PORAC Police & Fire Health Plan Prudent Buyer Classic Plan

Preferred Provider Organization (PPO)

Combined Evidence of Coverage and Disclosure Form for the Basic Plan

Effective January 1, 2016

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

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

CalPERS

COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM

Anthem Blue Cross (Anthem)
21555 Oxnard Street
Woodland Hills, California 91367

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

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

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

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

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

1-800-288-6928

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ADMINISTRATIVE AND BENEFIT CHANGES

Effective January 1, 2016, the following changes have been made to your plan.

Administrative Changes

- A description of Non-Participating Plan Provider is added under the Plan Providers section, to advise Members that he/she could be balance billed by a Non-Participating Plan Provider for services determined to not be payable due to fraud, waste, abuse, failure to submit medical records and other inappropriate activity pursuant to any requirements stated in state law.
- The Ambulance benefit is revised to further clarify that ambulance services for convenience and services unrelated to the Member's health are not covered services.
- The Dental Care benefit is revised to clarify chewing or biting injuries to the teeth due to a medical or mental condition will be covered.
- The Preventive Care Services benefit is revised to remove service setting criteria. Services will be covered regardless of setting if they are covered preventive care services. Also, reference to the external websites is deleted and the Member is directed to inquire under the definition of Preventive Care Services for the current websites.
- Under the Utilization Review Programs section, the Exception to the Utilization Review Programs is revised indicating Anthem may review its providers to determine appropriate billing practices from the provider.
- Additional clarification text is added to the Case Management section.
- Additional federal health care reform updates is made to the Preventive Prescription Drugs and Other Items benefit.
- The definition of compound drugs is revised to indicate compound medication must contain at least one ingredient which is commercially available as a FDA-approved product.
- Under the Prescription Drug Program Utilization Review section, procedures and details about prescription drug prior authorization is changed to state that Anthem will review and respond to such requests within two business days.
- Under the COBRA section additional information text is added which informs Members of other health coverage options to consider before enrolling in COBRA.
- The Payment to Providers provision is revised to delete an exception to a process when an authorized referral is made.
- The Nondiscrimination provision is added to comply with federal nondiscrimination guidelines.
- The Out of Area Services, BlueCard Program and Non-Participating Health Care Providers Outside Anthem Service Area has been combined under the provision Inter-Plan Programs.
- The Conformity with Laws provision is added to clarify that the plan complies with any applicable state and federal laws.
- The Voluntary Clinical Quality Programs and Voluntary Wellness Incentive Programs provisions have been added to comply with federal regulatory provision for rebates and non-discrimination rules.

Benefit Changes

- The copayment for orally administered anti-cancer medications will not exceed the lesser of any applicable prescription drug copayment (whether obtained from a retail pharmacy or through home delivery) or $200 for a 30 day supply (retail pharmacy) or $600 for a 90 day supply (home delivery). Also oral anti-cancer medications are considered specialty drugs.
- The Out-of-Pocket Expense Amount per Member is changed to $4,500 and for Two or more Members of the same family, the Out-of-Pocket Amount is changed to $9,000.
- The Prescription Drug Out-of-Pocket Amount per Member is changed to $2,350 and for Two or more Members of the same family, the Out-of-Pocket Amount is changed to $4,700.

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 PORAC PRUDENT BUYER 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 ANTHEM BLUE CROSS AT 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.

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

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

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, and 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	10%	10%*
Hospital Services Outpatient	Surgical room fee, radiation and chemotherapy treatment and renal dialysis	10%	10%*
	Non-emergency use of the emergency room	50%	50%*
Physician Care	Office visits	$20 Co-Pay (No deductible) Note: This Co-Pay applies to the charge for the Physician visit only.	10%*
	Home and hospital visits obstetrical care surgery	10%	10%*
	Allergy testing, serum injections and medication dispensed or administered by a Physician	10%	10%*
	Preventive Care Services	No charge (No deductible)	No charge* (No deductible)
	Body Scan up to $1,000 per scan, limited to one scan every 36 months	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 sections entitled DETERMINATION OF THE MAXIMUM ALLOWED AMOUNT beginning on page 19 and SCHEDULES FOR NON-PRUDENT BUYER PLAN PROVIDERS beginning on page 128 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*
Maternity Services	Room and board, delivery room special care units, nursery care	10%	10%*
	Alternative birth center	10%	10%*
	Certified nurse midwife services	10%	10%*
Family Planning	Voluntary sterilization	10%	10%*
Infertility Services	Infertility studies and treatment, up to a $5,000 lifetime maximum Anthem payment	50%	50%*
Diagnostic Radiology & Laboratory Services	Outpatient X-ray & lab services	10%	10%*
Advanced Imaging Procedures	Advanced imaging procedures	10%	10%*
Acupuncture	Office visits	$20 Co-Pay (No deductible) Note: This Co-Pay applies to the charge for the Physician visit only.	10%*
	Acupuncture	10%	10%*
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)	10%	10%
Ambulance	Ground or air ambulance transportation	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 sections entitled DETERMINATION OF THE MAXIMUM ALLOWED AMOUNT beginning on page 19 and SCHEDULES FOR NON-PRUDENT BUYER PLAN PROVIDERS beginning on page 128 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*
Home Health Care	100 visits per Calendar Year	10%	10%
Skilled Nursing Facility Care	100 days per Calendar Year	10%	10%
Hospice Care	Hospice care	10%	10%
Bariatric Surgery	Authorized bariatric surgery, only at Anthem Centers of Medical Excellence (CME)	10%	10%
	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	10%	10%
Specified Transplants	Authorized specified transplants, only at Anthem Centers of Medical Excellence (CME)	10%	10%
	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, Chiropractic Care	Outpatient office visits (up to 20 visits** maximum per year for Prudent Buyer Plan Providers)	$20 Co-Pay (No deductible) Note: This Co-Pay applies to the charge for the Physician visit only.	10%*
	For all other service	10%	10%*

