go to a lab in our Reference Lab Network to get In-Network benefits. Please call Member Services before you get services for more information.

If you need details about a Provider's license or training, or help choosing a Doctor who is right for you, call the Member Services number on the back of your Member Identification Card. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with your needs.

IMPORTANT NOTE: Please be aware that it is the Members' responsibility to verify that the health care providers who they receive treatment from have current Prudent Buyer Plan participating provider status for:

- The Hospital or other facility where care will be given. After verifying that the Hospital or other facility is a Prudent Buyer Plan Provider, you should not assume all providers at that Hospital are also Prudent Buyer Plan Providers. To receive the maximum benefits under this plan, you should request that all your services be performed by Prudent Buyer Plan Providers whenever you enter a Hospital or other facility.
- The specific location at which you will receive care. Some providers participate at one location, but not at others.
- The Physician providing your care, especially anesthesiologists, pathologists and radiologists.

It is important to know that when you enroll in the PORAC Prudent Buyer Plan, services are provided through the plan's delivery system, but the continued participation of any one doctor, hospital or other provider cannot be guaranteed.

Out-of-Area Members. You are considered to be out-of-area for reimbursement of covered medical and hospital services if your address of record indicates you reside within the following zip codes: 92328, 92384, 92389, 93512, 93513, 93514, 93515, 93517, 93522, 93526, 93529, 93530, 93541, 93545, 93546, 93549, 96107 and 96133. Covered charges will be based on the Maximum Allowed Amount as stated under the Non-Prudent Buyer Plan Provider Exceptions provision. Authorized Referral is not required.

PLAN PROVIDERS

Benefits for out-of-area Members shall only be subject to the Primary Deductible set forth under the section entitled PRUDENT BUYER PLAN BENEFITS – DEDUCTIBLES, and the Co-Payment shown in the SUMMARY OF BENEFITS for Prudent Buyer Plan Providers will apply. In addition to the deductible and Co-Payment, you will be required to pay any billed amount in excess of the Maximum Allowed Amount for the services of a Non-Prudent Buyer Plan Provider.

NON-PRUDENT BUYER PLAN PROVIDERS

Non-Prudent Buyer Plan Providers are providers which have not agreed to participate in our Prudent Buyer Plan network. They have not agreed to the reimbursement rates and other provisions of a Prudent Buyer Plan contract.

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

CENTERS OF MEDICAL EXCELLENCE AND BLUE DISTINCTION CENTERS

We are providing access to Centers of Medical Excellence (CME) and Blue Distinction Centers for Specialty Care (BDCSC) networks. The facilities included in each of these networks are selected to provide the following specified medical services:

- **Transplant Facilities.** Transplant facilities have been organized to provide services for the following specified transplants: heart, liver, lung, combination heart-lung, kidney, pancreas, simultaneous pancreas-kidney, or bone marrow/stem cell and similar procedures. **These procedures are covered only when performed at a CME or BDCSC**.

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

A Prudent Buyer Plan Provider is not necessarily a Centers of Medical Excellence or a Blue Distinction Centers for Specialty Care facility.

PARTICIPATING AND NON-PARTICIPATING PHARMACIES

(See PRESCRIPTION DRUG BENEFITS section beginning on page 74)

"Participating Pharmacies" agree to charge Members only the Prescription Drug Maximum Allowed Amount in effect at the time a Prescription is filled. The Member pays the copayment amount, based on the type of Prescription purchased.

"Non-Participating Pharmacies" have not agreed to the Prescription Drug Maximum Allowed Amount. The amount covered as Prescription Drug expense may be significantly lower than what these providers customarily charge.

PLAN PROVIDERS

Participating Providers Outside of California

If you are outside of our California service areas, please call the toll-free BlueCard Provider Access number on your ID card to find a participating provider in the area you are in. A directory of PPO Providers for outside of California is available. You can get a directory from us.

CARE OUTSIDE THE UNITED STATES—BLUE CROSS BLUE SHIELD GLOBAL CORE

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

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

Payment Information

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

Claim Filing

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

PLAN PROVIDERS

Claim Forms

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

  www.bcbsglobalcore.com.

  The address for submitting claims is on the form.

HOW TO USE YOUR PLAN

As a Prudent Buyer Plan Member, when using Prudent Buyer Plan Providers, there is no need to complete a claim form. Your Prudent Buyer Plan Provider has agreed to bill us directly.

To help ensure that your Prudent Buyer Plan Provider bills for the services provided:

- When scheduling an appointment, confirm with the Physician that he/she is a Prudent Buyer Plan Provider.
- At the time of your visit, remind your Prudent Buyer Plan Provider that you are a Prudent Buyer Plan Member.
- Ask your Prudent Buyer Plan Provider if he/she has an assignment of benefits on file for you. (This assignment ensures that we will pay your provider directly.)
- Prudent Buyer Plan Providers will bill us for you. However, they may ask that you pay the deductible and Co-Payment at the time of your visit.

Referral to Non-Prudent Buyer Plan Provider

A Physician who is a Prudent Buyer Plan Provider may refer you to a Non-Prudent Buyer Plan Provider. In order for the maximum benefits of this plan to be payable, advance authorization from us is required for services provided by Non-Prudent Buyer Plan Providers. You or your Physician must call the number on the back of your ID Card **prior to** scheduling an admission to, or receiving the services of, a Non-Prudent Buyer Plan Provider. If a referral is not an Authorized Referral, the services will be paid according to the limited allowances applicable to Non-Prudent Buyer Plan Providers as specified in the DETERMINATION OF THE MAXIMUM ALLOWED AMOUNT section. See Authorized Referral in the GENERAL DEFINITIONS section for additional information.

Passport to Service

Your identification card is your "passport to service" for office visits and Inpatient or outpatient Hospital care. Your identification card should be shown on the first visit to a Physician's office or when admitted to the Hospital.

Universal Acceptance

The benefits of this plan are available anywhere in the world.

Member Services

If you have questions regarding your benefits, please call PORAC member services toll-free telephone number at 800-655-6397.

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

HOW TO USE YOUR PLAN

Third Party Liability / Workers' Compensation Questionnaires

The benefits of this plan **are not** provided for services related to any illness, injury, disease or other condition for which a third party may be liable or legally responsible, or for services covered by workers' compensation insurance. In order to insure accurate claims payment, it is sometimes necessary for us to request information regarding services in the form of a questionnaire.

For possible workers' compensation claims, the questionnaire must be returned before claim payment will be made. For possible Third Party Liability claims, if the questionnaire is not returned, we will process the claim and then pursue payment from the responsible third party.

PRUDENT BUYER PLAN BENEFITS

DEDUCTIBLES

CALENDAR YEAR DEDUCTIBLES

- **Primary Deductible** (applies to all providers unless shown in the exceptions)

  Per Member..... **$300**
  Per Family **$900***

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

- **Non-Prudent Buyer Plan Providers** (unless shown in the exceptions)

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

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

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

  Exceptions:

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

     a. Office visit charges by a Physician who is a Prudent Buyer Plan Provider. (This applies only to the charge for the visit itself. Deductible will apply to any other charges made during that visit, such as testing procedures, surgery, etc.)

        — The deductible WILL apply to Non- Prudent Buyer Plan Providers —

     b. Diabetes education program services provided by a Physician who is a Prudent Buyer Plan Provider.

        — The deductible WILL apply to Non- Prudent Buyer Plan Providers —

     c. Services under Preventive Care Services.

     d. Services under Smoking Cessation Programs.

     e. Services under Hearing Aid Benefits.

     f. Covered travel expense in connection with an authorized bariatric surgical procedure provided at an approved Blue Distinction Centers for Specialty Care.

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

h. Covered transgender travel expenses in connection with an approved transgender surgery.

i. Services under Body Scan Benefits.

2. The following services are NOT subject to the Non-Prudent Buyer Plan Provider Deductible:

a. Emergency or Accidental Injury services, to include Ambulance/Emergency Transportation An Authorized Referral from a Physician who is a Prudent Buyer Plan Provider to a Non-Prudent Buyer Plan Provider (see GENERAL DEFINITIONS for details); or

b. Charges by a type of Physician not represented in the Prudent Buyer Plan network (for example, an audiologist).

CALENDAR YEAR DEDUCTIBLES - ADDITIONAL INFORMATION

Primary Deductible: Each Member must initially meet a deductible amount of $300.00 each Calendar Year for applicable services (see previous page and above for services which are not subject to the deductible). Once that amount has been reached, there is no further deductible for that Member that Year for covered charges incurred when services are received from the following providers or the following services:

1. Prudent Buyer Plan Providers,
2. Related Health Providers,
3. Authorized Referral services,
4. Non-Prudent Buyer Plan Physicians whose specialty is not represented in the Prudent Buyer Plan network,
5. Non-Prudent Buyer Plan Physicians/ Hospitals for Emergency Care or Accidental Injury,
6. Approved Blue Distinction Centers for Specialty Care for authorized bariatric surgery travel expense, and
7. Approved Centers of Medical Excellence or Blue Distinction Centers for Specialty Care for authorized specified transplant travel expense.

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

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

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

CO-PAYMENTS

After you have satisfied any applicable deductible, we will subtract your Co-Payment (Co-Pay) from the Maximum Allowed Amount remaining. Co-Payments are shown under each benefit listed in the section entitled PRUDENT BUYER PLAN - COVERED SERVICES AND SUPPLIES on pages 26 through 52.

If your Co-Payment is a percentage, we will multiply the applicable percentage by the Maximum Allowed Amount remaining after any deductible has been met. This will determine the dollar amount of your Co-Payment. In addition to the Co-Payment, you will be required to pay any amount in excess of the Maximum Allowed Amount for the services of a Related Health Provider or a Non-Prudent Buyer Plan Provider. Expense which is applied toward any deductible, which is incurred for non-covered expense, or which is in excess of the Maximum Allowed Amount, is the Members responsibility.

All Co-Payments are subject to any maximum benefits listed under PRUDENT BUYER PLAN BENEFITS - COVERED SERVICES AND SUPPLIES on pages 26 through 52.

Important Note: Any covered charges for services provided by Non-Prudent Buyer Plan Hospitals, Non-Prudent Buyer Plan Ambulatory Surgical Centers and Non-Prudent Buyer Plan Physicians is strictly limited. Please refer to DETERMINATION OF THE MAXIMUM ALLOWED AMOUNT to see how covered charges are determined for these providers, and please read the definitions of Maximum Allowed Amount and Scheduled Amount. Any amount in excess of the Maximum Allowed Amount for Non-Prudent Buyer Plan Providers is the Member's responsibility and will not accumulate toward the Out-of-Pocket Expense Amount.

Authorized Referrals. When an Authorized Referral from a Physician who is a Prudent Buyer Plan Provider to a Non-Prudent Buyer Plan Provider is approved by us **before** services are rendered, we will provide whatever benefits are appropriate for Prudent Buyer Plan Providers (see DETERMINATION OF THE MAXIMUM ALLOWED AMOUNT and GENERAL DEFINITIONS for additional information).

Providers Not Represented in the Prudent Buyer Plan Network. For charges by a type of Physician not represented in the Prudent Buyer Plan network (for example, an audiologist), we will provide whatever benefits are appropriate for Prudent Buyer Plan Providers.

Clinical Trials. For charges by Non-Prudent Buyer Plan Providers for services and supplies provided in connection with Clinical Trials, we will provide whatever benefits would be appropriate if the services and supplies were provided by a Prudent Buyer Plan Provider.

Bariatric Surgery. For bariatric surgical procedures authorized by us and performed at a designated Blue Distinction Centers for Specialty Care (BDCSC), your Co-Payment will be the same as for Prudent Buyer Plan Providers. Charges for bariatric surgical procedures are not covered when performed at other than a designated BDCSC. See PRUDENT BUYER PLAN BENEFITS - UTILIZATION REVIEW PROGRAMS.

Specified Transplants. For specified transplants (heart, liver, lung, combination heart-lung, kidney, pancreas, simultaneous pancreas-kidney, or bone marrow/stem cell and similar procedures) determined to be Medically Necessary, authorized by us and performed at a designated Centers of Medical Excellence (CME) or Blue Distinction Centers for Specialty Care (BDCSC), your Co-Payment will be the same as for Prudent Buyer Plan Providers. Charges for specified transplants are not covered when performed at other than a designated CME or BDCSC. See PRUDENT BUYER PLAN BENEFITS - UTILIZATION REVIEW PROGRAMS.

OUT-OF-POCKET EXPENSE AMOUNT

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

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

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

***Exception:**

– Expenses incurred for non-covered services or supplies, or in excess of the Maximum Allowed Amount, will not be applied towards your Out-of-Pocket Expense Amount.

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

DETERMINATION OF THE MAXIMUM ALLOWED AMOUNT

General

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

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

Example: The Plan has a Member Co-Payment of 30% for Prudent Buyer Plan Provider services after the Deductible has been met.

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

Example: The Plan has a Member Co-Payment of 50% for Non-Prudent Buyer Plan services after the Deductible has been met.

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

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

DETERMINATION OF THE MAXIMUM ALLOWED AMOUNT

Provider Network Status

The Maximum Allowed Amount may vary depending upon whether the provider is a Prudent Buyer Plan Provider, a Non-Prudent Buyer Plan Provider or a Related Health Provider.

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

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

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

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

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

Related Health Providers. Related Health Providers are providers for which there is no network. They are subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary providers. For covered services you receive from a Related Health Provider the Maximum Allowed Amount will be based on the applicable non-Prudent Buyer Plan Provider rate or fee schedule for this plan, an amount negotiated by us or a third party vendor which has been agreed to by the Non-Prudent Buyer Plan Provider, an amount derived from the total charges billed by the Non-Prudent Buyer Plan Provider, an amount based on information provided by a third party vendor, or an amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services ("CMS"). When basing the Maximum Allowed Amount upon the level or method of reimbursement used by CMS, we will update such information, which is unadjusted for geographic locality, no less than annually.

DETERMINATION OF THE MAXIMUM ALLOWED AMOUNT

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

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

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

Exceptions:

- **Clinical Trials.** The Maximum Allowed Amount for services and supplies provided in connection with Clinical Trials will be the lesser of the billed charge or the amount that ordinarily applies when services are provided by a Prudent Buyer Plan Provider.

- **If Medicare is the primary payer for a Member, the Maximum Allowed Amount for that Member does not include:**

  a. Charges by a Hospital, in excess of the approved amount as determined by Medicare; or

  b. Charges by a Physician, Home Health Agency, Ambulatory Surgical Center, facility which provides diagnostic imaging services, clinical laboratory, or Home Infusion Therapy Provider that is a Prudent Buyer Plan Provider or a Related Health Provider when the provider accepts Medicare assignment, in excess of the approved amount as determined by Medicare, or:

  c. Charges by a Physician, Home Health Agency, Ambulatory Surgical Center, facility which provides diagnostic imaging services, clinical laboratory, Home Infusion Therapy Provider that is a Non-Prudent Buyer Plan Provider or a Related Health Provider, in excess of the Maximum Allowed Amount, or:

     i. For providers who accept Medicare assignment, the approved amount as determined by Medicare; or
     ii. For providers who do not accept Medicare assignment, the limiting charge as determined by Medicare.

You will always be responsible for expenses incurred which are not covered under this Plan.

Cost sharing amounts apply for items and services within the scope of the surprise billing and cost-share protections for: (1) out-of-network emergency services, (2) non-emergency services performed by non Participating Providers at Participating Facilities, and (3) emergency air ambulance services furnished by non-Participating Providers of air ambulance providers.

If Your expense falls into one of these categories, then Your share of the cost will be the same as if the

services were obtained in-network, including co-payments and deductibles. In these circumstances, the provider payment for these items and services will be the Qualifying Payment Amount (QPA), which is the applicable median-contracted rate set by the current provider network, rather than the reasonable and customary charges paid by the Plan.

The QPA does not apply to ground ambulance services furnished by nonparticipating providers of ground ambulance providers.

DETERMINATION OF THE MAXIMUM ALLOWED AMOUNT

Member Cost Share

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

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

In some instances you may only be asked to pay the lower Prudent Buyer Plan Provider cost share percentage when you use a Non-Prudent Buyer Plan Provider. For example, if you go to a Prudent Buyer Plan hospital or facility and receive covered services from a Non-Prudent Buyer Plan Provider such as a radiologist, anesthesiologist or pathologist, you will pay the Prudent Buyer Plan Provider cost share percentage of the Maximum Allowed Amount for those covered services, and you may also be liable for the difference between the Maximum Allowed Amount and the Non-Prudent Buyer Plan Provider's charge.

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

Authorized Referrals

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

CONDITIONS OF COVERAGE

The following conditions of coverage must be met before expenses incurred for services or supplies will be covered under this Plan.

1. You must incur this expense while you are covered under this plan. An expense is incurred on the date you receive the service or supply for which the charge is made.

2. The expense must be for a medical service or supply furnished to you as a result of illness or injury or pregnancy, unless a specific exception is made.