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

*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 sections entitled DETERMINATION OF THE MAXIMUM ALLOWED AMOUNT beginning on page 19 and SCHEDULES FOR NON-PRUDENT BUYER PLAN PROVIDERS beginning on page 128 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*
Speech Therapy	Inpatient or outpatient treatment	10%	10%*
Biofeedback	For all covered conditions	10%	10%*
Other Benefits	--Unreplaced Blood --Blood Administration	20% 10%	20% 10%*
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 sections entitled DETERMINATION OF THE MAXIMUM ALLOWED AMOUNT beginning on page 19 and SCHEDULES FOR NON-PRUDENT BUYER PLAN PROVIDERS beginning on page 128 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 **$2,350** in total copayments in a Year (**$4,700** 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 Anthem determines that the Member has reached the Prescription Drug Out-of-Pocket Amount, Anthem 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.

In addition, the copayment for orally administered anti-cancer medications will not exceed the lesser of any applicable copayment listed above or:

- For a 30-day supply from a retail pharmacy $200
- For a 90-day supply through home delivery $600

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 19 and SCHEDULES FOR NON-PRUDENT BUYER PLAN PROVIDERS beginning on page 128. 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.

Anthem Blue Cross publishes a directory of Prudent Buyer Plan Providers. The directory lists all Prudent Buyer Plan Providers in your area, including health care facilities such as Hospitals and Skilled Nursing Facilities, Physicians, laboratories, and diagnostic x-ray and imaging providers. You may call Anthem Blue Cross at 1-800-288-6928 or you may write to Anthem Blue Cross at P.O. Box 60007, Los Angeles, CA 90060-0007 and ask to have a directory sent to you. You may also search for a Prudent Buyer Plan Provider using the "Provider Finder" function on the Anthem Blue Cross website at www.anthem.com/ca.

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. Any covered services you receive from Non-Prudent Buyer Plan Providers will not be subject to the SCHEDULES FOR NON-PRUDENT BUYER PLAN PROVIDERS. 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 Anthem Blue Cross' Prudent Buyer Plan network. They have not agreed to the reimbursement rates and other provisions of a Prudent Buyer Plan contract.

Anthem Blue Cross has 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

Anthem Blue Cross is providing access to the following separate Centers of Medical Excellence (CME) network. The facilities included in each of these CME 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**.
- **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 CME.**

A Prudent Buyer Plan Provider is not necessarily a Centers of Medical Excellence facility.

PARTICIPATING AND NON-PARTICIPATING PHARMACIES

(See PRESCRIPTION DRUG BENEFITS section beginning on page 70)

"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 Anthem Blue Cross' 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 Anthem Blue Cross.

CARE OUTSIDE THE UNITED STATES—BLUECARD WORLDWIDE

Prior to travel outside the United States, call the customer service telephone number listed on your ID card to find out if your plan has BlueCard Worldwide benefits. Your coverage outside the United States is limited and Anthem Blue Cross recommends:

- Before you leave home, call the customer service 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 BlueCard Worldwide 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 BlueCard Worldwide hospitals.** In most cases, you should not have to pay upfront for Inpatient care at participating BlueCard Worldwide 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 BlueCard Worldwide hospital. Then you can complete a BlueCard Worldwide claim form and send it with the original bill(s) to the BlueCard Worldwide Service Center (the address is on the form).

Claim Filing

- **Participating BlueCard Worldwide 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 BlueCard Worldwide hospital. You will need to pay the health care provider and subsequently send an international claim form with the original bills to Anthem Blue Cross.

Additional Information About BlueCard Worldwide Claims.

- You are responsible, at your expense, for obtaining an English-language translation of foreign country provider claims and medical records.

PLAN PROVIDERS

- Exchange rates are determined as follows:
  - For Inpatient Hospital care, the rate is based on the date of admission.
  - For outpatient and professional services, the rate is based on the date the service is provided.

Claim Forms

- International claim forms are available from Anthem Blue Cross, from the BlueCard Worldwide Service Center, or online at:

  www.bcbs.com/bluecardworldwide.

  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 Anthem Blue Cross 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 Anthem Blue Cross will pay your provider directly.)
- Prudent Buyer Plan Providers will bill Anthem Blue Cross 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 Anthem Blue Cross is required for services provided by Non-Prudent Buyer Plan Providers. You or your Physician must call Anthem Blue Cross **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 Anthem Blue Cross 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.

Customer Service

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

1-800-288-6928

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 Anthem Blue Cross 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, Anthem Blue Cross 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**

- **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)

  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 and Nicotine Patches.

     e. Services under Hearing Aid Benefits.

     f. Covered travel expense in connection with an authorized bariatric surgical procedure provided at an approved Centers of Medical Excellence.

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

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;

   b. 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

   c. 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 Centers of Medical Excellence for authorized bariatric surgery travel expense, and
7. Approved Centers of Medical Excellence 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, (or the Reasonable and Customary Value for Emergency Services provided by a Non-Prudent Buyer Plan Provider). Co-Payments are shown under each benefit listed in the section entitled PRUDENT BUYER PLAN - COVERED SERVICES AND SUPPLIES on pages 24 through 50.

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 24 through 50.