3. The expense must be for a medical service or supply included under PRUDENT BUYER PLAN BENEFITS - COVERED SERVICES AND SUPPLIES. Additional limits, if any, on covered charges are included under the specific benefits of that same section.

4. The expense must not be for a medical service or supply listed under PRUDENT BUYER PLAN BENEFITS - EXCLUSIONS AND LIMITATIONS. If the service or supply is partially excluded, then only that portion which is not excluded will be covered under this plan.

5. The expense must not exceed any of the maximum benefits or limitations of this plan.

6. Any services received must be those which are regularly provided and billed by the provider. In addition, those services must be consistent with the illness, injury, degree of disability and your medical needs. Benefits are provided only for the number of days required to treat your illness or injury.

7. All services and supplies must be ordered by a Physician.

COVERED SERVICES AND SUPPLIES

Subject to any benefit maximums shown in this section, the requirements set forth under PRUDENT BUYER PLAN BENEFITS - CONDITIONS OF COVERAGE and the exclusions or limitations listed under PRUDENT BUYER PLAN BENEFITS- EXCLUSIONS AND LIMITATIONS, we will provide benefits for the following services and supplies.

Acupuncture

20% Co-Pay for all other services provided by Prudent Buyer Plan Providers.

20% Co-Pay for Non-Prudent Buyer Plan Providers PLUS any amount in excess of the Maximum Allowed Amount.

20 Visit Limitation applies to any combination of services of acupuncture and Chiropractic services.

Subject to the Calendar Year Deductible and applies toward the Out-of-Pocket Expense Amount.

Covered services include the services of a Physician for acupuncture treatment to treat a disease, illness or injury, including a patient history visit, physical examination, treatment planning and treatment evaluation, electroacupuncture, cupping and moxibustion.

Advanced Imaging Procedures

20% Co-Pay for Prudent Buyer Plan Providers.

20% Co-Pay for Non-Prudent Buyer Plan Providers PLUS any amount in excess of the Maximum Allowed Amount.

Subject to the Calendar Year Deductible and applies toward the Out-of-Pocket Expense Amount.

Imaging procedures, including, but not limited to, Magnetic Resonance Imaging (MRI), Computer Axial Tomography (CAT scans), Positron Emission Tomography (PER scan), Magnetic Resonance Spectroscopy (MRS scan), Magnetic Resonance Angiogram (MRA scan), Echocardiography, and Nuclear Cardiac Imaging are subject to pre-service review to determine medical necessity. You may call the toll-free member services telephone number on your identification card to find out if an imaging procedure requires pre-service review. See the PRUDENT BUYER PLAN BENEFITS - UTILIZATION REVIEW PROGRAMS section beginning on page 59 for details.

Allergy Testing and Allergy Injections

$10 Co-Pay for office visit provided by a Prudent Buyer Plan Provider who is not a Specialist.

$35 Co-Pay for office visit provided by a Prudent Buyer Plan Provider who is a Specialist.

20% Co-Pay for all other services provided by Prudent Buyer Plan Providers.

20% Co-Pay for Non-Prudent Buyer Plan Providers PLUS any amount in excess of the Maximum Allowed Amount.

Subject to the Calendar Year Deductible and applies toward the Out-of-Pocket Expense Amount. The Calendar Year Deductible will not apply to office visit charges by a Physician who is a Prudent Buyer Plan Provider.

Ambulance

20% Co-Pay for Prudent Buyer Plan Providers.

20% Co-Pay for Non-Prudent Buyer Plan Providers, PLUS any amount in excess of the Maximum Allowed Amount.

Subject to the In Network Calendar Year Deductible and applies toward the Out-of-Pocket Expense Amount.

COVERED SERVICES AND SUPPLIES

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

- For ground ambulance, the Member is transported:
  - From the Member's home, or from the scene of an accident or medical Emergency, to a Hospital,
  - Between Hospitals, including when the Member is required to move from a Hospital that does not contract with us to one that does, or
  - Between a Hospital and a Skilled Nursing Facility or other approved facility.
- For air or water ambulance, the Member is transported:
  - From the scene of an accident or medical Emergency to a Hospital,
  - Between Hospitals, including when the Member is required to move from a Hospital that does not contract with us to one that does, or
  - Between a Hospital and another approved facility.
- **Cost sharing amounts apply for items and services within the scope of the surprise billing and cost-share protections for emergency air ambulance services furnished by non-Participating Providers of air ambulance providers. Your share of the cost will be the same as if the services were obtained in-network, including co-payments and deductibles. The provider payment for these items and services will be the Qualifying Payment Amount, which is the applicable median-contracted rate set by the current provider network, rather than the reasonable and customary charges paid by the Plan.**
- **The QPA does not apply to ground ambulance services furnished by nonparticipating providers of ground ambulance providers.**

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

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

Coverage includes Medically Necessary treatment of an illness or injury by medical professionals from an ambulance service, even if the Member is not transported to a Hospital. If provided through the 911 emergency response system*, ambulance services are covered if the Member reasonably believes that a medical Emergency existed even if the

Member is not transported to a Hospital. Ambulance services are not covered when another type of transportation can be used without endangering the Member's health. Ambulance services for the Member's convenience or the convenience of the Member's Family Members or Physician are not a covered service.

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

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

COVERED SERVICES AND SUPPLIES

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

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

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

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

Ambulatory Surgical Center Services

20% Co-Pay for Prudent Buyer Plan Providers.

20% Co-Pay for Non-Prudent Buyer Plan Providers PLUS any amount in excess of the Maximum Allowed Amount.

Ambulatory Surgical Center services are subject to pre-service review to determine medical necessity. Please refer to the PRUDENT BUYER PLAN BENEFITS - UTILIZATION REVIEW PROGRAMS section beginning on page 59 for information on how to obtain the proper reviews.

Subject to the Calendar Year Deductible and applies toward the Out-of-Pocket Expense Amount.

Services and supplies provided by an Ambulatory Surgical Center in connection with outpatient surgery are covered under this plan.

Bariatric Surgery

20% Co-Pay for Blue Distinction Centers for Specialty Care (BDCSC).

Subject to the Calendar Year Deductible and applies toward the Out-of-Pocket Expense Amount.

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

Bariatric surgical procedures are subject to pre-service review. Please refer to the PRUDENT BUYER PLAN BENEFITS - UTILIZATION REVIEW PROGRAMS section beginning on page 59 for information on how to obtain the proper reviews.

Bariatric Surgery Travel Expense. The following travel expense benefits will be provided in connection with a covered bariatric surgical procedure only when the Member's residence is outside the coverage area of the nearest designated BDCSC. Coverage area is the area within the 50-mile radius surrounding a designated BDCSC. Covered travel expense includes the following:

- Transportation for the Member to and from the BDCSC up to a maximum payment of **$130** per trip for a maximum of three (3) trips (one pre-surgical visit, the initial surgery and one follow-up visit).
- Transportation for one companion to and from the BDCSC up to a maximum payment of **$130** per trip for a maximum of two (2) trips (the initial surgery and one follow-up visit).
- Hotel accommodations for the Member and one companion not to exceed a maximum payment of **$100** per day for the pre-surgical visit and the follow-up visit, up to two (2) days per trip or as medically necessary. Limited to one room, double occupancy.
- Hotel accommodations for one companion not to exceed a maximum payment of **$100** per day for the duration of the Member's initial surgery stay, up to four (4) days. Limited to one room, double occupancy.
- Other reasonable expenses not to exceed a maximum payment of **$25** per day, up to four (4) days per trip. Tobacco, alcohol, drug and meal expenses are excluded from coverage.

The Calendar Year Deductibles will not apply, and no Co-Payment will be required for bariatric surgery travel expenses authorized by us.

All travel expenses must be approved by us in advance. Member services will confirm if the bariatric surgery travel expense benefit is provided in connection with access to the selected bariatric BDCSC. Details regarding reimbursement can be obtained by calling member services at the number on the back of your ID Card. A travel reimbursement form will be provided to you for submission of legible copies of all applicable receipts in order to obtain reimbursement.

Biofeedback Procedures

20% Co-Pay for Prudent Buyer Plan Providers.

20% Co-Pay for Non-Prudent Buyer Plan Providers PLUS any amount in excess of the Maximum Allowed Amount.

Subject to the Calendar Year Deductible and applies toward the Out-of-Pocket Expense Amount.

Blood

Unreplaced blood:

20% Co-Pay for Prudent Buyer Plan Providers.

20% Co-Pay for Non-Prudent Buyer Plan Providers PLUS any amount in excess of the Maximum Allowed Amount.

Blood administration:

20% Co-Pay for Prudent Buyer Plan Providers.

20% Co-Pay for Non-Prudent Buyer Plan Providers Co-Pay PLUS any amount in excess of the Maximum Allowed Amount.

COVERED SERVICES AND SUPPLIES

Subject to the Calendar Year Deductible and applies toward the Out-of-Pocket Expense Amount.

Covered charges include transfusions (including blood processing) and the cost of unreplaced blood and blood products.

Breast Cancer

See Hospital benefits on pages 39 and 40 as well as Physician/Professional Services on pages 41 and 42 for specific Co-Pay, Deductible and Out-of-Pocket Expense Amount information.

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

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

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

Body Scan

No Co-Pay and no out of pocket expense for any amount in excess of the Maximum Allowed Amount for all services provided by Body Scan International (BSI) as long as BSI remains a Prudent Buyer Plan Provider.

The Health Plan will pay for services and supplies for the body scan for screening purposes for only the Subscriber, (limited to one scan every 36 months) as long as BSI provides the body scan and remains a Prudent Buyer Plan Provider.

This Benefit is not subject to the Calendar Year Deductible and is not subject to the Out-Of-Pocket Expense Amount.

Chiropractic

20% Co-Pay for all other services provided by Prudent Buyer Plan Providers.

20% Co-Pay for Non-Prudent Buyer Plan Providers PLUS any amount in excess of the Maximum Allowed Amount.

20 Visit Limitation applies to any combination of services of Chiropractic and Acupuncture services.

Subject to the Calendar Year Deductible and applies toward the Out-of-Pocket Expense Amount.

Cell Therapy and Gene Therapy

The Plan covers charges related to gene/cell therapy, if those therapies have received approval from the U.S. Food and Drug Administration (FDA) and are not considered experimental nor investigational. All Cell or Gene Therapy

treatments require Prior Authorization. Any Gene/Cell Therapy treatments that did not receive prior authorization will be denied.

Cell therapy: Involves transplanting human cells into a patient to replace or repair damaged cells. Cells can be cultivated or modified outside the body before being injected into the patient. For example, stem cells can be isolated from the patient, genetically modified in culture, and then returned to the patient. Stem cell transplant is a type of cell therapy and routinely administered for most blood cancers

Gene-based cell therapy: Involves removing cells from a patient, altering them using gene therapy, and then implanting the modified cells back into the patient's body. For example, CAR-T cell therapy involves introducing a gene to a person's T cells, which are a type of immune cell. The gene provides instructions for making a protein that attaches to cancer cells, allowing the modified immune cells to specifically attack cancer cells

Gene Therapy: A therapy that modifies a person's genes to treat or cure disease. Gene therapies can work by several mechanisms: replacing a disease-causing gene with a healthy copy of the gene, inactivating a disease-causing gene that is not functioning properly, introducing a new or modified gene into the body to help treat a disease.

All Cell and Gene Therapy as defined above require prior authorization and pre-certification. Any Cell or Gene Therapy treatments that did not receive prior authorization or pre-certification will be denied.

Clinical Trials

See Hospital benefits on pages 39 and 40 as well as Physician/Professional Services on page 41 and 42 for specific Co-Pay, Deductible and Out-of-Pocket Expense Amount Information. The Plan will provide whatever benefits would be appropriate if the services and supplies were provided by a Prudent Buyer Plan Provider for charges by Non-Prudent Buyer Plan Providers for services and supplies provided in connection with Clinical Trials.

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

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

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

— Federally funded trials approved or funded by one or more of the following:

- The National Institutes of Health,
- The Centers for Disease Control and Prevention,
- The Agency for Health Care Research and Quality,
- The Centers for Medicare and Medicaid Services,
- A cooperative group or center of any of the four entities listed above or the Department of Defense or the Department of Veterans Affairs,
- A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants, or

- Any of the following departments if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of Health and Human Services determines (1) to be comparable to the system of peer review of investigations and studies used by the National Institutes of Health, and (2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review:

i. The Department of Veterans Affairs,

ii. The Department of Defense, or

iii. The Department of Energy.

— Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration.

— Studies or investigations done for drug trials that are exempt from the investigational new drug application.

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

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

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

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

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

Contraceptives

$10 Co-Pay for office visit provided by a Prudent Buyer Plan Provider who is not a Specialist.

$35 Co-Pay for office visit provided by a Prudent Buyer Plan Provider who is a Specialist.

20% Co-Pay for all other services provided by Prudent Buyer Plan Providers.

20% Co-Pay for Non-Prudent Buyer Plan Providers PLUS any amount in excess of the Maximum Allowed Amount.

- Subject to the Calendar Year Deductible and applies toward the Out-of-Pocket Expense Amount. The Calendar Year Deductible will not apply to office visit charges by a Physician who is a Prudent Buyer Plan Provider. Injectable drugs and implants for birth control, administered in a Physician's office, if Medically Necessary.

- Intrauterine contraceptive devices (IUDs) and diaphragms, dispensed by a Physician if Medically Necessary.
- Professional services of a Physician in connection with the prescribing, fitting, and insertion of intrauterine contraceptive devices or diaphragms.

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

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

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

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

Dental Care

PHYSICIAN SERVICES

$10 Co-Pay for office visit provided by a Prudent Buyer Plan Provider who is not a Specialist.

$35 Co-Pay for office visit provided by a Prudent Buyer Plan Provider who is a Specialist.

20% Co-Pay for all other services provided by Prudent Buyer Plan Physicians.

20% Co-Pay for Non-Prudent Buyer Plan Physicians PLUS any amount in excess of the Maximum Allowed Amount.

Subject to the Calendar Year Deductible and applies toward the Out-of-Pocket Expense Amount. The Calendar Year Deductible will not apply to office visit charges by a Physician who is a Prudent Buyer Plan Provider.

Coverage For Dental Injury. Services of a Physician (M.D.) or Dentist (D.D.S. or D.M.D.) solely to treat an Accidental Injury to teeth. Coverage shall be limited to only such services that are Medically Necessary to repair the damage done by Accidental Injury and/or restore function lost as a direct result of the Accidental Injury. Damage to teeth due to chewing or biting is not an Accidental Injury unless the chewing or biting results from a medical or mental condition.

Coverage for Cleft Palate. Medically Necessary dental or orthodontic services that are an integral part of Reconstructive Surgery for cleft palate procedures. "Cleft palate" means a condition that may include cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate.

Orthognathic surgery. Orthognathic surgery for a physical abnormality that prevents normal function of the upper or lower jaw and is Medically Necessary to attain functional capacity of the affected part.

HOSPITAL SERVICES

20% Co-Pay for all other services provided by Prudent Buyer Plan Providers.

20% Co-Pay for Non-Prudent Buyer Plan Providers PLUS any amount in excess of the Maximum Allowed Amount.

COVERED SERVICES AND SUPPLIES

Inpatient Hospital services are subject to pre-service review to determine medical necessity. Please refer to the PRUDENT BUYER PLAN BENEFITS - UTILIZATION REVIEW PROGRAMS section beginning on page 59 for information on how to obtain the proper reviews.

Subject to the Calendar Year Deductible and applies toward the Out-of-Pocket Expense Amount.

Coverage for Admissions for Dental Care: Listed Inpatient Hospital services, subject to the conditions of service stated above, when a Hospital Stay for dental treatment is required due to an unrelated medical condition of the Member, and has been ordered by a Physician (M.D.) and a Dentist (D.D.S. or D.M.D.). We will make the final determination as to whether the dental treatment could have been safely rendered in another setting due to the nature of the procedure or the Member's medical condition. Hospital Stays for the purpose of administering general anesthesia are not considered Medically Necessary and are not covered except as specified below.

Coverage for General Anesthesia: General anesthesia and associated facility charges when the Member's clinical status or underlying medical condition requires that dental procedures be rendered in a Hospital or Ambulatory Surgical Center. This applies only if (a) the Member is less than seven years old, (b) the Member is developmentally disabled, or (c) the Member's health is compromised and general anesthesia is Medically Necessary. Charges for the dental procedure itself, including professional fees of a dentist, may not be covered.

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

Diabetes Education Programs

$10 Co-Pay for office visit provided by a Prudent Buyer Plan Provider who is not a Specialist.

$35 Co-Pay for office visit provided by a Prudent Buyer Plan Provider who is a Specialist.

Note: This co-pay applies to the charge for the Physician visit only.

20% Co-Pay for Non-Prudent Buyer Plan Providers PLUS any amount in excess of the Maximum Allowed Amount.

Subject to the Calendar Year Deductible and applies toward the Out-of-Pocket Expense Amount.

Covered services include a diabetes instruction program in an outpatient setting 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.

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

Diagnostic Radiology (X-Rays) and Laboratory Services

20% Co-Pay for Prudent Buyer Plan Providers.

20% Co-Pay for Non-Prudent Buyer Plan Providers PLUS any amount in excess of the Maximum Allowed Amount.

Subject to the Calendar Year Deductible and applies toward the Out-of-Pocket Expense Amount.

COVERED SERVICES AND SUPPLIES

Benefits include outpatient diagnostic imaging, laboratory services and genetic tests. Genetic tests are subject to pre-service review to determine medical necessity. Please refer to the PRUDENT BUYER PLAN BENEFITS - UTILIZATION REVIEW PROGRAMS section beginning on page 59 for information on how to obtain the proper reviews. This does not include services covered under the Advanced Imaging Procedures benefit.

Durable Medical Equipment

20% Co-Pay for Prudent Buyer Plan Providers.

20% Co-Pay for Non-Prudent Buyer Plan Providers PLUS any amount in excess of the Maximum Allowed Amount.

Specific Durable Medical Equipment is subject to pre-service review to determine medical necessity. Please refer to the PRUDENT BUYER PLAN BENEFITS - UTILIZATION REVIEW PROGRAMS section beginning on page 59 for information on how to obtain the proper reviews.

Subject to the Calendar Year Deductible and applies toward the Out-of-Pocket Expense Amount.

Benefits include rental or purchase of dialysis equipment and dialysis supplies. Nebulizers, including face masks and tubing, when required for the Medically Necessary treatment of asthma in a child. Rental or purchase of other Durable Medical Equipment and supplies which are:

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

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

Emergency Care

20% Co-Pay for Prudent Buyer Plan Providers.

20% Co-Pay for Non-Prudent Buyer Plan Providers, PLUS any amount in excess of the Maximum Allowed Amount.

Inpatient Hospital services are subject to utilization review to determine medical necessity. Please refer to the PRUDENT BUYER PLAN BENEFITS - UTILIZATION REVIEW PROGRAMS section beginning on page 59 for information on how to obtain the proper reviews.

Subject to Primary Calendar Year Deductible, but the additional deductible applicable to Non-Prudent Buyer Plan providers will be waived for Emergency Care.

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

COVERED SERVICES AND SUPPLIES

See pages 39 and 40 Hospital - Outpatient for information regarding **Non-emergency services** provided by a Hospital emergency room.

Hearing Aid Benefits

20% Co-Pay for Prudent Buyer Plan Providers.

20% Co-Pay for Non-Prudent Buyer Plan Providers, PLUS any amount in excess of the Maximum Allowed Amount.

Not subject to the Calendar Year Deductible and does apply toward the Out-of-Pocket Expense Amount.

The following services and supplies are covered:

1. Hearing aids and bone-anchored hearing aids, including replacement only when purchased as a result of a written recommendation by a Physician certified as either an otologist, an otolaryngologist or a state certified audiologist. Benefits are limited to one hearing aid, per ear, during any **36** month period.
2. Evaluation and audio-metric examinations in conjunction with the purchase of a hearing aid.

Home Health Care

20% Co-Pay for services provided by Prudent Buyer Plan Providers.

20% Co-Pay for Non-Prudent Buyer Plan Providers PLUS any amount in excess of the Maximum Allowed Amount.

Subject to the Calendar Year Deductible and applies toward the Out-of-Pocket Expense Amount.

Home Health Care services are subject to pre-service review to determine medical necessity. Please refer to the PRUDENT BUYER PLAN BENEFITS - UTILIZATION REVIEW PROGRAMS section beginning on page 59 for information on how to obtain the proper reviews.

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

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

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

COVERED SERVICES AND SUPPLIES

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

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

Home Infusion Therapy

20% Co-Pay for Prudent Buyer Plan Providers.

20% Co-Pay for Non-Prudent Buyer Plan Providers PLUS any amount in excess of the Maximum Allowed Amount.

Subject to the Calendar Year Deductible and applies toward the Out-of-Pocket Expense Amount.

Home infusion therapy is subject to pre-service review to determine medical necessity. Please refer to the PRUDENT BUYER PLAN BENEFITS - UTILIZATION REVIEW PROGRAMS section beginning on page 59 for information on how to obtain the proper reviews.

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

1. Medication, ancillary medical supplies and supply delivery, (not to exceed a 14-day supply); however, medication which is delivered but not administered is not covered;
2. Pharmacy compounding and dispensing services (including pharmacy support) for intravenous solutions and medications;
3. Hospital and home clinical visits related to the administration of infusion therapy, including skilled nursing services including those provided for: (a) patient or alternative caregiver training; and (b) visits to monitor the therapy;
4. Rental and purchase charges for Durable Medical Equipment (as shown on page 35); maintenance and repair charges for such equipment;
5. Laboratory services to monitor the patient's response to therapy regimen.
6. Total Parenteral Nutrition (TPN), Enteral Nutrition Therapy, antibiotic therapy, pain management, chemotherapy, and may also include injections (intra-muscular, subcutaneous, or continuous subcutaneous).

Hospice Care

20% Co-Pay for Prudent Buyer Plan Providers.

20% Co-Pay for Non-Prudent Buyer Plan Providers PLUS any amount in excess of the Maximum Allowed Amount.

Subject to the Calendar Year Deductible and applies toward the Out-of-Pocket Expense Amount.

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

COVERED SERVICES AND SUPPLIES

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

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

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

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

Special Hospice Care Exclusions. In addition to the PRUDENT BUYER PLAN BENEFITS - EXCLUSIONS AND LIMITATIONS listed elsewhere in this Evidence of Coverage, **no benefits will be paid for the following**:

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

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

Hospital - Inpatient

20% Co-Pay for Prudent Buyer Plan Providers. (No Co-Pay will be required for inpatient Physical Therapy and Occupational Therapy provided by Prudent Buyer Plan Providers.)

20% Co-Pay for Non-Prudent Buyer Plan Providers PLUS any amount in excess of the Maximum Allowed Amount.

Inpatient Hospital services are subject to utilization review to determine medical necessity. Please refer to the PRUDENT BUYER PLAN BENEFITS - UTILIZATION REVIEW PROGRAMS section beginning on page 59 for information on how to obtain the proper reviews.

Subject to the Calendar Year Deductible and applies toward the Out-of-Pocket Expense Amount.

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

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

Hospital - Outpatient

20% Co-Pay for Prudent Buyer Plan Providers.

20% Co-Pay for Non-Prudent Buyer Plan Providers PLUS any amount in excess of the Maximum Allowed Amount.

50% Co-Pay for **Non-Emergency Use of a Hospital Emergency Room**, whether provided by a Prudent Buyer or Non-Prudent Buyer Plan Provider.

Specific outpatient services, including diagnostic and other services are subject to pre-service review to determine medical necessity. Please refer to the PRUDENT BUYER PLAN BENEFITS - UTILIZATION REVIEW PROGRAMS section beginning on page 59 for information on how to obtain the proper reviews.

Subject to the Calendar Year Deductible and applies toward the Out-of-Pocket Expense Amount.

COVERED SERVICES AND SUPPLIES

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

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

Infertility Services

50% Co-Pay PLUS any amount in excess of the Maximum Allowed Amount.

Subject to the Calendar Year Deductible and applies toward the Out-of-Pocket Expense Amount.

Covered services include Infertility studies, x-ray and lab tests and treatment of Infertility. Benefits are limited to a maximum payment of **$5,000** during each Members lifetime. In no event will benefits of this Evidence of Coverage be provided for or in connection with sterilization reversal, artificial insemination, gamete intrafallopian transfer, in vitro fertilization.

Jaw Joint Disorders

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

Osteoporosis

$10 Co-Pay for office visit provided by a Prudent Buyer Plan Provider who is not a Specialist.

$35 Co-Pay for office visit provided by a Prudent Buyer Plan Provider who is a Specialist.

20% Co-Pay for all other services provided by Prudent Buyer Plan Physicians.

20% Co-Pay for Non-Prudent Buyer Plan Physicians PLUS any amount in excess of the Maximum Allowed Amount. Subject to the Calendar Year Deductible and applies toward the Out-of-Pocket Expense Amount. The Calendar Year Deductible will not apply to office visit charges by a Physician who is a Prudent Buyer Plan Provider.

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

Outpatient Drugs and Medicines

(When dispensed by a Physician or administered by a Physician)

20% Co-Pay for services provided by Prudent Buyer Plan Providers.

20% Co-Pay for Non-Prudent Buyer Plan Providers PLUS any amount in excess of the Maximum Allowed Amount.

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

1. dispensed by a Physician, or
2. administered by a Physician or an individual licensed to administer drugs and medicines under the supervision of a Physician.

Exceptions: The following outpatient drugs and medicines are not included:

- Drugs which are sold by a retail pharmacy and prescribed for the Member to self-administer (See pages 74 through 87 for your PRESCRIPTION DRUG BENEFITS).
- Intravenous drugs in a setting other than a Physician's office or the outpatient department of a Hospital.

Physical Therapy – Physical Medicine

20% Co-Pay for all other services provided by Prudent Buyer Plan Providers.

20% Co-Pay for Non-Prudent Buyer Plan Providers PLUS any amount in excess of the Maximum Allowed Amount.

Subject to the Calendar Year Deductible and applies toward the Out-of-Pocket Expense Amount.

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

Benefits are **not** payable for care provided to relieve general soreness or for conditions that may be expected to improve without treatment. The Member must not be receiving benefits provided under the Home Health Care or Hospice Care portion of the plan.

For physical therapy, physical medicine or occupational therapy, covered services are payable if Medically Necessary. There is no limit on the number of covered visits for Medically Necessary physical therapy, physical medicine, and occupational therapy.

Physician / Professional Services

$10 Co-Pay for office visit provided by a Prudent Buyer Plan Provider who is not a Specialist.

$35 Co-Pay for office visit provided by a Prudent Buyer Plan Provider who is a Specialist.

20% Co-Pay for all other services provided by Prudent Buyer Plan Providers.

20% Co-Pay for Non-Prudent Buyer Plan Providers PLUS any amount in excess of the Maximum Allowed Amount.

Subject to the Calendar Year Deductible and applies toward the Out-of-Pocket Expense Amount. The Calendar Year Deductible will not apply to office visit charges by a Physician who is a Prudent Buyer Plan Provider. Covered services include:

COVERED SERVICES AND SUPPLIES

1. Services of a Physician, including but not limited to Medically Necessary office visits, consultations, hospital visits and surgery.

   "Physician" means more than an M.D. Certain other practitioners are included in this term as it is used throughout the plan. This doesn't mean they can provide every service that a medical doctor could; it just means that the plan will cover expense Members incur from them, when they're practicing within their specialty, the same as it would if the care were provided by a medical doctor. As with the other terms, be sure to read the definition of Physician to determine which providers' services are covered. Only providers listed in the definition are covered as Physicians. Please note also that certain providers' services are covered only upon referral of an M.D. (medical doctor) or D.O. (doctor of osteopathy). Providers for whom referral is required are indicated in the definition of Physician by an asterisk (*).

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

3. Education for pediatric asthma, including education to enable the child to properly use nebulizers (covered under Durable Medical Equipment benefits), inhaler spacers and peak flow meters (see PRESCRIPTION DRUG BENEFITS). This education will be covered under the plan's benefit for office visits to a Physician.

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

   Non-covered services include, but are not limited to, the following: reporting normal lab or other test results; office visit appointment requests or changes; billing, insurance coverage, or payment questions; requests for referrals to other Physicians or healthcare practitioners; benefit precertification; consultations between Physicians; and consultations provided by telephone, electronic mail, or facsimile machines.

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

For Mental Health Conditions or substance abuse online care visits, please see the "Mental Health Conditions and Substance Abuse" benefit for a description of this coverage.

Pregnancy, Maternity Care and Family Planning

PHYSICIAN SERVICES

$10 Co-Pay for office visit provided by a Prudent Buyer Plan Provider who is not a Specialist.

$35 Co-Pay for office visit provided by a Prudent Buyer Plan Provider who is a Specialist.

20% Co-Pay for all other services provided by Prudent Buyer Plan Physicians.

20% Co-Pay for Non-Prudent Buyer Plan Physicians, PLUS any amount in excess of the Maximum Allowed Amount.

Subject to the Calendar Year Deductible and applies toward the Out-of-Pocket Expense Amount. The Calendar Year Deductible will not apply to office visit charges by a Physician who is a Prudent Buyer Plan Provider.

All benefits provided under this plan are available when provided for pregnancy, maternity care and abortion.

HOSPITAL SERVICES

20% Co-Pay for services provided by Prudent Buyer Plan Providers.

20% Co-Pay for Non-Prudent Buyer Plan Providers PLUS any amount in excess of the Maximum Allowed Amount.

COVERED SERVICES AND SUPPLIES

Inpatient Hospital benefits in connection with childbirth will be provided for at least 48 hours following a normal delivery or 96 hours following a cesarean section, unless the mother and her Physician decide on an earlier discharge. Please see the section entitled FOR YOUR INFORMATION for a statement of your rights under federal law regarding these services.

Subject to the Calendar Year Deductible and applies toward the Out-of-Pocket Expense Amount.

The following services are covered under this plan.

1. All benefits provided under this plan are available for an enrolled Member when provided for pregnancy, maternity care and abortion. The following services are included:

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

2. Services listed under Hospital for routine nursery care of a newborn child if the child's natural mother is an enrolled Member. Routine nursery care of a newborn child includes screening of a newborn for genetic diseases, congenital conditions, and other health conditions provided through a program established by law or regulation.

3. Services provided by an approved Alternative Birth Center and a certified nurse midwife are included.

4. Services when provided for sterilizations: In no event will benefits be provided for or in connection with sterilization reversal or contraceptive devices (other than Prescription oral contraceptives as stated under PRESCRIPTION DRUG BENEFITS or as specifically stated in Contraceptives under PRUDENT BUYER PLAN BENEFITS - COVERED SERVICES AND SUPPLIES).

5. Certain services are covered under the Preventive Care Services benefit. Please see that benefit for further details.

Preventive Care Services

No Co-Pay except any amount in excess of the Maximum Allowed Amount for services provided by Non-Prudent Buyer Plan Providers. Not subject to the Calendar Year Deductible and applies toward the Out-of-Pocket Expense Amount.

Preventive care includes screenings and other services for adults and children. All recommended preventive services will be covered as required by the Affordable Care Act (ACA).

1. A Physician's services for routine physical examinations.

2. Immunizations prescribed by the examining Physician.

3. Radiology and laboratory services and tests ordered by the examining Physician in connection with a routine physical examination, excluding any such tests related to an illness or injury. Those radiology and laboratory services and tests related to an illness or injury will be covered as any other medical service available under the terms and conditions of the Diagnostic Radiology (X-Rays) and Laboratory Services benefit.

4. Health screenings as ordered by the examining Physician for the following: breast cancer, including BRCA testing if appropriate (in conjunction with genetic counseling and evaluation), cervical cancer, including human papillomavirus (HPV), prostate cancer, colorectal cancer, and other medically accepted cancer screening tests, blood lead levels, high blood pressure, type 2 diabetes mellitus, cholesterol, obesity, and screening for iron deficiency anemia in pregnant women.
5. Human immunodeficiency virus (HIV) testing, regardless of whether the testing is related to a primary diagnosis.
6. Counseling and risk factor reduction intervention services for sexually transmitted infections, human immunodeficiency virus (HIV), contraception, tobacco use, smoking cessation and tobacco use-related diseases.
7. Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:

    a. All FDA-approved contraceptive drugs, devices, and other products for women, including over-the-counter items, if prescribed by a physician. This includes contraceptive drugs, injectable contraceptives, patches and devices such as diaphragms, intra uterine devices (IUDs) and implants, as well as voluntary sterilization procedures, contraceptive education and counseling. It also includes follow-up services related to the drugs, devices, products and procedures, including but not limited to management of side effects, counseling for continued adherence, and device insertion and removal.

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

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

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

    b. Breast feeding support, supplies, and counseling. One breast pump will be covered per pregnancy under this benefit.

    c. Gestational diabetes screening. Preventive prenatal care.

8. Preventive services for certain high-risk populations as determined by your Physician, based on clinical expertise.

This list of Preventive Care Services is not exhaustive. Preventive tests and screenings with a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF), or those supported by the Health Resources and Services Administration (HRSA).

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

COVERED SERVICES AND SUPPLIES

Prosthetic Devices

20% Co-Pay for services provided by Prudent Buyer Plan Providers.

20% Co-Pay for Non-Prudent Buyer Plan Providers PLUS any amount in excess of the Maximum Allowed Amount.

Subject to the Calendar Year Deductible and applies toward the Out-of-Pocket Expense Amount.