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 Anthem Blue Cross **before** services are rendered, Anthem Blue Cross 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), Anthem Blue Cross 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, Anthem Blue Cross 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 Anthem Blue Cross and performed at a designated Centers of Medical Excellence (CME), 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 CME. 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 Anthem Blue Cross and performed at a designated Centers of Medical Excellence (CME), 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. 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** ..... **$4,500 ***
- **Two or more Members of the same family** ..... **$9,000 *** †

† Not to exceed $4,500 for any one 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 Combined Evidence of Coverage and Disclosure Form, and what the term means to you when obtaining covered services under this plan. The Maximum Allowed Amount is the total reimbursement payable under your plan for covered services you receive from Prudent Buyer Plan Providers and Non-Prudent Buyer Plan Providers. It is Anthem Blue Cross' 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 Anthem Blue Cross' 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. Anthem Blue Cross 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. Anthem Blue Cross pays 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, Anthem Blue Cross will, to the extent applicable, apply claim processing rules to the claim submitted. Anthem Blue Cross uses 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 Anthem Blue Cross determines 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 customer service 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. The Maximum Allowed Amount for services provided by a Non-Prudent Buyer Plan Provider will always be the lesser of the billed charge or the Scheduled Amount. See the SCHEDULES FOR NON-PRUDENT BUYER PLAN PROVIDERS, and the definition of Scheduled Amount in the DEFINITIONS section. You will be responsible for any billed charge which exceeds the Scheduled Amount for services provided by a Non-Prudent Buyer Plan Provider.

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 Anthem Blue Cross non-Prudent Buyer Plan Provider rate or fee schedule for this plan, an amount negotiated by Anthem Blue Cross 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, Anthem 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.

DETERMINATION OF THE MAXIMUM ALLOWED AMOUNT

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 customer service number on your ID card for help in finding a Prudent Buyer Plan Provider or visit Anthem Blue Cross' website at www.anthem.com/ca. Customer service 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:

- **Emergency Services Provided by Non-Prudent Buyer Plan Providers**

  For emergency services provided by Non-Prudent Buyer Plan Provider, reimbursement is based on the Reasonable and Customary Value. You will not be responsible for any amounts in excess of the Reasonable and Customary Value for emergency services rendered within California.

- **Emergency Ambulance Services Provided by Non-Prudent Buyer Plan Providers.** For Emergency ambulance services received from Non-Prudent Buyer Plan Providers outside of California, the plan's payment is based on the Maximum Allowed Amount. Non-Prudent Buyer Plan Providers (both inside and outside of California) may also bill you for any charges over the plan's Reasonable and Customary Value or Maximum Allowed Amount, respectively.

- **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 lesser of the Maximum Allowed Amount stated on pages 128 through 134, 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.

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 customer service 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.

Anthem Blue Cross 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 providing services at the hospital or facility, you will pay the Prudent Buyer Plan Provider cost share percentage of the Maximum Allowed Amount for those covered services. However, you also may be liable for the difference between the Maximum Allowed Amount and the Non-Prudent Buyer Plan Provider's charge.

Authorized Referrals

In some circumstances Anthem Blue Cross 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 Anthem Blue Cross in advance of obtaining the covered service. It is your responsibility to ensure that Anthem Blue Cross has been contacted. If Anthem Blue Cross authorizes 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 customer service 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 office visit provided by Prudent Buyer Plan Providers. Note: This co-pay applies to the charge for the Physician visit only.

10% Co-Pay for all other services provided by Prudent Buyer Plan Providers.

10% Co-Pay for Non-Prudent Buyer Plan Providers PLUS any amount in excess of the Maximum Allowed Amount which is strictly limited as shown on pages 128 through 134.

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

10% Co-Pay for Prudent Buyer Plan Providers.

10% Co-Pay for Non-Prudent Buyer Plan Providers PLUS any amount in excess of the Maximum Allowed Amount which is strictly limited as shown on pages 128 through 134.

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 customer service 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 54 for details.

Allergy Testing and Allergy Injections

$20 Co-Pay for office visit provided by Prudent Buyer Plan Providers.

10% Co-Pay for all other services provided by Prudent Buyer Plan Providers.

10% Co-Pay for Non-Prudent Buyer Plan Providers PLUS any amount in excess of the Maximum Allowed Amount which is strictly limited as shown on pages 128 through 134.

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

COVERED SERVICES AND SUPPLIES

Ambulance

20% 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.

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 Anthem Blue Cross 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 Anthem Blue Cross to one that does, or
  - Between a Hospital and another approved facility.

Ambulance services are subject to medical necessity reviews. Pre-service review is required for air ambulance in a non-medical Emergency. When using an air ambulance in a non-emergency situation, Anthem Blue Cross reserves the right to select the air ambulance provider. If the Member does not use the air ambulance Anthem Blue Cross 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.

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 a skilled nursing 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

10% Co-Pay for Prudent Buyer Plan Providers.

10% Co-payment for Non-Prudent Buyer Plan Providers PLUS any amount in excess of the Maximum Allowed Amount which is strictly limited as shown on pages 128 through 134.

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 54 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

10% Co-Pay for Centers of Medical Excellence (CME).

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 CME facility. **Charges for services provided for or in connection with a bariatric surgical procedure performed at a facility other than a CME 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 54 for information on how to obtain the proper reviews.

COVERED SERVICES AND SUPPLIES

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 CME. Coverage area is the area within the 50-mile radius surrounding a designated CME. Covered travel expense includes the following:

1. Transportation for the Member to and from the CME 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).
2. Transportation for one companion to and from the CME up to a maximum payment of **$130** per trip for a maximum of two (2) trips (the initial surgery and one follow-up visit).
3. 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.
4. 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.
5. 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 Anthem Blue Cross.