Covered charges include:

1. Surgical implants, including but not limited to cochlear implants and breast prostheses and surgical bras following a mastectomy.
2. Prosthetic devices to restore a method of speaking when required as a result of a covered Medically Necessary laryngectomy.
3. 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.
4. The first pair of contact lenses or the first pair of eyeglasses when required as a result of a covered and Medically Necessary eye surgery.
5. Therapeutic shoes and inserts for the prevention and treatment of diabetes-related foot complications.

6 Benefits are available for certain types of orthotics (braces, boots, splints). Covered services include the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part.

Radiation, Chemotherapy and Hemodialysis

For RADIATION therapy, CHEMOTHERAPY and HEMODIALYSIS treatment. See Hospital - Outpatient on pages 39 and 40 for specific Co-Pay, Deductible and Out-of-Pocket Expense Amount information.

Radiation Therapy. This includes treatment of disease using x-ray, radium or radioactive isotopes, other treatment methods (such as teletherapy, brachytherapy, intra operative radiation, photon or high energy particle sources), material and supplies used in the therapy process and treatment planning. These services can be provided in a facility or professional setting.

Chemotherapy. This includes the treatment of disease using chemical or antineoplastic agents and the cost of such agents in a professional or facility setting. **Hemodialysis Treatment.** This includes services related to renal failure and chronic (end-stage) renal disease, including hemodialysis, home intermittent peritoneal dialysis home continuous cycling peritoneal dialysis and home continuous ambulatory peritoneal dialysis.

The following renal dialysis services are covered:

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

COVERED SERVICES AND SUPPLIES

Reconstructive Surgery

See Hospital benefits on pages 39 and 40 as well as Physician/Professional Services on pages 41 and 42 for specific Co-Pay, Deductible and Out-of-Pocket Expense Amount information.

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

This does not apply to orthognathic surgery. Please see the Dental Care benefit for a description of this service.

Retail Health Clinic

See Preventive Care Services on pages 43 and 44 as well as Physician/Professional Services on pages 41 and 42 for specific Co-Pay, Deductible and Out-of-Pocket Expense Amount Information. we will provide whatever benefits would be appropriate if the services and supplies were provided by a Prudent Buyer Plan Provider for charges by Non-Prudent Buyer Plan Providers for services and supplies provided in connection with Retail Health Clinic.

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

- Exams for minor illnesses and injuries.
- Preventive services and vaccinations.
- Health condition monitoring and testing.

Skilled Nursing Facility

20% Co-Pay for Prudent Buyer Plan Providers.

20% Co-Pay for Non-Prudent Buyer Plan Providers PLUS any amount in excess of the Maximum Allowed Amount.

Subject to the Calendar Year Deductible and applies toward the Out-of-Pocket Expense Amount.

Skilled Nursing Facility services are subject to pre-service review to determine medical necessity. Please refer to the PRUDENT BUYER PLAN BENEFITS - UTILIZATION REVIEW PROGRAMS section beginning on page 59 for information on how to obtain the proper reviews. The following services and supplies are covered, when provided by a Skilled Nursing Facility for up to **100** days during each Year.

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

COVERED SERVICES AND SUPPLIES

Smoking Cessation Programs

No Co-Pay except any amount in excess of the Maximum Allowed Amount.

Not subject to the Calendar Year Deductible and applies toward the Out-of-Pocket Expense Amount.

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

Class Supported Programs

1. American Lung Association - "Freedom From Smoking". Call the number on the back of your ID Card or the local lung association office or visit the web site at www.lungusa.org for information.
2. Medical clinic or Hospital-based programs. Consult the Member's Physician or local community Hospital for information.

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

Note: Smokenders programs purchased from any other source will not be reimbursed.

Benefits will be provided subject to the following:

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

Speech Therapy

20% Co-Pay for Prudent Buyer Plan Providers.

20% Co-Pay for Non-Prudent Buyer Plan Providers PLUS any amount in excess of the Maximum Allowed Amount.

Subject to the Calendar Year Deductible and applies toward the Out-of-Pocket Expense Amount.

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

Special Duty Nursing Care

20% Co-Pay for Prudent Buyer Plan Providers.

20% Co-Pay for Non-Prudent Buyer Plan Providers PLUS any amount in excess of the Maximum Allowed Amount.

Subject to the Calendar Year Deductible and applies toward the Out-of-Pocket Expense Amount.

Transgender Services

PHYSICIAN SERVICES

$10 Co-Pay for office visit provided by a Prudent Buyer Plan Provider who is not a Specialist.

$35 Co-Pay for office visit provided by a Prudent Buyer Plan Provider who is a Specialist.

20% Co-Pay for all other services provided by Prudent Buyer Plan Physicians.

20% Co-Pay for Non-Prudent Buyer Plan Physicians PLUS any amount in excess of the Maximum Allowed Amount.

Subject to the Calendar Year Deductible and applies toward the Out-of-Pocket Expense Amount. The Calendar Year Deductible will not apply to office visit charges by a Physician who is a Prudent Buyer Plan Provider.

HOSPITAL SERVICES

20% Co-Pay for services provided by Prudent Buyer Plan Providers.

20% Co-Pay for Non-Prudent Buyer Plan Providers PLUS any amount in excess of the Maximum Allowed Amount.

Inpatient Hospital services are subject to pre-service review to determine medical necessity. Please refer to the UTILIZATION REVIEW PROGRAMS section beginning on page 59 for information on how to obtain the proper reviews.

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

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

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

TRANSGENDER TRAVEL EXPENSE

Certain travel expenses incurred in connection with an approved transgender surgery, when the Hospital at which the surgery is performed is 75 miles or more from your place of residence, provided the expenses are authorized in advance by us. The plan's maximum payment will not exceed **$10,000** per transgender surgery, or series of surgeries (if multiple surgical procedures are performed), for the following travel expenses incurred by you and one companion:

- Ground transportation to and from the Hospital when it is 75 miles or more from your place of residence.

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

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

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

Transplant Services

PHYSICIAN SERVICES

$10 Co-Pay for office visit provided by a Prudent Buyer Plan Provider who is not a Specialist.

$35 Co-Pay for office visit provided by a Prudent Buyer Plan Provider who is a Specialist.

20% Co-Pay for all other services provided by Prudent Buyer Plan Physicians.

20% Co-Pay for Non-Prudent Buyer Plan Physicians PLUS any amount in excess of the Maximum Allowed Amount.

HOSPITAL SERVICES

20% Co-Pay for services provided by Prudent Buyer Plan Providers.

20% Co-Pay for Non-Prudent Buyer Plan Providers PLUS any amount in excess of the Maximum Allowed Amount.

Subject to the Calendar Year Deductible and applies toward the Out-of-Pocket Expense Amount. The Calendar Year Deductible will not apply to office visit charges by a Physician who is a Prudent Buyer Plan Provider.

Inpatient Hospital services are subject to pre-service review to determine medical necessity. Please refer to the UTILIZATION REVIEW PROGRAMS section beginning on page 59 for information on how to obtain the proper reviews.

Services and supplies in connection with non-Investigational organ or tissue transplants, such as skin or cornea transplants, that are commonly accepted medical practice in the United States. Benefits include all services provided elsewhere under this Evidence of Coverage for:

1. a Member who receives the organ or tissue, and
2. a Member who donates the organ or tissue.

Benefits for a Member who donates the organ or tissue are as follows:

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

- If a covered Member is donating the organ to someone who is **not** a covered Member, benefits are not available under this plan.

Covered charges for a donor, including donor testing and donor search is limited to expense incurred for Medically Necessary medical services only. The Maximum Allowed Amount for services incident to obtaining the transplanted material from living donor or a human organ transplant bank will be covered. Such charges, including complications from the donor procedure for up to six weeks from the date of procurement, are covered. Services for treatment of a condition that is not directly related to, or a direct result of, the transplant are not covered. An unrelated donor search may be required when the patient has a disease for which a transplant is needed and a suitable donor within the family is not available. Payment for unrelated donor services from an authorized, licensed registry for covered bone marrow/stem cell transplants will not exceed **$30,000** per transplant.

The Maximum Allowed Amount does not include charges for services received without first obtaining pre-service review according to the provisions stated under PRUDENT BUYER PLAN BENEFITS - UTILIZATION REVIEW PROGRAMS beginning on page 59. Benefits for authorized services are subject to all other conditions, limitations, exclusions and provisions of this plan.

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

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

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

SPECIFIED TRANSPLANTS

20% Co-Pay for Centers of Medical Excellence (CME) or Blue Distinction Centers for Specialty Care (BDCSC).

Subject to the Calendar Year Deductible and applies toward the Out-of-Pocket Expense Amount.

The Member must obtain pre-service review to determined medical necessity for all services including, but not limited to preoperative tests and postoperative care related to the following specified transplants: heart, liver, lung, combination heart-lung, kidney, pancreas, simultaneous pancreas-kidney, or bone marrow/stem cell and similar procedures. Specified transplants must be performed at a Centers of Medical Excellence (CME) or Blue Distinction Centers for Specialty Care (BDCSC). **Charges for services provided for or in connection with a specified transplant performed at a facility other than a CME or BDCSC will not be considered covered under this Plan.** Call the member services toll-free number for pre-service review if your Physician recommends a specified transplant for your medical care. A case manager transplant coordinator will assist in facilitating your access to a CME or BDCSC. Please

refer to the PRUDENT BUYER PLAN BENEFITS - UTILIZATION REVIEW PROGRAMS section beginning on page 59 for information on how to obtain the proper reviews.

No benefits are payable for Experimental or Investigational transplants. If services are denied because it is determined that they are Experimental or Investigational, an independent review may be requested. The Member may request an independent review of a coverage decision for services that have been denied as being Experimental or Investigational if: (1) the Member has a terminal condition; (2) the Member's Physician certifies that standard therapies have been ineffective or would be inappropriate; and (3) either the Member's Physician certifies in writing that the denied therapy is likely to be more beneficial than standard therapies, or the Member or Member's Physician has requested a therapy that, based on documented medical and scientific evidence, is likely to be more beneficial than standard therapies. The Member will be notified of the opportunity to request this review when services are denied.

TRANSPLANT TRAVEL EXPENSE

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

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

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

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

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

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

Urgent Care

See Hospital benefits on pages 39 and 40 as well as Physician/Professional Services on pages 41 and 42 for specific Co-Pay, Deductible and Out-of-Pocket Expense Amount Information. We will provide whatever benefits would be appropriate if the services and supplies were provided by a Prudent Buyer Plan Provider for charges by Non-Prudent Buyer Plan Providers for services and supplies provided in connection with Urgent Care.

COVERED SERVICES AND SUPPLIES

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

BENEFITS FOR MENTAL HEALTH CONDITIONS AND SUBSTANCE ABUSE

This Plan provides coverage for the Medically Necessary treatment of Mental Health Conditions and substance abuse. This coverage is provided according to the terms and conditions of this plan that apply to all other medical conditions, except as specifically stated in this section.

Services for the treatment of Mental Health Conditions and substance abuse covered under this plan are subject to the same deductibles, coinsurance, and copayments that apply to services provided for other covered medical conditions and Prescription Drugs.

DEFINITIONS

The meanings of key terms used in this section are capitalized. Please see the GENERAL DEFINITIONS section for detailed explanations of any capitalized words used in the section.

SUMMARY OF BENEFITS

DEDUCTIBLES

Please see the PORAC PRUDENT BUYER PLAN: SUMMARY OF BENEFITS section for your cost share responsibilities. The amounts listed and any exceptions, if applicable, also apply to services provided for the treatment of Mental Health Conditions and substance abuse.

CO-PAYMENTS

Mental Health Conditions and Substance Abuse Co-Payments. You are responsible for the following amounts (percentages are based on the Maximum Allowed Amount*):*

Inpatient Services

- Prudent Buyer Plan Providers **20%**
- Non-Prudent Buyer Plan Providers **20%***
  *PLUS any amount in excess of the Maximum Allowed Amount

Outpatient Office Visit Services

- Prudent Buyer Plan Providers..... **$10****
  **This Co-Payment will not apply toward the satisfaction of any Deductible.
- Non-Prudent Buyer Plan Providers **20%***
  *PLUS any amount in excess of the Maximum Allowed Amount

Other Outpatient Items and Services

- Prudent Buyer Plan Providers..... **20%**
- Non-Prudent Buyer Plan Providers **20%***
  *PLUS any amount in excess of the Maximum Allowed Amount

BENEFITS FOR MENTAL HEALTH CONDITIONS AND SUBSTANCE ABUSE

OUT-OF-POCKET AMOUNTS

Please see the PORAC PRUDENT BUYER PLAN: SUMMARY OF BENEFITS section for your plan's out-of-pocket amounts. The amounts listed and any exceptions, if applicable, also apply to services provided for the treatment of Mental Health Conditions and substance abuse.

BENEFIT MAXIMUMS

For all other services covered under this benefit, please see the Medical Benefit Maximums in the PORAC PRUDENT BUYER PLAN: SUMMARY OF BENEFITS section for any benefit maximums that apply to your plan. The amounts listed and any exceptions, if applicable, also apply to services provided for the treatment of Mental Health Conditions and substance abuse.

MENTAL HEALTH CONDITIONS AND SUBSTANCE ABUSE THAT ARE COVERED

Mental Health Conditions and Substance Abuse. Covered services shown below for the Medically Necessary treatment of Mental Health Conditions and substance abuse, or to prevent the deterioration of chronic conditions.

- **Inpatient Services**: Inpatient Hospital services and services from a Residential Treatment Center (including crisis residential treatment) as stated in the "Hospital" provision of this section, for inpatient services and supplies, and Physician visits during a covered inpatient Stay.
- **Outpatient Office Visits** for the following:
  - online visits,
  - intensive in-home behavioral health services, when available in your area,
  - individual and group mental health evaluation and treatment,
  - nutritional counseling for the treatment of eating disorders such as anorexia nervosa and bulimia nervosa,
  - drug therapy monitoring,
  - individual and group chemical dependency counseling,
  - medical treatment for withdrawal symptoms,
  - methadone maintenance treatment,
  - Behavioral health treatment for pervasive Developmental Disorder or autism delivered in an office setting.
- **Other Outpatient Items and Services**:
  - Partial hospitalization, including intensive outpatient programs and visits to a day treatment center. Partial hospitalization is covered as stated in the "Hospital" provision of this section, for outpatient services and supplies.
  - Psychological testing,
  - Multidisciplinary treatment in an intensive outpatient psychiatric treatment program,
  - Behavioral health treatment for Pervasive Developmental Disorder or autism delivered at home.

- **Behavioral health treatment for pervasive developmental disorder or autism**. Inpatient services, office visits, and other outpatient items and services are covered under this section. See the section BENEFITS FOR PERVASIVE DEVELOPMENTAL DISORDER OR AUTISM for a description of the services that are covered. **Note:** You must obtain pre-service review for all behavioral health treatment services for the treatment of pervasive developmental disorder or autism in order for these services to be covered by this plan (see UTILIZATION REVIEW PROGRAM for details).
- Diagnosis and all Medically Necessary treatment of Severe Mental Disorder of a person of any age and serious emotional disturbances of a child.

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

MENTAL HEALTH CONDITIONS AND SUBSTANCE ABUSE THAT ARE NOT COVERED

Please see the exclusions or limitations listed under EXCLUSIONS AND LIMITATIONS for a list of services not covered under your plan. Services that are not covered, if applicable, also apply to services provided for the treatment of Mental Health Conditions and substance abuse.

BENEFITS FOR PERVASIVE DEVELOPMENTAL DISORDER OR AUTISM

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

Behavioral health treatment services covered under this plan are subject to the same deductibles, coinsurance, and copayments that apply to services provided for other covered medical conditions. Services provided by Qualified Autism Service Providers, Qualified Autism Service Professionals, and Qualified Autism Service Paraprofessionals (see the "Definitions" below) will be covered under plan benefits that apply for outpatient office visits or other outpatient items and services. Services provided in a facility, such as the outpatient department of a Hospital, will be covered under plan benefits that apply to such facilities. See also the section Mental Health And Substance Abuse (Chemical Dependency) Services for more detail.

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

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

DEFINITIONS

Pervasive Developmental Disorder or autism means one or more of the disorders defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.

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

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

Qualified Autism Service Provider is either of the following:

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

Our network of Prudent Buyer Plan Providers is limited to licensed Qualified Autism Service Providers who contract with us and who may supervise and employ Qualified Autism Service Professionals or Qualified Autism Service Paraprofessionals who provide and administer Behavioral Health Treatment.

BENEFITS FOR PERVASIVE DEVELOPMENTAL DISORDER OR AUTISM

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

- Provides behavioral health treatment, which may include clinical case management and case supervision under the direction and supervision of a Qualified Autism Service Provider,
- Is employed and supervised by a Qualified Autism Service Provider,
- Provides treatment according to a treatment plan developed and approved by the Qualified Autism Service Provider,
- Is a behavioral service provider who meets the education and experience qualifications described in Section 54342 of Title 17 of the California Code of Regulations for an associate behavior analyst, behavior analyst, behavior management assistant, behavior management consultant, or behavior management program, and
- Has training and experience in providing services for Pervasive Developmental Disorder or autism pursuant to Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the Government Code, and
- Is employed by the Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers responsible for the autism treatment plan.