All travel expenses must be approved by Anthem Blue Cross in advance. Customer service will confirm if the bariatric surgery travel expense benefit is provided in connection with access to the selected bariatric CME. Details regarding reimbursement can be obtained by calling customer service at 1-800-288-6928. 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

10% Co-Pay for Prudent Buyer Plan Providers.

10% Co-Pay for Non-Prudent Buyer Plan Providers PLUS any amount in excess of the Maximum Allowed Amount which is strictly limited as shown on pages 128 through 134.

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

Blood

20% 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 charges include transfusions (including blood processing) and the cost of unreplaced blood and blood products.

COVERED SERVICES AND SUPPLIES

Breast Cancer

See Hospital benefits on pages 36 & 37 as well as Physician/Professional Services on page 40 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 according to the terms and conditions of this plan that apply to all other medical conditions.

Body Scan

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.

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

Clinical Trials

See Hospital benefits on pages 36 & 37 as well as Physician/Professional Services on page 40 for specific Co-Pay, Deductible and Out-of-Pocket Expense Amount Information. Anthem Blue Cross 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 services and supplies 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.

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

1. Federally funded trials approved or funded by one or more of the following:
   a. The National Institutes of Health,
   b. The Centers for Disease Control and Prevention,

c. The Agency for Health Care Research and Quality,

d. The Centers for Medicare and Medicaid Services,

e. A cooperative group or center of any of the four entities listed above or the Department of Defense or the Department of Veterans Affairs,

f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants, or

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

   i. The Department of Veterans Affairs,

   ii. The Department of Defense, or

   iii. The Department of Energy.

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

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

When a service is part of an approved clinical trial, it is covered even though it may otherwise be an Investigative service as defined by the plan (see the DEFINITIONS section).

Participation in the clinical trial must be recommended by the Member's Physician after determining participation has a meaningful potential to benefit the Member.

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

1. The investigational item, device, or service itself.

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, or should have been paid for, by the sponsor of 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 CLAIMS REVIEW / GRIEVANCE PROCEDURES.

COVERED SERVICES AND SUPPLIES

Contraceptives

$20 Co-Pay for office visit provided by Prudent Buyer Plan Providers.

10% Co-Pay for all other services provided by Prudent Buyer Plan Providers.

10% Co-Pay for Non-Prudent Buyer Plan Providers PLUS any amount in excess of the Maximum Allowed Amount which is strictly limited as shown on pages 128 through 134.

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

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

If 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.

Dental Care

PHYSICIAN SERVICES

$20 Co-Pay for office visit provided by Prudent Buyer Plan Physicians.

10% Co-Pay for all other services provided by Prudent Buyer Plan Physicians.

10% Co-Pay for Non-Prudent Buyer Plan Physicians PLUS any amount in excess of the Maximum Allowed Amount which is strictly limited as shown on pages 128 through 134.

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

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 natural teeth. Coverage shall be limited to only such services that are Medically Necessary to repair the damage done by Accidental Injury and/or restore function lost as a direct result of the Accidental Injury. Damage to natural teeth due to chewing or biting is not 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.

COVERED SERVICES AND SUPPLIES

HOSPITAL SERVICES

10% Co-Pay for all other services provided by Prudent Buyer Plan Providers.

10% Co-Pay for Non-Prudent Buyer Plan Providers PLUS any amount in excess of the Maximum Allowed Amount which is strictly limited as shown on pages 128 through 134.

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 54 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.). Anthem Blue Cross 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, are not 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 customer service telephone number listed on your ID card. To fully understand your coverage under this plan, please carefully review this Evidence of Coverage document.

Diabetes Education Programs

$20 Co-Pay for diabetes education program services provided by Prudent Buyer Plan Providers. Note: This co-pay applies to the charge for the Physician visit only.

10% Co-Pay for Non-Prudent Buyer Plan Providers PLUS any amount in excess of the Maximum Allowed Amount which is strictly limited as shown on pages 128 through 134.

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

10% Co-Pay for Prudent Buyer Plan Providers.

10% Co-Pay for Non-Prudent Buyer Plan Providers PLUS any amount in excess of the Maximum Allowed Amount which is strictly limited as shown on pages 128 through 134.

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

Benefits include outpatient diagnostic imaging and laboratory services. This does not include services covered under the Advanced Imaging Procedures benefit.

Durable Medical Equipment

20% Co-Pay 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 54 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. Anthem Blue Cross determines whether the item meets the above conditions.

Emergency Care

10% Co-Pay PLUS any amount in excess of the Reasonable and Customary Value for services provided by Non-Prudent Buyer Plan Providers, except for ambulance services which require a 20% Co-Pay 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 54 for information on how to obtain the proper reviews.

COVERED SERVICES AND SUPPLIES

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 Anthem Blue Cross.

See pages 36 & 37 Hospital - Outpatient for information regarding **Non-emergency services** provided by a Hospital emergency room.

Hearing Aid Benefits

20% Co-Pay PLUS 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 does applies toward the Out-of-Pocket Expense Amount.

The following services and supplies are covered:

1. 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

10% Co-Pay for services provided by Prudent Buyer Plan Providers.

10% 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 54 for information on how to obtain the proper reviews.

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. 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.

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

10% Co-Pay for Prudent Buyer Plan Providers.

10% 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 54 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, 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 32); maintenance and repair charges for such equipment;
5. Laboratory services to monitor the patient's response to therapy regimen.

Hospice Care

10% 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.

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. The Member must be suffering from a terminal illness for which the prognosis of life expectancy is one year or less, as certified by a Physician and submitted to Anthem Blue Cross. Covered services are available on a 24-hour basis for the management of the condition.

COVERED SERVICES AND SUPPLIES

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 Anthem Blue Cross every 30 days.