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

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

BEHAVIORAL HEALTH TREATMENT SERVICES COVERED

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

- The treatment must be prescribed by a licensed physician and surgeon (an M.D. or D.O.) or developed by a licensed psychologist,

BENEFITS FOR PERVASIVE DEVELOPMENTAL DISORDER OR AUTISM

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

UTILIZATION REVIEW PROGRAMS

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

REVIEWING WHERE SERVICES ARE PROVIDED

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

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

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

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

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

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

TYPES OF REVIEWS

- **Pre-service Review –** A review of a service, treatment or admission for a benefit coverage determination which is done before the service or treatment begins or admission date.
    - **Precertification** – A required pre-service review for a benefit coverage determination for a service or treatment. Certain services require precertification in order for you to get benefits. The benefit coverage review will include a review to decide whether the service meets the definition of medical necessity or is Experimental / Investigative as those terms are defined in this booklet.

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

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

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

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

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

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

— All scheduled, non-Emergency Inpatient Hospital Stays and Residential Treatment Center admissions, including detoxification and rehabilitation.

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

  - Maternity care of 48 hours less following a normal delivery or 96 hours or less following a cesarean section, and
  - Mastectomy and lymph node dissection.

— Specific non-Emergency outpatient services, including diagnostic treatment, genetic tests and other outpatient services provided at a Hospital or Ambulatory Surgical Center.

— Surgical procedures, wherever performed.

— Transplant Services, as follows:

  - For bone, skin or cornea transplants if the Physicians on the surgical team and the facility in which the transplant is to take place are approved by us for the transplant requested.

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

— Cell therapy or Gene Therapy.

— Air ambulance in a non-medical Emergency.

— Visits for physical therapy, physical medicine and occupational therapy beyond those described under the "Physical Therapy – Physical Medicine" provision of PRUDENT BUYER PLAN BENEFITS: COVERED SERVICES AND SUPPLIES. A specified number of additional visits may be authorized after your initial visit. While there is no limit on the number of covered visits for Medically Necessary physical therapy, physical medicine, and occupational therapy, additional visits in excess of the stated number of visits must be authorized in advance.

— Specific Durable Medical Equipment.

— Services of a Home Infusion Therapy Provider if the attending Physician has submitted both a prescription and a plan of treatment before services are rendered.

— Home health care services if:

- The services can be safely provided in the Member's home, as certified by the attending Physician; and
- The attending Physician manages and directs the Member's medical care at home; and
- The attending Physician has established a definitive treatment plan which must be consistent with the Member's medical needs and list the services to be provided by the Home Health Agency.

— Admissions to a Skilled Nursing Facility if the Member requires daily skilled nursing or rehabilitation, as certified by the attending Physician.

— Bariatric surgical services, such as gastric bypass and other surgical procedures for weight loss if:

- The services are to be performed for the treatment of morbid obesity; and
- The Physicians on the surgical team and the facility in which the surgical procedure is to take place are approved for the surgical procedure requested; and
- The bariatric surgical procedure will be performed at a Blue Distinction Centers for Specialty Care.

— Advanced imaging procedures, including, but not limited to: Magnetic Resonance Imaging (MRI), Computer Axial Tomography (CAT scans), Positron Emission Tomography (PET scan), Magnetic Resonance Spectroscopy (MRS scan), Magnetic Resonance Angiogram (MRA scan), Echocardiography and Nuclear Cardiac Imaging. The Member may call member services to find out if an imaging procedure requires pre-service review.

— Behavioral health treatment for pervasive developmental disorder or autism, as specified in the section BENEFITS FOR PERVASIVE DEVELOPMENTAL DISORDER OR AUTISM.

— All interventional spine pain, elective hip, knee, and shoulder arthroscopic/open sports medicine, and outpatient spine surgery procedures must be authorized in advance.

— Partial hospitalization, intensive outpatient programs, transcranial magnetic stimulation (TMS).

— Transgender services, including transgender travel expense, as specified under the "Transgender Services" provision of PRUDENT BUYER PLAN BENEFITS: COVERED SERVICES AND SUPPLIES. You must be diagnosed with gender identity disorder or gender dysphoria by a Physician.

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

WHO IS RESPONSIBLE FOR PRECERTIFICATION?

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

Provider Network Status	Responsibility to Get Precertification	Comments
Prudent Buyer Plan Providers	Provider	• The provider must get precertification when required.
Non-Prudent Buyer Plan Providers	Member	• Member must get precertification when required. (Call Member Services.) • Member may be financially responsible for charges or costs related to the service and/or setting in whole or in part if the service and/or setting is found to not be Medically *N*ecessary.

UTILIZATION REVIEW PROGRAMS

Provider Network Status	Responsibility to Get Precertification	Comments
Blue Card Provider	Member **(Except for Inpatient Admissions)**	• Member must get precertification when required. (Call Member Services.) • Member may be financially responsible for charges or costs related to the service and/or setting in whole or in part if the service and or setting is found to not be Medically Necessary. • **Blue Card Providers must obtain pre-certification for all Inpatient Admissions.**
NOTE: For an Emergency admission, precertification is not required. However, you, your authorized representative or Physician must tell us within 24 hours of the admission or as soon as possible within a reasonable period of time.		

HOW DECISIONS ARE MADE

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

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

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

UTILIZATION REVIEW PROGRAMS

DECISION AND NOTICE REQUIREMENTS

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

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

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

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

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

- The Member's coverage under this plan ends;
- The agreement with the PORAC and us terminates;
- The Member reaches a benefit maximum that applies to the services in question; or

- Benefits under the plan change so that the services in question are no longer covered or are covered in a different way.

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

Questions About or Disagreements With Utilization Review Determinations

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

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

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

Exceptions to the Utilization Review Programs

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

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

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

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

HEALTH PLAN INDIVIDUAL CASE MANAGEMENT

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

How Health Plan Individual Case Management Works

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

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

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

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

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

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, including services that are not specifically listed as covered in this booklet. (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 group health 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. **Caffeine Addiction.** Any expense incurred for caffeine addiction.

4. **Clinical Trials.** Any investigational drugs or devices, non-health services required for you to receive the treatment, the costs of managing the research, or costs that would not be a covered service under this plan for non-Investigative treatments, except as specifically stated in Clinical Trials under the section PRUDENT BUYER PLAN BENEFITS - COVERED SERVICES AND SUPPLIES.

5. **Commercial Weight Loss Programs.** Weight loss programs, whether or not they are pursued under medical or Physician supervision, unless specifically listed as covered in this plan. This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs. This exclusion does not apply to Medically Necessary treatments for morbid obesity or dietary evaluations and counseling, and behavioral modification programs for the treatment of anorexia nervosa or bulimia nervosa. Surgical treatment for morbid obesity is covered as stated in Bariatric Surgery under PRUDENT BUYER PLAN BENEFITS - COVERED SERVICES AND SUPPLIES.

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

7. **Custodial Care or Rest Cures.** Inpatient room and board charges in connection with a Hospital Stay primarily for environmental change, physical therapy or treatment of chronic pain, Custodial Care or rest cures. Services provided by a rest home, a home for the aged, a nursing home or any similar facility. Services provided by a Skilled Nursing Facility, except as specifically stated in Skilled Nursing Facility under PRUDENT BUYER PLAN BENEFITS - COVERED SERVICES AND SUPPLIES.

EXCLUSIONS AND LIMITATIONS

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

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

   This exclusion does not apply to the following:

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

9. **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.

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

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

      If you or your Physician believes you need to use a different Prescription Drug, please have your Physician or pharmacist get in touch with us. We will cover the other Prescription Drug only if we agree that it is Medically Necessary and appropriate over the clinically equivalent Drug. We will review benefits for the Prescription Drug from time to time to make sure the Drug is still Medically Necessary**.**
    - **Compound Drugs.** Compound Drugs unless all of the ingredients are FDA-approved in the form in which they are used in the *C*ompound Drug and as designated in the FDA's Orange Book: *Approved Drug Products with Therapeutic Equivalence Evaluations*, require a prescription to dispense, and the Compound Drug is not essentially the same as an FDA-approved product from a Drug manufacturer. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants.
    - **Drugs Contrary to Approved Medical and Professional Standards.** Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.
    - **Drugs Over Quantity or Age Limits.** Drugs which are over any quantity or age limits set by the Plan or us.
    - **Drugs Over the Quantity Prescribed or Refills After One Year.** Drugs in amounts over the quantity prescribed or for any refill given more than one year after the date of the original Prescription.

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

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

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

12. **Excess Amounts.** Any expense incurred for services of a Non-Prudent Buyer Plan Provider or Related Health Provider in excess of the amount stated in DETERMINATION OF THE MAXIMUM ALLOWED AMOUNT.

13. **Experimental or Investigational**. Experimental or Investigational procedures or medications. But, if the Member is denied benefits because it is determined that the requested treatment is Experimental or Investigative, the Member may request an independent medical review as described in YOUR RIGHT TO APPEALS.

14. **Family Members.** Services prescribed, ordered, referred by or given by a member of your immediate family, including your *spouse*, *child*, brother, sister, parent, in-law or self.

15. **Fitness for Duty.** Fitness for duty determinations or authorizations for leaves of absence or time off, if such services are beyond or outside the scope of an established and authorized treatment program or exceed the benefits of this plan.

16. **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.

17. **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.

18. **Government Services.** Any services a Member received that were provided 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 the Member is not required to pay for them or they are given to the Member for free. You are not required to seek any such services prior to receiving Medically Necessary health care services that are covered by this plan.

19. **Hearing Aids or Tests.** Hearing aids or routine hearing tests, including bone-anchored hearing aids, except as specifically stated under the Hearing Aid Benefits and Preventive Care Services provisions of PRUDENT BUYER PLAN BENEFITS - COVERED SERVICES AND SUPPLIES. This exclusion does not apply to cochlear implants.

20. **Hospital Services Billed Separately.** Services rendered by hospital resident physicians or interns that are billed separately. This includes separately billed charges for services rendered by employees of hospitals, labs or other institutions, and charges included in other duplicate billings.

21. **Hyperhidrosis Treatment.** Medical and surgical treatment of excessive sweating (hyperhidrosis).

22. **In-vitro Fertilization.** Services or supplies for in-vitro fertilization (IVF) for purposes of pre-implant genetic diagnosis (PGD) of embryos, regardless of whether they are provided in connection with infertility treatment.

23. **Legal Proceedings.** Evaluations or reports for legal proceedings.

24. **Mandated Counseling.** Counseling mandated by a court or government agency or any treatment or therapy ordered or required as a condition of parole, probation, custody, visitation, or forensic evaluations exceeding the benefits of this plan or that are not obtained by prior referral and authorization of the Care Manager.

25. **Medical Equipment, Devices and Supplies.** This Plan does not cover the following:

- Replacement or repair of purchased or rental equipment because of misuse, abuse, or loss/theft.
- Surgical supports, corsets, or articles of clothing unless needed to recover from surgery or injury.
- Enhancements to standard equipment and devices that is not Medically Necessary.
- Supplies, equipment and appliances that include comfort, luxury, or convenience items or features that exceed what is Medically Necessary in your situation.
- Disposable supplies for use in the home such as bandages, gauze, tape, antiseptics, dressings, ace-type bandages, and any other supplies, dressings, appliances or devices that are not specifically listed as covered under the “Durable Medical Equipment” provision of PRUDENT BUYER PLAN BENEFITS - COVERED SERVICES AND SUPPLIES.

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

26. **Medicare.** For which benefits are payable under Medicare Parts A and/or B, or would have been payable if you had applied for Parts A and/or B, except as listed in this booklet or as required by federal law, as described in the section titled "BENEFITS FOR MEDICARE ELIGIBLE MEMBERS: Coordinating Benefits With Medicare". If you do not enroll in Medicare Part B when you are eligible, you may have large out-of-pocket costs. Please refer to Medicare.gov for more details on when you should enroll and when you are allowed to delay enrollment without penalties.

27. **Mobile/Wearable Devices.** Consumer wearable / personal mobile devices such as a smart phone, smart watch, or other personal tracking devices), including any software or applications.

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

29. **Non-Approved Facility.** Services from a provider that does not meet the definition of facility.

30. **Non-Licensed Providers.** Treatment or services rendered by non-licensed health care providers and treatment or services for which the provider of services is not required to be licensed. This includes treatment or services from a non-licensed provider under the supervision of a licensed Physician, except as specifically provided or arranged by us. This exclusion does not apply to the Medically Necessary treatment of pervasive developmental disorder or autism, to the extent stated in the section BENEFITS FOR PERVASIVE DEVELOPMENTAL DISORDER OR AUTISM.

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

32. **Orthodontic Care.** Braces, other orthodontic appliances or orthodontic services, except as specifically stated under the Reconstructive Surgery or Dental Care provisions of PRUDENT BUYER PLAN BENEFITS - COVERED SERVICES AND SUPPLIES.

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

34. **Outpatient Speech Therapy.** Outpatient speech therapy, except following surgery, injury or non-congenital organic disease, or except as specifically stated in Hospice Care under PRUDENT BUYER PLAN BENEFITS - COVERED SERVICES AND SUPPLIES**.** This exclusion also does not apply to the Medically Necessary treatment of Severe Mental Disorders, or to the Medically Necessary treatment of pervasive developmental disorder or autism, to the extent stated in the section BENEFITS FOR PERVASIVE DEVELOPMENTAL DISORDER OR AUTISM.

35. **Over The Maximum Allowed Amount.** Any expense incurred for services of a Prudent Buyer Plan Provider in excess of the Maximum Allowed Amount.

36. **Personal Items and Services.** Air purifiers, air conditioners, humidifiers, exercise equipment and supplies for comfort, hygiene or beautification, health club memberships, health spas, charges from a physical fitness instructor or personal trainer, or other charges for activities, equipment or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. Nutritional and /or dietary supplements and counseling (other than for the treatment of phenylketonuria), except as provided in this plan or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written prescription or dispensing by a licensed pharmacist. Formulas and food products approved by the FDA and prescribed by a Physician for the treatment of phenylketonuria are covered under this plan.

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

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

39. **Relatives.** Professional services received from a person who lives in the Member's home or who is related to the Member by blood or marriage, except as specifically stated in Home Infusion Therapy under PRUDENT BUYER PLAN BENEFITS - COVERED SERVICES AND SUPPLIES.

40. **Residential accommodations.** Residential accommodations to treat medical or behavioral health conditions, except when provided in a Hospital, Hospice, Skilled Nursing Facility or Residential Treatment Center.

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

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

41. **Routine Physicals and Immunizations.** Physical exams and immunizations required for travel, enrollment in any insurance program, as a condition of employment, for licensing, sports programs, or for other purposes, which are not required by law under Preventive Care Services under PRUDENT BUYER PLAN BENEFITS - COVERED SERVICES AND SUPPLIES.

42. **Scalp hair prostheses.** Scalp hair prostheses, including wigs or any form of hair replacement.

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

EXCLUSIONS AND LIMITATIONS

44. **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. Contraceptive devices, except for Prescription oral contraceptives as specifically stated under PRESCRIPTION DRUG BENEFITS or as specifically stated in Contraceptives under PRUDENT BUYER PLAN BENEFITS - COVERED SERVICES AND SUPPLIES.

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

46. **Telephone, Facsimile Machine and Electronic Mail Consultations.** Consultations provided using telephone, facsimile machine or electronic mail.

47. **Transportation and Travel Expense.** Expense incurred for transportation, except as specifically stated in the Ambulance, Transplant Travel Expense and Bariatric Surgery Travel Expense under PRUDENT BUYER PLAN BENEFITS - COVERED SERVICES AND SUPPLIES. Mileage reimbursement except as specifically stated in the Transplant Travel Expense and Bariatric Surgery Travel Expense under PRUDENT BUYER PLAN BENEFITS - COVERED SERVICES AND SUPPLIES and approved by us. Charges incurred in the purchase or modification of a motor vehicle. Charges incurred for child care, telephone calls, laundry, postage, or entertainment. Frequent flyer miles; coupons, vouchers or travel tickets; prepayments of deposits.

48. **Unlisted Services.** Services not specifically listed in this booklet as covered services.

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

50. **Vision Services or Supplies.** Optometric services, eye exercises including orthoptics, routine eye exams and routine eye refractions. Eyeglasses or contact lenses, except as specifically stated in Prosthetic Devices under PRUDENT BUYER PLAN BENEFITS - COVERED SERVICES AND SUPPLIES.

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

52. **Wilderness.** Wilderness or other outdoor camps and/or programs.

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

PRESCRIPTION DRUG BENEFITS

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

PARTICIPATING PHARMACIES

Most Participating Pharmacies are located in California, but there is a limited network of Participating Pharmacies located outside of California. The Member may call the number on the back of their ID Card for assistance in locating a Participating Pharmacy.