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

10% Co-Pay for Prudent Buyer Plan Providers.

10% Co-Pay for Non-Prudent Buyer Plan Providers PLUS any amount in excess of the Maximum Allowed Amount which is strictly limited as shown on pages 128 through 134.

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 54 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 Anthem Blue Cross authorizes, 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 Anthem Blue Cross 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.

Hospital - Outpatient

10% Co-Pay for Prudent Buyer Plan Providers.

10% 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 54 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 Anthem Blue Cross 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.

Mental Disorders and Substance Abuse

PHYSICIAN SERVICES

$20 Co-Pay for office visit provided by Prudent Buyer Plan Physicians.

10% Co-Pay for Prudent Buyer Plan Providers.

10% Co-Pay for Non-Prudent Buyer Plan Providers PLUS any amount in excess of the Maximum Allowed Amount which is strictly limited as shown on pages 128 through 134.

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

Physician visits during a covered Inpatient Stay or for outpatient treatment of Mental Disorders or substance abuse. Physician visits for outpatient psychotherapy, psychological testing or rehabilitative care for treatment of Mental Disorders or substance abuse. This includes nutritional counseling for the treatment of eating disorders such as anorexia nervosa and bulimia nervosa.

Behavioral health treatment for pervasive developmental disorder or autism. See the section BENEFITS FOR PERVASIVE DEVELOPMENTAL DISORDER OR AUTISM for a description of the services that are covered. **Note:** You must obtain pre-service review for all behavioral health treatment services for the treatment of pervasive developmental disorder or autism in order for these services to be covered by this plan (see UTILIZATION REVIEW PROGRAM for details). No benefits are payable for these services if pre-service review is not obtained.

COVERED SERVICES AND SUPPLIES

HOSPITAL SERVICES

10% Co-Pay for all other services provided by Prudent Buyer Plan Providers.

10% Co-Pay for Non-Prudent Buyer Plan Providers PLUS any amount in excess of the Maximum Allowed Amount which is strictly limited as shown on pages 128 through 134.

Hospital services and Residential Treatment Center admissions 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 54 for information on how to obtain the proper reviews.

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

Hospital services include:

1. Inpatient Hospital services as provided in the "Hospital - Inpatient" benefit of this plan.

2. Services from a Residential Treatment Center where the Member resides in a modified community environment and follows a comprehensive medical treatment regimen for treatment and rehabilitation as the result of Mental Disorders or substance abuse.

3. Partial hospitalization, including intensive outpatient programs and visits to a Day Treatment Center for outpatient psychiatric services and supplies for treatment of Mental Disorders or substance abuse under the supervision of the Physician.

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

Nicotine Patches

50% Co-Pay PLUS 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.

After successfully completing one of the approved Smoking Cessation Programs specified on page 45 and submitting a Certificate of Completion, benefits are provided for one 90-day supply of nicotine patches per lifetime.

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

Outpatient Drugs and Medicines

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

10% Co-Pay for services provided by Prudent Buyer Plan Providers.

10% Co-Pay for Non-Prudent Buyer Plan Providers PLUS any amount in excess of the Maximum Allowed Amount.

COVERED SERVICES AND SUPPLIES

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 70 through 81 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 office visit provided by Prudent Buyer Plan Providers. Note: This co-pay applies to the charge for the Physician visit only.

10% Co-Pay for all other services provided by Prudent Buyer Plan Providers.

10% Co-Pay for Non-Prudent Buyer Plan Providers PLUS any amount in excess of the Maximum Allowed Amount which is strictly limited as shown on pages 128 through 134.

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 chiropractors, physical therapists and osteopaths.)
2. Occupational therapy provided on an outpatient basis when the ability to perform daily life tasks has been lost or reduced by, or has not been developed due to, illness or injury, including programs which are designed to rehabilitate mentally, physically or emotionally handicapped persons. Occupational therapy programs which are designed to maximize or improve a patient's upper extremity function, perceptual motor skills and ability to function in daily living activities.

Benefits are **not** payable for care provided to relieve general soreness or for conditions that 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 Prudent Buyer Plan Providers, up to a combined maximum of 20 visits in a Year for all covered services are payable if Medically Necessary. If additional visits are needed after receiving 20 visits in a Year, pre-service review must be obtained prior to receiving the services. If Anthem Blue Cross determines that an additional period of physical therapy, physical medicine or occupational therapy is Medically Necessary, Anthem Blue Cross will specify a specific number of additional visits.

Such additional visits are not payable if pre-service review is not obtained. (See PRUDENT BUYER PLAN BENEFITS - UTILIZATION REVIEW PROGRAMS section beginning on page 54.)

COVERED SERVICES AND SUPPLIES

For the purposes of this benefit, the term "visit" shall include any visit by a Physician in that Physician's office, or in any other outpatient setting, during which one or more of the services covered under this limited benefit are rendered, even if other services are provided during the same visit.

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

Physician / Professional Services

$20 Co-Pay for office visit provided by Prudent Buyer Plan Providers.

10% Co-Pay for all other services provided by Prudent Buyer Plan Providers.

10% Co-Pay for Non-Prudent Buyer Plan Providers PLUS any amount in excess of the Maximum Allowed Amount which is strictly limited as shown on pages 128 through 134.

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

Covered services include:

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 Care Services when available in your area, covered services will include medical consultations using the internet via webcam, chat, or voice. Online care services 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.

COVERED SERVICES AND SUPPLIES

Pregnancy, Maternity Care and Family Planning

PHYSICIAN SERVICES

$20 Co-Pay for office visit provided by Prudent Buyer Plan Physicians.

10% Co-Pay for all other services provided by Prudent Buyer Plan Physicians.

10% Co-Pay for Non-Prudent Buyer Plan Physicians PLUS any amount in excess of the Maximum Allowed Amount which is strictly limited as shown on pages 128 through 134.

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

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

HOSPITAL SERVICES

10% Co-Pay for services provided by Prudent Buyer Plan Providers.

10% Co-Pay for Non-Prudent Buyer Plan Providers PLUS any amount in excess of the Maximum Allowed Amount which is strictly limited as shown on pages 128 through 134.

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:
   a. Prenatal and postnatal care;
   b. Ambulatory care services (including ultrasounds, fetal non-stress tests, Physician office visits, and other Medically Necessary maternity services performed outside of a Hospital);
   c. Involuntary complications of pregnancy;
   d. Diagnosis of genetic disorders in cases of high-risk pregnancy; and
   e. 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.

Screening services and supplies provided in connection with Preventive Care Services as shown below.

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, 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 methods for women, including over-the-counter items, if prescribed by a Physician. In order to be covered as preventive care, contraceptive Prescription Drugs must be either a Generic or Single-Source Brand Name Drug. Also covered are sterilization procedures and counseling.

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

   c. Gestational diabetes screening.

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

COVERED SERVICES AND SUPPLIES

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.

Prosthetic Devices

20% 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 charges include:

1. Surgical implants including breast prostheses 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 Orthopedic footwear used as an integral part of a brace; shoe inserts that are custom molded to the patient.

Radiation, Chemotherapy and Hemodialysis

RADIATION therapy, CHEMOTHERAPY and HEMODIALYSIS treatment. See Hospital - Outpatient on pages 36-37 for benefit information.

Reconstructive Surgery

See Hospital benefits on pages 36 & 37 as well as Physician/Professional Services on page 40 for specific Co-Pay, Deductible and Out-of-Pocket Expense Amount information.

Benefits are provided for reconstructive surgery performed to correct deformities caused by congenital or developmental abnormalities, illness, or injury for the purpose of improving bodily function or symptomatology or creating a normal appearance. This 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.

COVERED SERVICES AND SUPPLIES

Retail Health Clinic

See Preventive Care Services on pages 42 & 43 as well as Physician/Professional Services on page 40 for specific Co-Pay, Deductible and Out-of-Pocket Expense Amount Information. Anthem Blue Cross 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:

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

Skilled Nursing Facility

10% Co-Pay for Prudent Buyer Plan Providers.

10% 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 54 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.

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 Anthem Blue Cross:

Class Supported Programs

1. American Lung Association - "Freedom From Smoking". Call 1-800-586-4872 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. Anthem Blue Cross has 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 - Anthem Blue Cross customer service unit.

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

Benefits will be provided subject to the following:

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

Speech Therapy

10% Co-Pay for Prudent Buyer Plan Providers.

10% 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.

COVERED SERVICES AND SUPPLIES

Special Duty Nursing Care

20% 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.

Transgender Services

PHYSICIAN SERVICES

$20 Co-Pay for office visit provided by Prudent Buyer Plan Physicians.

10% Co-Pay for all other services provided by Prudent Buyer Plan Physicians.

10% Co-Pay for Non-Prudent Buyer Plan Physicians PLUS any amount in excess of the Maximum Allowed Amount which is strictly limited as shown on pages 128 through 134.

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

HOSPITAL SERVICES

10% Co-Pay for services provided by Prudent Buyer Plan Providers.

10% Co-Pay for Non-Prudent Buyer Plan Providers PLUS any amount in excess of the Maximum Allowed Amount which is strictly limited as shown on pages 128 through 134.

Inpatient Hospital services are subject to pre-service review to determine medical necessity. Please refer to the UTILIZATION REVIEW PROGRAMS section beginning on page 54 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).

Services that are excluded on the basis that they are cosmetic include, but are not limited to, liposuction, facial bone reconstruction, voice modification surgery, breast implants, and hair removal. 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 Anthem. 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 Anthem. Anthem 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 customer service 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

$20 Co-Pay for office visit provided by Prudent Buyer Plan Physicians.

10% Co-Pay for all other services provided by Prudent Buyer Plan Physicians.

10% Co-Pay for Non-Prudent Buyer Plan Physicians PLUS any amount in excess of the Maximum Allowed Amount which is strictly limited as shown on pages 128 through 134.

HOSPITAL SERVICES

10% Co-Pay for services provided by Prudent Buyer Plan Providers.

10% Co-Pay for Non-Prudent Buyer Plan Providers PLUS any amount in excess of the Maximum Allowed Amount which is strictly limited as shown on pages 128 through 134.

Subject to the Calendar Year Deductible and applies toward the Out-of-Pocket Expense 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 54 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. 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 54. Benefits for authorized services are subject to all other conditions, limitations, exclusions and provisions of this plan.

The Member can maximize benefits by calling Anthem Blue Cross' 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)* rules, or exclusions apply. Call the customer service phone number on the back of your ID card and ask for the transplant coordinator.

The Member or the Member's Physician must call Anthem Blue Cross' 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 Anthem Blue Cross will provide benefits for a transplant. The Member's Physician must certify, and Anthem Blue Cross must agree, that the transplant is Medically Necessary. The Member's Physician should send a written request for prior authorization to Anthem Blue Cross 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 harvest 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 harvest and storage request will be reviewed for medical necessity and may be approved. However, such an approval for HLA testing, donor search, or harvest and storage is NOT an approval for the later transplant. A separate medical necessity decision will be needed for the transplant itself.

SPECIFIED TRANSPLANTS

10% Co-Pay for Centers of Medical Excellence (CME).