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

When the Member presents his or her Identification Card to a Participating Pharmacy, the Member will only pay the applicable copayment amount for each covered Prescription and each refill (see pages 77 and 78 for copayment amounts).

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

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

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

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

In addition, if we determine that you may be using Controlled Substance Prescription Drugs in a harmful or abusive manner, or with harmful frequency, your selection of Participating Providers for Controlled Substance Prescriptions may be limited. If this happens, we may require you to select a single Participating Provider that will provide and coordinate all Controlled Substance Prescriptions. Benefits for Controlled Substance Prescriptions will only be paid if you use the single Participating Provider. We will contact you if it is determined that use of a single Participating Provider is needed and give you options as to which Participating Provider you may use. If you do not select one of the Participating Providers that is offered within 31 days, we will select a single Participating Provider for you. If you disagree with the decision, you may file complaint.

NON-PARTICIPATING PHARMACIES

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

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

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

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

HOME DELIVERY PROGRAM

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

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

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

Order forms or verify whether the Drug is available through the home delivery program, contact the Pharmacy Benefits Manager at the number on the back of your ID Card.

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

SPECIALTY DRUG PROGRAM

Certain Specialty Drugs must be obtained through the specialty drug program unless a Member is given an exception from the specialty drug program (See PRESCRIPTION DRUG CONDITIONS OF SERVICE on pages 79 through 81 of this section). These specified Specialty Drugs that must be obtained through the Specialty Drug Program are limited to up to a 30-day supply. The Specialty Drug Program only fills Prescriptions for Specialty Drugs and will ship medication to the Member by mail or common carrier (Members cannot pick up their medications at our office).

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

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

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

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

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

PREVENTIVE PRESCRIPTION DRUGS AND OTHER ITEMS

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

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

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

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

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

COPAYMENTS AT A RETAIL PHARMACY

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

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

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

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

E. The copayments specified in A., B., C. and D. above will apply to each 34-day supply. See page 80 for more information.

COPAYMENTS THROUGH THE HOME DELIVERY PROGRAM

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

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

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

D. The copayments specified in A., B. and C. above will apply to each 90-day supply (see page 80 for more information).

REIMBURSEMENT

A. When the Member has a Prescription filled at a Participating Pharmacy or through the Specialty Drug Program, the Member pays only the applicable copayment amount.

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

   1. The Pharmacy Benefits Manager determines the amount of Prescription Drug Covered Expense; then,

   2. The Pharmacy Benefits Manager subtracts the Member's applicable copayment from Prescription Drug Covered Expense.

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

PRESCRIPTION DRUG BENEFITS

PRESCRIPTION DRUG OUT-OF-POCKET AMOUNTS

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

DETERMINATION OF COVERED EXPENSE

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

PRESCRIPTION DRUG CONDITION OF SERVICE

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

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

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

C. It must be for the direct care and treatment of the Member's illness, injury or condition. Dietary supplements, health aids or drugs for cosmetic purposes are not included. However the following items are covered:

   a. Formulas prescribed by a Physician for the treatment of phenylketonuria.

   b. Vitamins, supplements, and health aids as specified under PREVENTIVE PRESCRIPTION DRUGS AND OTHER ITEMS, subject to all terms of this plan that apply to those benefits.

D. It must be dispensed from a licensed retail Pharmacy, a Home Health Agency, the home delivery program or through the specialty drug program.

E. **An approved Compound Medication must be dispensed by a Participating Pharmacy.** Call the number on the back of your ID Card to find out where to take the Member's Prescription for an approved Compound Medication to be filled. (You can also find a Participating Pharmacy online at www.anthem.com/ca.) **Some Compound Medications must be approved before the Member can get them** (See PRESCRIPTION DRUG FORMULARY)**. The Member will have to pay the full cost of the Compound Medications the Member chooses to get from a Non-Participating Pharmacy.**

F. **A specified Specialty Drug must be obtained by using the specialty drug program.** See SPECIALTY DRUG PROGRAM on page 76 of this section for information on how to get the Member's Drugs by using the specialty drug program. **The Member will have to pay the full cost of a Specialty Drug which the Member fills at a retail Pharmacy that should have obtained through the specialty drug program. If a Member orders a Specialty Drug that must be obtained using the specialty drug program through the home delivery program, it will be forwarded to the specialty drug program for processing and will be processed according to specialty drug program rules.**

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

   1. The first two months' supply of a specified Specialty Drug which is available through a Participating Pharmacy; or

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

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

4. A Member for whom, according to the Coordination of Benefit rules, this plan is not the primary plan.

How to obtain an exception to the specialty drug program. If the Member believes that he or she should not be required to get his or her medication through the specialty drug program for any of the reasons listed above, except item 4, the Member must complete an Exception to Specialty Drug Program form to request an exception and send this form to the Pharmacy Benefits Manager. If the Member needs a copy of the form, the Member may call the number on the back of their ID Card to request one. If we have given the Member an exception, it will be good for a limited period of time based on the reason for the exception. When the exception period ends, if the Member believes that he or she should still not be required to get his or her medication through the specialty drug program, the Member must again request an exception. If we deny the Member's request for an exception, it will be in writing and will tell the Member why the exception was not approved.

Urgent or emergency need of a Specialty Drug subject to the specialty drug program. If the Member is out of a Specialty Drug which must be obtained through the specialty drug program, we will authorize an override of the specialty drug program requirement for 72 hours, or until the next business day following a holiday or weekend, to allow the Member to get an emergency supply of medication if the Member's Physician decides that it is appropriate and Medically Necessary. The Member may have to pay the applicable copayment, shown in PORAC PRUDENT BUYER PLAN: SUMMARY OF BENEFITS on page 4 and under COPAYMENTS AT A RETAIL PHARMACY or COPAYMENTS THROUGH THE HOME DELIVERY PROGRAM on page 77 and 78 of this section, for the 72-hour supply of his or her Drug.

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

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

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

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

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

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

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

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

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

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

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

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

N. Be prescribed by a licensed Physician with an active Drug Enforcement Administration (DEA) license, if the Drug is considered a Controlled Substance.

PRESCRIPTION DRUG SERVICES AND SUPPLIES THAT ARE COVERED

A. Outpatient Drugs and medications which the law restricts to sale by Prescription except as specifically stated in this section. Formulas and special food products prescribed by a Physician for the treatment of phenylketonuria. These formulas are subject to the copayment for Brand Name Drugs.

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

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

D. Drugs with FDA labeling for self-administration.

E. AIDS vaccine (when approved by the federal Food and Drug Administration and that is recommended by the US Public Health Service).

F. Prescription Drugs, vaccinations (including administration), vitamins, supplements, and certain over-the-counter items as specified under PREVENTIVE PRESCRIPTION DRUGS AND OTHER ITEMS, subject to all terms of this plan that apply to those benefits.

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

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

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

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

PRESCRIPTION DRUG BENEFITS

PRESCRIPTION DRUG SERVICES AND SUPPLIES THAT ARE NOT COVERED

In addition to the items listed in this Evidence of Coverage under PRUDENT BUYER PLAN BENEFITS - EXCLUSIONS AND LIMITATIONS, Prescription Drug benefits are not provided for or in connection with the following:

A. Immunizing agents, biological sera, blood, blood products or blood plasma. While not covered under PRESCRIPTION DRUG BENEFITS, these items are covered as specified under the Blood and Preventive Care Services provisions of the PRUDENT BUYER PLAN BENEFITS, subject to all terms of this plan that apply to those benefits.

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

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

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

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

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

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

G. Durable Medical Equipment, devices, appliances and supplies, even if prescribed by a Physician, except Prescription contraceptives as specified under PREVENTIVE PRESCRIPTION DRUGS AND OTHER ITEMS. While not covered under PRESCRIPTION DRUG BENEFITS, these items are covered as specified under the Durable Medical Equipment and Hearing Aid Benefits provisions of the PRUDENT BUYER PLAN BENEFITS, subject to all terms of this plan that apply to those benefits.

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

PRESCRIPTION DRUG BENEFITS

I. Oxygen. While not covered under PRESCRIPTION DRUG BENEFITS, this item is covered as specified under the Home Health Care, Hospice Care, Hospital and Skilled Nursing Facility provisions of the PRUDENT BUYER PLAN BENEFITS, subject to all terms of this plan that apply to those benefits.

J. Cosmetics and health or beauty aids. However, health aids that are Medically Necessary and meet the requirements for Durable Medical Equipment, as specified under the Durable Medical Equipment provision of the PRUDENT BUYER PLAN BENEFITS, are covered, subject to all terms of this plan that apply to that benefit. Herbal, nutritional, and dietary supplements, except as described in this Plan or what must covered by law. This exclusion includes, but is not limited to, nutritional formulas and dietary supplements that you can buy over the counter and those you can get without a written Prescription or from a licensed pharmacist. However, formulas prescribed by a Physician for the treatment of phenylketonuria that are obtained from a Pharmacy are covered as specified under PRESCRIPTION DRUG SERVICES AND SUPPLIES THAT ARE COVERED. Also, vitamins, supplements, and certain over-the-counter items as specified under PREVENTIVE PRESCRIPTION DRUGS AND OTHER ITEMS are covered under this plan only when obtained with a Physician's Prescription, subject to all terms of this plan that apply to those benefits.

K. Any Drug labeled "Caution, Limited By Federal Law to Investigational Use" or non-FDA approved Investigational Drugs. Any Drug or medication prescribed for Experimental indications. If the Member is denied a Drug because we determine that the Drug is Experimental or Investigational, the Member may ask that the denial be reviewed. See YOUR RIGHT TO APPEALS for more information for information on how to ask for a review of a Drug denial.

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

M. Any expense incurred for a Drug or medication in excess of the Prescription Drug Maximum Allowed Amount.

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

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

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

Q. Infusion Drugs, except Drugs that are self-administered subcutaneously. While not covered under PRESCRIPTION DRUG BENEFITS, infusion Drugs are covered as specified under the Home Infusion Therapy and Physician / Professional Services provisions of the PRUDENT BUYER PLAN BENEFITS, subject to all terms of this plan that apply to those benefits.

R. Allergy desensitization products or allergy serum. While not covered under PRESCRIPTION DRUG BENEFITS, such Drugs are covered as specified under the Hospital, Physician / Professional Services and Skilled Nursing Facility provisions of the PRUDENT BUYER PLAN BENEFITS, subject to all terms of this plan that apply to those benefits.

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

T. Drugs and medications used to induce spontaneous and non-spontaneous abortions. While not covered under PRESCRIPTION DRUG BENEFITS, FDA approved medications that may only be dispensed by or under direct

supervision of a Physician, such as Drugs and medications used to induce non-spontaneous abortions, are covered as specifically stated in the Pregnancy, Maternity Care and Family Planning provision of PRUDENT BUYER PLAN BENEFITS, subject to all terms of this plan that apply to that benefit.

U. Onychomycosis (toenail fungus) Drugs except to treat patients who are immuno-compromised or diabetic.

V. All compound Prescription Drugs when a commercially available dosage form of a Medically Necessary medication is not available, all the ingredients of the compound drug are FDA approved in the form in which they are used in the Compound Medication and as designated in the FDA's Orange Book: *Approved Drug Products with Therapeutic Equivalence Evaluations*, require a prescription to dispense and are not essentially the same as an FDA approved product from a *drug* manufacturer. Non-FDA approved non-proprietary, multisource ingredients that are vehicles essential for compound administration may be covered. **The Member will have to pay the full cost of the Compound Medications the Member gets from a Non-Participating Pharmacy**. If the Member is denied a Compound Medication because the Member obtained it from a Non-Participating Pharmacy, the Member may file a grievance by following the procedures described in the section entitled YOUR RIGHT TO APPEALS.

W. Specialty Drugs that must be obtained from the specialty drug program but which are obtained from a retail Pharmacy or through the home delivery program are not covered by this plan. Unless the Member qualifies for an exception, these Drugs are not covered by this Plan (see YOUR PRESCRIPTION DRUG BENEFITS: PRESCRIPTION DRUG CONDITIONS OF SERVICE). **The Member will have to pay the full cost of the Specialty Drugs the Member gets from a retail Pharmacy that the Member should have gotten through the specialty drug program**.

If a Member orders a Specialty Drug through the home delivery program, it will be forwarded to the specialty pharmacy program for processing and will be processed according to the specialty pharmacy program rules.

X. Charges for pharmacy services not related to conditions, diagnoses, and/or recommended medications described in your medical records.

Y. Certain Prescription Drugs may not be covered if you could use a clinically equivalent Drug, unless required by law. "Clinically equivalent" means Drugs that for most Members, will give you similar results for a disease or condition. If you have questions about whether a certain Drug is covered and which Drugs fall into this group, please call the number on the back of your Identification Card.
If you or your Physician believes you need to use a different Prescription Drug, please have your Physician or pharmacist get in touch with us. We will cover the other Prescription Drug only if we agree that it is Medically Necessary and appropriate over the clinically equivalent Drug. We will review benefits for the Prescription Drug from time to time to make sure the Drug is still Medically Necessary.

Z. Drugs which are over any quantity or age limits set by the Plan or us.

AA. Prescription Drugs prescribed by a provider that does not have the necessary qualifications, registrations and/or certifications.

BB. Drugs prescribed, ordered, referred by or given by a member of your immediate family, including your Spouse, Child, brother, sister, parent, in-law or self.

CC. Services we conclude are not Medically Necessary. This includes services that do not meet medical policy, clinical coverage, or benefit policy guidelines.

DD. Any investigative drugs or devices, non-health services required for you to receive the treatment, the costs of managing the research, or costs that would not be a covered service under this plan for non-investigative treatments.

EE. Prescription drugs related to the medical and surgical treatment of excessive sweating (hyperhidrosis).

PRESCRIPTION DRUG PROGRAM UTILIZATION REVIEW

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

PRESCRIPTION DRUG FORMULARY

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

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

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

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

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

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

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

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

PRESCRIPTION DRUG BENEFITS

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

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

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

- Specific clinical criteria and/or recommendations made by state or federal agencies (including, but not limited to, requirements regarding age, test result requirements, presence of a specific condition or disease, quantity, dose and/or frequency of administration);
- Specific provider qualifications including, but not limited to, REMS certification (Risk, Evaluation and Mitigation Strategies) as recommended by the FDA;
- Step therapy requiring one Drug, Drug regimen, or treatment be used prior to use of another Drug, Drug regimen, or treatment for safety and/or cost-effectiveness when clinically similar results may be anticipated;
- Use of a Prescription Drug Formulary which is a list of FDA-approved Drugs that have been reviewed and recommended for use based on their quality and cost effectiveness.

You or your Physician can get the list of the Prescription Drug that require prior authorization by calling the phone number on the back of your identification card. The list will be reviewed and updated from time to time. Including a Prescription Drug or related item on the list does not guarantee coverage under your Plan. Your Physician may check with us to verify Prescription Drug, to find out which Prescription Drugs are covered under this section and if any drug edits apply.

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

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

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

While we are reviewing the request, a 72-hour Emergency supply of medication may be dispensed to the Member if the Member's Physician or pharmacist determines that it is appropriate and Medically Necessary. The Member may have to pay the applicable copayment, shown in PORAC PRUDENT BUYER PLAN: SUMMARY OF BENEFITS on page 4 and under COPAYMENTS AT A RETAIL PHARMACY of this section on pages 77 and 78, for the 72-hour supply of the Drug. If the request for the Drug is approved after the Member has received a 72-hour supply, the Member will receive the remainder of the 30-day supply of the Drug with no additional copayment.

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

If a request for prior authorization of a Drug that is not part of the Formulary Drug list is denied, the member or Member's prescribing Physician may appeal the decision by calling the number on the back of your ID Card. If the Member is not satisfied with the resolution based on such an inquiry, the Member may file an appeal with us by following the procedures described in the section entitled YOUR RIGHT TO APPEALS.

A prior authorization of benefit for prescription drug may be revoked or modified prior to the Member receiving the drugs for reasons including but not limited to the following:

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

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

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

SERVICES COVERED BY OTHER BENEFITS

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

SUBROGATION AND REIMBURSEMENT

COORDINATION OF BENEFITS

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

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:

SUBROGATION AND REIMBURSEMENT

- 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.

SUBROGATION AND REIMBURSEMENT

- You must send the Plan copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to you.
- You must promptly notify the Plan if you retain an attorney or if a lawsuit is filed on your behalf.
- You must immediately notify the Plan if a trial is commenced, if a settlement occurs or if potentially dispositive motions are filed in a case.

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

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

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

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

The Plan has the right to assert, in full, a lien for costs of health benefits paid on behalf of a plan Member against any settlement with, or arbitration award or judgment against, a third party. The Plan will be entitled to collect on its full lien even if the amount you or anyone recovered for you (or your estate, parent or legal guardian) from or for the account of such third party as compensation for the injury, illness or condition is less than the actual loss you suffered.