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). **Charges for services provided for or in connection with a specified transplant performed at a facility other than a CME will not be covered.** Call the customer service 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. Please refer to the PRUDENT BUYER PLAN BENEFITS - UTILIZATION REVIEW PROGRAMS section beginning on page 54 for information on how to obtain the proper reviews.

No benefits are payable for Experimental or Investigational transplants. If services are denied because Anthem Blue Cross determines 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 that is 75 miles or more from the recipient's or donor's place of residence are covered, provided the expenses are authorized by Anthem Blue Cross 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 when the designated CME is 75 miles or more from the recipient's or donor's place of residence.
- Coach airfare to and from the CME when the designated CME is 300 miles or more from the recipient's or donor's residence.
- Lodging, limited to one room, double occupancy.
- Other reasonable expenses. 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 Anthem Blue Cross. 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 customer service 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 36 & 37 as well as Physician/Professional Services on page 40 for specific Co-Pay, Deductible and Out-of-Pocket Expense Amount Information. Anthem Blue Cross 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.

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 PERVASIVE DEVELOPMENTAL DISORDER OR AUTISM

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

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

You must obtain pre-service review for all behavioral health treatment services for the treatment of Pervasive Developmental Disorder or autism in order for these services to be covered by this plan (see UTILIZATION REVIEW PROGRAMS for details). No benefits are payable for these services if pre-service review is not obtained.

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

DEFINITIONS

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

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

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

Qualified Autism Service Provider is either of the following:

- A person, entity, or group that is certified by a national entity, such as the Behavior Analyst Certification Board, 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, entity, or group that 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,
- 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 approved as a vendor by a California regional center to provide services as an associate behavior analyst, behavior analyst, behavior management assistant, behavior management consultant, or behavior management program as defined in state regulation, and
- Has training and experience in providing services for Pervasive Developmental Disorder or autism pursuant to applicable state law.

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

- Is employed and supervised by a Qualified Autism Service Provider,
- 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, and
- Has adequate education, training, and experience, as certified by a Qualified Autism Service Provider.

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,
- 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:

BENEFITS FOR PERVASIVE DEVELOPMENTAL DISORDER OR AUTISM

- Describes the patient's behavioral health impairments to be treated,
- Designs an intervention plan that includes the service type, number of hours, and parent participation needed to achieve the intervention plan's goal and objectives, and the frequency at which the patient's progress is evaluated and reported,
- Provides intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating Pervasive Developmental Disorder or autism,
- Discontinues Intensive Behavioral Intervention services when the treatment goals and objectives are achieved or no longer appropriate, and
- The treatment plan is not used for purposes of providing or for the reimbursement of respite care, day care, or educational services, and is not used to reimburse a parent for participating in the treatment program. No coverage will be provided for any of these services or costs. The treatment plan must be made available to Anthem upon request.

UTILIZATION REVIEW PROGRAMS

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

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

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

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

This plan includes the processes of pre-service, care coordination, and retrospective reviews to determine when services should be covered. Their purpose is to promote the delivery of cost-effective medical care by reviewing the use of procedures and, where appropriate, the setting or place of service where care is provided. This plan requires that covered services be Medically Necessary for benefits to be provided.

Certain services require pre-service review of benefits in order for benefits to be provided. Prudent Buyer Plan Providers will initiate the review on the Member's behalf. A Non-Prudent Buyer Plan Provider may or may not initiate the review for the Member. In both cases, it is the Member's responsibility to initiate the process and ask their Physician to request pre-service review. The Member may also call Anthem Blue Cross directly. Pre-service review criteria are based on multiple sources including medical policy, clinical guidelines, and pharmacy and therapeutics guidelines. Anthem Blue Cross may determine that a service that was initially prescribed or requested is not Medically Necessary if the Member has not previously tried alternative treatments that are more cost effective.

It is the Member's responsibility to determine whether a particular service requires pre-service authorization. Read the following information that follows to assist in this determination and visit www.anthem.com or call the toll-free number for pre-service printed on the Member's identification card for any questions about making this determination.

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

UTILIZATION REVIEW PROGRAMS

Utilization Review Requirements and How Benefits Are Affected By Utilization Reviews

The stages of utilization review are pre-service review, care coordination review, and retrospective review.

Pre-service review determines in advance the medical necessity and appropriateness of certain procedures or admissions and the appropriate length of stay, if applicable. Pre-service review is required for the services listed below.

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.

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

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

  - Maternity care of 48 hours 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 and other services.

— Specific outpatient surgeries performed in an outpatient facility of a doctor's office.

— 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 Anthem Blue Cross 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) facility.

— Air ambulance in a non-medical Emergency.

— Visits for physical therapy, physical medicine and occupational therapy beyond those described under the "Physical Therapy – Physical Medicine" provision of PRUDENT BUYER PLAN BENEFITS: COVERED SERVICES AND SUPPLIES. A specified number of additional visits may be authorized. 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 Centers of Medical Excellence.

— 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 customer service toll-free at 1-800-288-6928 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.

— 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.

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

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

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

Services that are not reviewed prior to or during service delivery will be reviewed retrospectively when the bill is submitted for benefit payment. If that review results in the determination that part or all of the services were not Medically Necessary and appropriate, benefits will not be provided for those services. Remaining benefits will be subject to previously noted reductions that apply when the required reviews are not obtained.

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

No benefits are payable unless the Member's coverage is in force at the time services are rendered.