THIRD PARTY LIABILITY

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

1. promptly assign your rights to reimbursement from any source for the costs of such covered services; and
2. reimburse the Plan, who is entitled to a first right to reimbursement from full and partial recoveries, to the extent of benefits provided, immediately upon collection of damages by you for such injury from any source, including any applicable automobile uninsured or underinsured motorist coverage, whether by action of law, settlement, or otherwise; and
3. provide the Plan with a lien, to the extent of benefits provided by the Plan, upon your claim against or because of the third party. The lien may be filed with the third party, the third party's agent, the insurance company, or the court; and
4. the release of all information, medical or otherwise, which may be relevant to the identification of and collection from parties responsible for your illness or injury; and
5. notify us and the Plan of any claim filed against a third party for recovery of the cost of medical services obtained for injuries caused by the third party; and
6. cooperate with the IBT of PORAC in protecting the lien rights of the Plan against any recovery from the third party, which includes, but is not limited to, providing timely and periodic updates regarding the status of any claims or actions brought against the third party or any related claim; and
7. obtain written consent from IBT of PORAC prior to settling any claim with the third party that would release the third party from the lien or limit the rights of the Plan to recovery.

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

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

The Plan has the right to assert, in full, a lien for costs of health benefits paid on behalf of a plan Member against any settlement with, or arbitration award or judgment against, a third party. The Plan will be entitled to collect on its full lien even if the amount you or anyone recovered for you (or your estate, parent or legal guardian) from or for the account of such third party as compensation for the injury, illness or condition is less than the actual loss you suffered. No attorney fees or costs may be deducted from the Plan's recovery without written consent of the Plan.

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

WORKERS' COMPENSATION INSURANCE

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

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

BENEFITS FOR MEDICARE ELIGIBLE MEMBERS

If a Member is eligible for Medicare Parts A and B, the Member shall **not** be enrolled in a basic health benefits plan (including the "PORAC Prudent Buyer Plan"). This Plan will provide the Member with information regarding his or her eligibility for a supplement to original Medicare plan.

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

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

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

When Medicare is the primary payer for a Member, the Maximum Allowed Amount for covered services is determined as stated under Exception in the section PRUDENT BUYER PLAN BENEFITS - DETERMINATION OF THE MAXIMUM ALLOWED AMOUNT.

If you have questions about your eligibility for a Basic or Supplement to Original Medicare Plan, please contact the IBT of PORAC Planat 800-655-6397.

BENEFITS FOR MEDICARE ELIGIBLE MEMBERS continued

COORDINATING BENEFITS WITH MEDICARE

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

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

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

ENROLLMENT PROVISIONS

ELIGIBILITY FOR ENROLLMENT*

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

Family Member means the spouse or Domestic Partner and children of an Active Employee or Retired Employee who would otherwise qualify under Articles 1 and 5 of the Public Employees' Medical and Hospital Care Act ("PEMHCA"), including under sections 22775 and 22770, respectively, of PEMCHA and Sections 599.500, 599.501 and 599.502 of the Regulations attendant to the "PEMHCA"), as if PEMCHA and its attendant regulations applied to this Plan. Such children include: (1) the Active Employee's or Retired Employee's adopted, step or recognized natural child up to age 26, and (2) any other child up to age 26 for whom the Active Employee or Retired Employee has intentionally assumed a parent-child relationship or assumed parental duties, except for a foster child, as certified by the Active Employee or Retied Employee 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 Family Member must meet the criteria provided in Section 22775 of PEMHCA, as if PEMHCA applied to this Plan, to be eligible for coverage.

A Domestic Partner must meet the criteria provided in Section 22770 of PEMHCA, as if PEMHCA applied to this Plan, to be eligible for coverage. Generally, this means that the individual must be either an Active Employee's or Retired Employe'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).

If you are Medicare eligible and **do not** enroll in Medicare Parts A and B and a IBT of PORAC Medicare health plan, you and your enrolled Dependents will be excluded from coverage under the IBT of PORAC Plan .

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

ENROLLMENT PROVISIONS

CONDITIONS OF ENROLLMENT

A. Each Active Employee or Retired Employee eligible to become a Subscriber according to the provisions stated under ENROLLMENT PROVISIONS, and who files an application for membership for himself or herself and his or her eligible Family Members (on forms provided by the Employer) with the Employer during an Open Enrollment Period or period of initial eligibility under PEMHCA, as if PEMHCA applied to this Plan shall have fulfilled the Conditions of Enrollment.

B. If an Active Employee or Retired Employee fails to enroll himself or herself or his or her eligible Family Members during an Open Enrollment Period or the period of initial eligibility, as if PEMHCA applied, the Active Employee or Retired Employee may apply for enrollment for himself or herself and any eligible Family Members in accordance with the rules of enrollment under the IBT of PORAC or applicable law under PEMHCA as if it applied under this Plan. Contact your Employer or the IBT of PORAC Plan by calling 800-655-6397 for further information.

C. For Employees and their eligible Family members to maintain enrollment in the Plan, Employees must be members of PORAC.

Important Note: It is the Active Employee's and Retired Employee's responsibility to request additions, deletions or changes in enrollment in a timely manner and to stay informed about the eligibility requirements as set out in PEMHCA as if it applied to this Plan. The Active Employee and Retired Employee may be held liable retroactively for any services provided to ineligible Dependents.

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

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

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

COMMENCEMENT OF COVERAGE

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

TIMELY PAYMENT OF CONTRIBUTION/PREMIUM

Payment of the Contribution must be made by the 10th of the prior month for the following month's coverage. For example: payment must be made by October 10, 2026 for the coverage period of November 1, 2026. Coverage for the Active Employee or the Retired Employee and their Family Members, Domestic Partners, and/or dependents, will not take effect or will terminate on the last day of the month for which payment of Contribution was made.

TERMINATION PROVISIONS

TERMINATION OF PLAN

This Plan may be terminated by the Insurance and Benefits Trust of PORAC.

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) (4) of the PEMHCA Regulations, as if PEMHCA applied to this Plan, and the continuation benefits provided under CONTINUATION OF GROUP COVERAGE and TERMINAL BENEFITS sections of this Plan:

1. By the Board's termination of this Plant.
2. Delayed payment or non-payment of the Contribution/Premium.
3. By voluntary cancellation by the Subscriber or Family Member in accordance with Section 599.505 of PEMHCA, as if PEMHCA applied to this Plan. In the event of such voluntary cancellation, the Member shall cease to be covered hereunder without notice from the Employer, Plan or us at midnight of the day on which such cancellation becomes effective in accordance with Section 599.505 of the PEMHCA Regulations, as if PEMHCA applied to this Plan.
4. If a Subscriber or Family Member ceases to be eligible for coverage in accordance with Section 599.506 of the PEMHCA Regulations, as if PEMHCA applied to this Plan.
5. By the end of the month in which a Subscriber (or Employee) ceases being a member of PORAC.

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

OPEN ENROLLMENT

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

CONTINUATION OF GROUP COVERAGE

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

A. Eligibility for Continuation - Qualifying Events

Employers who contribute to the IBT of PORAC Plan 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 requirements for such status under PEMHCA and its Regulations, as if PEMHCA applied to this Plan;
7. The Subscriber's entitlement to Medicare.

B. Requirements for Continuation

1. Notice

For qualifying events 1, 2 or 3 above, the Subscriber's Employer will notify the Subscriber of the right to continue coverage. For qualifying events 4 and 7, a Family Member will be notified of the continuation right. Anyone choosing to continue coverage must so notify the IBT of PORAC Plan 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 Family Member must inform the IBT of PORAC Plan 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.

CONTINUATION OF GROUP 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 Active Employee or Retired Employee shall be deemed notice to all other eligible Family Members residing with such Employee or Spouse at the time such notification is made.

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

Once a Subscriber and/or Family Member elects the COBRA continuation, the COBRA Administrator shall provide written notice to each covered Active Employee or Retired Employee of their rights to continuation of coverage. In addition to the written notice, an Evidence of Coverage booklet shall be sent to each enrolled Subscriber at his/her address on the enrollment document(s) and shall be deemed notice to such Subscriber and his/her Spouse.

2. Family Members Acquired During Continuation

A spouse or child newly acquired during the continuation period is eligible to be enrolled as a Family Member as defined in section 22775 of PEMHCA, as if PEMHCA applied to this Plan. The standard enrollment provisions of the PEMHCA and its Regulations shall apply to this Plan with respect to enrollees during the continuation period (as if PEMHCA applied to this Plan, which it does not). 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.

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% 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 PEMHCA and its Regulations, as if PEMHCA applied to this Plan.

CONTINUATION OF GROUP COVERAGE

C. When The Continuation Ends

This continuation will end on the earliest of:

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

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

   a. the 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 end of 36 months from the date the Subscriber became entitled to Medicare, if the qualifying event was the Subscriber's entitlement to Medicare.

4. The date the Plan terminates.

5. The end of the last period for which the final subscription charge was paid.

6. The date after the date of election of COBRA, the Member first becomes eligible for Medicare.

7. The date after the date of election of COBRA, the Member first becomes covered under any other group health plan.

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

CONTINUATION OF GROUP COVERAGE

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

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

MONTHLY RATES

Premiums for Active Employees and Retired Employees

Active Employees and Retired Employees

For Active Employees, the employer is making the Contribution and must timely remit the gross rate to the IBT.

For Retired Employees, Contributions can be made by your employer or the employee. If the employer is making the Contribution, the employer is responsible for timely remitting the gross rate to the IBT. If the employee is making the Contribution, the employee is responsible for timely remitting the gross rate to the IBT.

Plan Rates Change Annually

The Plan rates will change annually on January 1 and written notice will be provided. The IBT of PORAC Board has full discretion in determining rates.

GENERAL PROVISIONS

Identification Cards

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

Medical Necessity

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

Expense in Excess of Benefits

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

Payment of Benefits

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

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

GENERAL PROVISIONS

Provider Reimbursement

Physicians and other professional providers are paid on a fee-for-service basis, according to an agreed schedule. A Prudent Buyer Plan Provider Physician may, after notice from us, be subject to a reduced Maximum Allowed Amount in the event the Prudent Buyer Plan Provider Physician fails to make routine referrals to Prudent Buyer Plan Providers, except as otherwise allowed (such as for emergency services). Hospitals and other health care facilities may be paid either a fixed fee or on a discounted fee-for-service basis.

Other forms of payment arrangement are Payment Innovation Programs. These programs may include financial incentives to help improve quality of care and promote the delivery of health care services in a cost-efficient manner. The programs may vary in methodology and subject area of focus and may be modified by us from time to time, but they will be generally designed to tie a certain portion of a Participating Provider's total compensation to pre-defined quality, cost, efficiency or service standards or metrics. In some instances, Participating Providers may be required to make payment to us under the program as a consequence of failing to meet these pre-defined standards. The programs are not intended to affect the Member's access to health care. The program payments are not made as payment for specific covered services provided to the Member, but instead, are based on the Participating Provider's achievement of these pre-defined standards. The Member is not responsible for any co-payment amounts related to payments made by us or to us under the programs and the member does not share in any payments made by Participating Providers to the Plan under the programs.

Claims Procedures

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

If you have any questions regarding the status of a claim, please call the PORAC claims and member services telephone number on the back of your ID Card.

Care Coordination. We pay Prudent Buyer Plan Providers in various ways to provide covered services to you. For example, sometimes we may pay Prudent Buyer Plan 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 Prudent Buyer Plan 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 Prudent Buyer Plan Providers for coordination of your care. In some instances, Prudent Buyer Plan 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 Prudent Buyer Plan Providers to us under these programs.

GENERAL PROVISIONS

Right of Recovery

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

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

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

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

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

Free Choice of Hospital and Physician

This Plan in no way interferes with the right of any Member entitled to Hospital benefits to select 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, your choice may affect the benefits payable according to this Plan.

GENERAL PROVISIONS

Workers' Compensation Insurance

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

Non-Regulation of Providers

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

Area of Service

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

Benefits Non-Transferable

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

Independent Contractors

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

Clerical Error

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

Your Right to Appeals

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

Right to Receive and Release Information

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

Member Cooperation

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

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

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

GENERAL PROVISIONS

Protection of Coverage

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

A. This Plan is still in effect, and

B. You are eligible under the terms of the Plan, and

C. Your premiums are paid according to the terms of the Plan.

Providing of Care

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

Terms of Coverage

1. In order for you to be entitled to benefits under the Plan, your coverage under the Plan must be in effect on the date the expense giving rise to a claim for benefits is incurred.

2. The benefits to which you may be entitled will depend on the terms of coverage in effect on the date the expense giving rise to a claim for benefits is incurred. An expense is incurred on the date you receive the service or supply for which the charge is made.

3. The Plan is subject to amendment, modification or termination according to the provisions of the Plan without your consent or concurrence.

Right to Receive Benefit

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

Inter-Plan Arrangements

Out-of-Area Services

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

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

Inter-Plan Arrangements Eligibility – Claim Types

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

A. BlueCard® Program

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

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

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

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

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

B. Negotiated (non–BlueCard Program) Arrangements

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

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

C. Special Cases: Value-Based Programs

BlueCard® Program

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

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

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

GENERAL PROVISIONS

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

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

E. Non-participating Providers Outside Our Service Area

1. Allowed Amounts and Member Liability Calculation

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

2. Exceptions

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

F. Blue Cross Blue Shield Global Core Program

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

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

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

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

How Claims are Paid with Blue Cross Blue Shield Global Core

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

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

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

- Outpatient services.

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

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

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

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

Transition Assistance for New Members

Transition Assistance is a process that allows for completion of covered services for new Members receiving services from a Non-Prudent Buyer Plan Provider. If you are a new Member, you may request Transition Assistance if any one of the following conditions applies:

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

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

We will notify you by telephone, and the provider by telephone and facsimile, as to whether or not your request for Transition Assistance is approved. If approved, you will be financially responsible only for applicable deductibles, coinsurance, and Co-Payments under the plan. Financial arrangements with Non-Prudent Buyer Plan Providers are negotiated on a case-by-case basis. We will request that the Non-Prudent Buyer Plan Provider agree to accept reimbursement and contractual requirements that apply to Prudent Buyer Plan Providers, including payment terms. If the Non-Prudent Buyer Plan Provider does not agree to accept said reimbursement and contractual requirements, we are not required to continue that provider's services. If you do not meet the criteria for Transition Assistance, you are afforded due process including having a Physician review the request.

Continuity of Care After Termination of Provider

Subject to the terms and conditions set forth below, we will provide benefits to a Member at the Prudent Buyer Plan Provider level for covered services (subject to applicable Co-Payments, coinsurance, deductibles and other terms) received from a provider at the time the provider's contract with us terminates (unless the provider's contract terminates for reasons of medical disciplinary cause or reason, fraud, or other criminal activity).

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

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

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

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

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

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

5. The care of a newborn child between birth and age thirty-six (36) months. Completion of covered services shall not exceed twelve (12) months from the date the provider's contract terminates.

6. Performance of a surgery or other procedure that we have authorized as part of a documented course of treatment and that has been recommended and documented by the provider to occur within 180 days of the date the provider's contract terminates.

Such benefits will not apply to providers who have been terminated due to medical disciplinary cause or reason, fraud, or other criminal activity.

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

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

Confidentiality and Release of Information

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

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

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

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

GENERAL PROVISIONS

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

Protecting your privacy

Where to find our Notice of Privacy Practices

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

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

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

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

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

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

GENERAL PROVISIONS

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

Health Insurance Portability and Accountability Act (HIPAA) Information

The IBT of PORAC complies with the federal Health Insurance Portability and Accountability Act (HIPAA) and the privacy regulations that have been adopted under it. Your privacy rights under HIPAA are detailed in the IBT of PORAC's Notice of Privacy Practices (NOPP).

IBT of PORAC's Notice of Privacy Practices

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

GENERAL INFORMATION

Information pertaining to eligibility, enrollment, cancellation or termination of insurance, etc., is found in the informational pamphlet entitled The IBT of PORAC *Health Program Guide*. This pamphlet is prepared by The IBT of PORAC in Sacramento, California. To receive a copy of this pamphlet, contact your employing office, or you may request a copy online by visiting the IBT of PORAC web site at (https://ibtofporac.org) or by calling at 800-655-6397.

Remember, it is your responsibility to stay informed about your health plan coverage. If you have any questions call the IBT of PORAC Health Department at 800-655-6397 or write to IBT of PORAC 2960 Advantage Way, Sacramento, CA 95834-3725.

Direct Payment of Contributions/Premiums

If you arrange for direct payment of premiums, send your payment, together with Form HPF 21 to IBT of PORAC 2960 Advantage Way, Sacramento, CA 95834-3725. Be sure to include your Subscriber number with your payment.

YOUR RIGHT TO APPEALS

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

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

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

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

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

Notice of Adverse Benefit Determination

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

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

YOUR RIGHT TO APPEALS

For claims involving urgent/concurrent care:

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

Appeals

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

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

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

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

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

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

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

YOUR RIGHT TO APPEALS

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

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

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

How Your Appeal will be Decided

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

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

Notification of the Outcome of the Appeal

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

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

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

Appeal Denial

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

YOUR RIGHT TO APPEALS

Voluntary Second Level Appeals

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

External Review

If the outcome of the mandatory first level appeal is adverse to you and it was based:

(1) on medical judgment,

(2) a determination that a treatment is experimental or investigational;

(3) a rescission of coverage, or

(4) consideration of whether the Plan is complying with the surprise balance billing and cost-sharing protection requirements the No Surprises Act,

you may be eligible for an independent External Review pursuant to federal law.

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

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

For pre-service claims involving urgent/concurrent care, you may proceed with an Expedited External Review without filing an internal appeal or while simultaneously pursuing an expedited appeal through our internal appeal process. You or your authorized representative may request it orally or in writing. All necessary information, including our decision, can be sent between us 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.

YOUR RIGHT TO APPEALS

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

Insurance and Benefits Trust of the Peace Officers Research Association of California (IBT of PORAC)

2960 Advantage Way
Sacramento, CA, 95834

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

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

YOUR RIGHT TO APPEALS

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

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

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

Limitation of Remedies. The Plan pays benefits only as set out in this EOC. The Plan shall not pay extracontractual damages for emotional distress, wage loss, special damages, indirect damages, and punitive damages.

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

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

GENERAL DEFINITIONS

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

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

Active Employee is defined in accordance with the definition currently in effect in PEMHCA, CA Government Code section 22772 (a)(1), (2), (6) and (b), as if such section and subsections of PEMCHA applied to this Plan. Notwithstanding the foregoing, an Active Employee is not an employee as defined in subsections (a)(3), (4), or (5) of CA Government Code section 22772

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

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

Anniversary Date is the first day of each contract term.

An **Authorized Referral** occurs when a Member, because of his or her medical needs, requires the services of a specialist who is a Non-Prudent Buyer Plan Hospital, Non-Prudent Buyer Plan Ambulatory Surgical Center or Non-Prudent Buyer Plan Physician, or requires special services or facilities not available at a contracting hospital, but only when the referral has been authorized by us before services are rendered and when the following conditions are met:

1. There is no Prudent Buyer Plan Physician who practices in the appropriate specialty, or there is no Prudent Buyer Plan Hospital or Ambulatory Surgical Center or contracting hospital which provides the required services or has the necessary facilities;
2. That meets the adequacy and accessibility requirements of state or federal law; and
3. The Member is referred to a Hospital or Physician that does not have an agreement with us for a covered service by a Prudent Buyer Plan Physician.

Such Authorized Referrals are not available to bariatric surgical services. These services are only covered when performed at a Blue Distinction Centers for Specialty Care. Authorized Referrals are not required for the services of Physicians of a type not available within the Prudent Buyer Plan network. However, a Physician's written referral is required in order for the services of some Physicians to be covered under this plan. Refer to the definition of Physician in this section.

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

GENERAL DEFINITIONS

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

Board of Trustees or "Board" means the Board of Trustees of the Insurance & Benefits Trust of the Peace Officers Research Association of California.

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

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

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

A **Contracting Hospital** is a Hospital which has a contract with us to provide care to Members. A Contracting Hospital is not necessarily a Prudent Buyer Plan Hospital. A list of Contracting Hospitals will be sent upon request.

Contribution/Premium is the monthly premium rate to cover the cost of benefits and administration as set by the IBT of PORAC, in its, discretion, annually.

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

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

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

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

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

A **Day Treatment Center** is an outpatient psychiatric facility which is licensed according to state and local laws to provide outpatient programs and treatment of Mental Health Conditions or substance abuse under the supervision of Physicians.

GENERAL DEFINITIONS

A **Dependent** is a Subscriber's spouse, domestic partner, as defined in California Government Code section 227700, or child, as defined in Title 2, California Code of Regulations, Section 599.500, as if PEMHCA applied.

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

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

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

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

Emergency 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
- 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.

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

GENERAL DEFINITIONS

Employer means any contracting agency or other entity which offers the Plan as a benefit to its employees.

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 Active Employee who qualify under Articles 1 and 5 of the PEMHCA, including under section 22775 of PEMHCA, and Sections 599.500, 599.501 and 599.502 of its Regulations, as if PEMHCA applied to this Plan. In addition, a Family Member shall include a Domestic Partner as defined in Section 22770 of PEMHCA, as if PEMCHA applied to this Plan. **Family Member also** means the spouse and children of a Retired Employee.

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

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

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

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

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

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

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

A **Hospital** is a facility which provides diagnosis, treatment and care of persons who need acute Inpatient Hospital care under the supervision of Physicians. It must be licensed as a general acute care Hospital according to state and local laws. It must also be registered as a general Hospital by the American Hospital Association and meet accreditation standards of The Joint Commission (TJC). For the limited purpose of Inpatient care, the definition of hospital also includes (1) Psychiatric Health Facilities (only for the acute phase of a Mental Health Condition or substance abuse), (2) and Residential Treatment Centers.

IBT of PORAC or "IBT" is the Insurance and Benefits Trust of Peace Officers Research Association of California.

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

GENERAL 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.

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

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

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

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

Maximum allowed amount is the maximum amount of reimbursement we will allow for covered medical services and supplies under this plan. See the section entitled DETERMINATION OF THE MAXIMUM ALLOWED AMOUNT.

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

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

GENERAL DEFINITIONS

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 Active Employee, Retired Employee or Family Member enrolled under the Plan.

Mental Health Conditions include conditions that constitute Severe Mental Disorders and serious emotional disturbances of a child, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), as well as any mental health condition identified as a "mental disorder" in the DSM, Fourth Edition Text Revision (DSM IV). Substance abuse means drug or alcohol abuse or dependence.

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

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

A **Non-Prudent Buyer Plan Provider** is one of the following providers which is eligible to enter into a Prudent Buyer Plan Participating Agreement with us but does not have a Prudent Buyer Plan Participating Agreement in effect with us at the time services are rendered:

- A Hospital. A Hospital that is a Non-Prudent Buyer Plan Provider may also be referred to as a Non-Prudent Buyer Plan Hospital.
- A Physician. A Physician who is a Non-Prudent Buyer Plan Provider may also be referred to as a Non-Prudent Buyer Plan Physician.
- A Home Health Agency (Home Health Agency). A Home Health Agency that is a Non-Prudent Buyer Plan Provider may also be referred to as a Non-Prudent Buyer Plan Home Health Agency.
- An Ambulatory Surgical Center. An Ambulatory Surgical Center that is a Non-Prudent Buyer Plan Provider may also be referred to as a Non-Prudent Buyer Plan Ambulatory Surgical Center.
- A facility which provides diagnostic imaging services.
- A clinical laboratory.
- A Home Infusion Therapy Provider.
- A Skilled Nursing Facility. A Skilled Nursing Facility that is a Non-Prudent Buyer Plan Provider may also be referred to as a Non-Prudent Buyer Plan Skilled Nursing Facility.
- A Durable Medical Equipment outlet.
- An Urgent Care Center.
- A Retail Health Clinic.
- A Hospice.
- A licensed ambulance company.
- A licensed qualified autism service provider.

Any of the above providers is a Non-Prudent Buyer Plan Provider. Remember that the Maximum Allowed Amount may only represent a portion of the amount which a Non-Prudent Buyer Plan Provider charges for services. See DETERMINATION OF THE MAXIMUM ALLOWED AMOUNT.

GENERAL DEFINITIONS

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

Out-of-Pocket Expense is the difference between the Maximum Allowed Amount and our payment. You are responsible to pay Out-of-Pocket Expense until your total out-of-pocket payments in a Year equal the Out-of-Pocket Expense Amount shown in the PRUDENT BUYER PLAN BENEFITS section. Out-of-Pocket Expense Amount does not include any expense amounts exceeding the Scheduled Amount for Non-Prudent Buyer Plan Providers and any other charges which are not considered covered charges. In addition, any Co-Payments made for non-Emergency services received in a Hospital emergency room, charges covered under PRESCRIPTION DRUG BENEFITS do not accrue towards the Out-of-Pocket Expense Amount, and you will continue to be required to pay such Co-Payments after the Out-of-Pocket Expense Amount is reached.

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

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

PEMHCA or **Act** means the Public Employees' Medical and Hospital Care Act (Part 5, Division 5, Title 2 of the Government Code of State of California). PEMHCA does not govern this Plan, but some provisions of this Plan refer to PEMHCA as if PEMHCA did apply to this Plan.

Pharmacy means a licensed retail pharmacy.

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

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

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

A **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 this 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 licensed educational psychologist or other provider permitted by California law to provide behavioral health treatment services for the treatment of pervasive developmental disorder or autism only
- 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 licensed professional clinical counselor (L.P.C.C.)*
- A physical therapist (P.T. or R.P.T.)*
- A speech pathologist*
- An audiologist*
- An occupational therapist (O.T.R.)*
- A respiratory care practitioner (R.C.P)*
- A nurse midwife**
- A nurse practitioner
- A physician assistant
- A psychiatric mental health nurse (R.N.)*
- 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.
- A qualified autism service provider, qualified autism service professional, and a qualified autism service paraprofessional, as described under the BENEFITS FOR PERVASIVE DEVELOPMENTAL DISORDER OR AUTISM section.

Notes:

-- The providers indicated by asterisks (*) are covered only by referral of a Physician as defined in 1. above.
-- Providers listed in 2. may not be represented in the Prudent Buyer Plan Provider Network.
-- **If there is no nurse midwife who is a Prudent Buyer Plan Provider in your area, you may call the member services telephone number on your ID card for a referral to an OB/GYN.

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).

PORAC is the Peace Officers Research Association of California.

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

GENERAL DEFINITIONS

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

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

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

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

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

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

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

http://www.ahrq.gov

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

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

A **Prudent Buyer Plan Provider** is one of the following providers in the State of California which has a Prudent Buyer Plan Participating Agreement in effect with us at the time services are rendered. Prudent Buyer Plan Providers agree to accept the Maximum Allowed Amount as payment for covered services. Prudent Buyer Plan Providers have agreed to participate in procedures established to review the utilization of services. All Prudent Buyer Plan Providers are independent contractors and are not employees or our agents. Those providers alone have undertaken and are responsible for providing medical care:

- A Hospital. A Hospital which is a Prudent Buyer Plan Provider may also be referred to as a Prudent Buyer Plan Hospital. Hospital services determined to be not Medically Necessary, according to the Prudent Buyer Plan utilization review procedures, are not covered by this Evidence of Coverage. A directory of Prudent Buyer Plan Hospitals is available upon request.
- A Physician. A Physician who is a Prudent Buyer Plan Provider may also be referred to as a Prudent Buyer Plan Physician. A directory of Prudent Buyer Plan Physicians is available upon request.
- A Home Health Agency (Home Health Agency). A Home Health Agency that is a Prudent Buyer Plan Provider may also be referred to as a Prudent Buyer Plan Home Health Agency. Home health services determined to be not Medically Necessary, according to the Prudent Buyer Plan utilization review procedures, are not covered by this Evidence of Coverage. A list of Prudent Buyer Plan Home Health Agencies is available upon request.
- An Ambulatory Surgical Center. An Ambulatory Surgical Center that is a Prudent Buyer Plan Provider may also be referred to as a Prudent Buyer Plan Ambulatory Surgical Center. Ambulatory Surgical Center services determined to be not Medically Necessary according to the Prudent Buyer Plan utilization review procedures are not covered by this Evidence of Coverage. A list of Prudent Buyer Plan Ambulatory Surgical Centers is available upon request.
- A facility which provides diagnostic imaging services.
- A clinical laboratory.
- A Home Infusion Therapy provider.
- A Skilled Nursing Facility. A Skilled Nursing Facility that is a Non-Prudent Buyer Plan Provider may also be referred to as a Non-Prudent Buyer Plan Skilled Nursing Facility.
- A Durable Medical Equipment outlet.
- An Urgent Care Centers.
- A Retail Health Clinic.
- A Hospice.
- A licensed ambulance company.
- A licensed qualified autism service provider.

A **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.

A **Psychiatric Health Facility** is an acute 24-hour facility as defined in California Health and Safety Code Section 1250.2. It must be:

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

GENERAL DEFINITIONS

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

Qualifying Payment Amount (QPA) is the amount of the payment to the provider when you incur: (1) out-of-network emergency services, (2) non-emergency services performed by non Participating Providers at Participating Facilities, and (3) emergency air ambulance services furnished by non-Participating Providers of air ambulance providers. The provider payment is the applicable median-contracted rate set by the current provider network, rather than the reasonable and customary charges paid by the Plan.

The QPA does not apply to ground ambulance services furnished by nonparticipating providers of ground ambulance providers.

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

Regulations means the Public Employees' Medical and Hospital Care Act ("PEMHCA") Regulations set forth in Subchapter 3, Chapter 2, Division 1, Title 2 of the California Code of Regulations, as if such Regulations applied to this Plan.

A **Related Health Provider** is one of the following, licensed according to state and local laws to provide covered medical services:

- A registered nurse anesthetist.
- A blood bank.

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

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

Retired Employee is a Retired Associate Member (RAM) or a member of the Peace Officers Research Association of California; and is not otherwise eligible for coverage under a CalPERS health plan; and who pays the Retired Employee rates set by the IBT of PORAC**.**

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

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

Severe Mental Disorders include severe mental illness as 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 most recent edition of 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 (Education Code Section 56320).

Single Source Brand Name Drugs are drugs with no generic substitute.

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

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

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

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

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

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

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

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

GENERAL DEFINITIONS

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

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

FOR YOUR INFORMATION

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, 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.

SPECIAL NOTICE REGARDING REPRODUCTIVE HEALTH CARE SERVICES

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

FOR YOUR INFORMATION

STATEMENT OF RIGHTS UNDER THE NEWBORNS AND MOTHERS HEALTH PROTECTION ACT

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

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

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

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

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

ADDENDUM A

Plan Rates Change Annually

The Plan rates will change annually on January 1 and written notice will be provided. The IBT of PORAC Board has full discretion in determining rates.

2026 Universal Health Plan Rates

Active Employee	Premium
Basic Single Contract	$974.00
Basic Two Party	$1,950.00
Basic Family	$2,534.00

Non-Medicare Retired	Premium
Basic Single Contract	$1,800.00
Basic Two Party	$3,600.00
Basic Family	$4,184.00

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 الستعانة بشخص ما ليساعدك على قراءتها. كما يمكنك أي اضلحصول على هذا الخطاب

مكتو با بلغتك. للحصول على المساعدة المجانية، يرجى االتصال فو ًرا بالرقم1-888-254-2721)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 1-888-254-2721 تماس بگیرید.)TTY/TDD:711(

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MCASH4644CML 06/16 DMHC3 DMHCW

Hindi

महत्वप : क्या आप यह पत्र पढ़ सकते हैं? अगर नह ी,ं 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। ननि:शु ल्क मदद केलिए, कृ पया 1-888-254-2721 पर त्ररंत कॉि 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៖ តេតើ អ ក អ ាច អនលិខតតន ើ េ ីរ? ត េ ើ មិនអេចើត ត េ ើងអចឲ្យនណ មនន ក ង់អ ានរ ាជ ន អ ក។ អ្ន កក អ េ ចរ ើ េ ីរេលល ិខិតេនើ េ ីេ ោ សរតសរជភាសារ ស់ អ្ន កជងេដ ។ ដេតើ មប េ ើ លជន តតគ ិតថ ល់ ស េ ើេ ើ រស័ព ភ្ន ក់ មៗេ ីេ ោ ត លខ 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, ਤ ਾਂ ਅਸੀਂ ਇਸ ਨ ੂੰ ਪੜ੍ਹਨ ਵਵੱਚ ਤੁਹ ਡੀ ਮਦਦ ਲਈ ਵਕਸੇ ਨ ੂੰ ਬੁਲ ਸਕਦ ਹਾਂ ਤੁਸੀਂਸ਼ਾਂ ਇਦ ਪੱਤਰ ਨ ੂੰ ਆਪਣੀ ਭ ਸ਼ ਵਵੱਚ ਵਲਵਵਆ ਹੋਇਆ ਵਬੀ ਪਰ ਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਮੁਫ਼ਤ ਮਦਦ ਲਈ, ਵਕਰਪ ਕਰਕੇ ਫੌਰਨ 1-888-254-2721 ਤੇ ਕ ਲ 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
หมายเหตส าค : ทานสามารถอานจดหมายฉบับนห รอไม่ หากทานไมสามารถอานจดหมายฉบับน เราสามารถจัดหาเจาหนา านฟังได ั ทานย อาจใหเ ัจา ั วยเขย นจดหมายในภาษาของทา นอก ดว ย ั ทมาอานใหท หนา ั ช

หากตองการความชว ยเหลอ โดยไมม คาใชจ ้าย โปรดโทรตดตอทหมายเลข 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)

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It's important we treat you fairly

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

For claims and customer service, contact:

Insurance and Benefits Trust of PORAC

2960 Advantage Way

Sacramento, CA 95834

1-800-655-6397

Email to: healthplan@ibtofporac.org