UTILIZATION REVIEW PROGRAMS

How To Obtain Utilization Reviews

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

1. Pre-service Reviews

Obtain required Pre-service Review before receiving scheduled services as follows:

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

The Member must inform his or her Physician that this plan requires pre-service review. Prudent Buyer Plan Physicians will initiate the review on the Member's behalf. A Non-Prudent Buyer Plan Provider may initiate the review for the Member, or the Member may call Anthem Blue Cross directly. The toll-free telephone number for pre-service review is 1-800-274-7767.

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

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

2. Care Coordination Reviews

If pre-service review was not performed, the Member, the Member's Physician or the provider of service must contact Anthem Blue Cross for care coordination review. **For an Emergency Hospital admission or procedure, Anthem Blue Cross must be notified within one working day of the admission or procedure, unless extraordinary circumstances* prevent such notification within that time period**. The toll-free telephone number for concurrent review is 1-800-274-7767.

When a Prudent Buyer Plan Provider has been informed of the Member's need for utilization review, they will initiate the review on the Member's behalf. The Member may ask a Non-Prudent Buyer Plan Provider to call the toll free number, or the Member may call Anthem Blue Cross directly.

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

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

***Extraordinary Circumstances.** In determining "extraordinary circumstances", Anthem Blue Cross may take into account whether or not the Member's condition was severe enough to prevent him or her from notifying Anthem Blue Cross, or whether or not someone from the Member's family was available to notify Anthem Blue Cross for the Member. The Member may have to prove that such "extraordinary circumstances" were present at the time of the Emergency.

3. Retrospective Reviews

If a pre-service or a care coordination review was not performed, a retrospective review will be done to review services that have already been provided to determine if they are Medically Necessary.

Retrospective review is performed when Anthem Blue Cross has not been notified of the services the Member received and therefore is unable to perform the appropriate review. It is also performed when pre-service or care coordination review has been done, but services continue longer than originally certified.

Retrospective review may also be performed for the evaluation and audit of medical documentation after services have been provided, whether or not pre-service or care coordination review was performed.

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

The Medical Necessity Review Process

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

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

   When the Member's medical condition is such that the Member faces an imminent and serious threat to their health, including the potential loss of life, limb, or other major bodily function and the normal five day timeframe described above would be detrimental to your life or health or could jeopardize your ability to regain maximum function, a decision on the medical necessity of a pre-service request will be made no later than 72 hours after receipt of the information reasonably necessary to make the decision (or within any shorter period of time required by applicable federal law, rule, or regulation).

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

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

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

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

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

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

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

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

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

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

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

- The information submitted with the claim differs from that given by phone;
- The service is excluded from coverage; or
- The Member is not eligible for coverage when the service is actually provided.

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

- The Member's coverage under this plan ends;
- The Agreement with the PORAC and Anthem Blue Cross 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.

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 Anthem Blue Cross.

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

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

Anthem Blue Cross 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 Anthem Blue Cross 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.

UTILIZATION REVIEW PROGRAMS

The Member may determine whether a health care provider participates in certain programs by checking Anthem Blue Cross' online provider directory on their website at www.anthemcom/ca or by calling the customer service telephone number listed on the Member's ID card.

Quality Assurance

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

CASE MANAGEMENT

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

How Case Management Works

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

Anthem Blue Cross' 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.

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

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

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

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

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

How Benefits Are Affected By Case Management

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

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

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

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

EXCLUSIONS AND LIMITATIONS

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

Benefits of this Evidence of Coverage are not provided for or in connection with the following items, 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 CalPERS plan, the exclusion for hospitalization beginning prior to the Member's Effective Date shall apply only during the first 90 days of enrollment under this plan unless the prior carrier provides coverage for the condition causing the Hospital confinement beyond the 90th day following the Member's Effective Date under this plan.

3. **Caffeine Addiction.** Any expense incurred for caffeine addiction.

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

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 Anthem Blue Cross is required by law to cover;
   - Services specified as covered in this Certificate of Evidence of Coverage;
   - 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. **Educational or Academic Services.** This plan does not cover:

    - Educational or academic counseling, remediation, or other services that are designed to increase academic knowledge or skills.
    - Educational or academic counseling, remediation, or other services that are designed to increase socialization, adaptive, or communication skills.
    - Academic or educational testing.
    - Teaching skills for employment or vocational purposes.
    - Teaching art, dance, horseback riding, music, play, swimming, or any similar activities.
    - Teaching manners and etiquette or any other social skills.
    - Teaching and support services to develop planning and organizational skills such as daily activity planning and project or task planning.

    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.

11. **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.

12. **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 CLAIMS REVIEW / GRIEVANCE PROCEDURES.

EXCLUSIONS AND LIMITATIONS

13. **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.

14. **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.

15. **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.

16. **Hearing Aids or Tests.** Hearing aids or routine hearing tests, except as specifically stated under the Hearing Aid Benefits and Preventive Care Services provisions of PRUDENT BUYER PLAN BENEFITS - COVERED SERVICES AND SUPPLIES.

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

18. **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.

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

20. **Nicotine Addiction.** Services for smoking cessation or reduction; nicotine use or addiction if the program is not affiliated with Anthem Blue Cross and, except as specifically stated in the Smoking Cessation Programs and Nicotine Patches provisions of PRUDENT BUYER PLAN BENEFITS - COVERED SERVICES AND SUPPLIES. Smoking cessation Drugs, except as specifically stated under the section entitled PRESCRIPTION DRUG BENEFITS.

EXCLUSIONS AND LIMITATIONS

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

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

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

24. **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.

25. **Orthopedics.** Orthopedic shoes and shoe inserts. This exclusion does not apply to orthopedic footwear used as an integral part of a brace, shoe inserts that are custom molded to the patient, or therapeutic shoes and inserts designed to treat foot complications due to diabetes, as specifically stated under the Durable Medical Equipment provision of PRUDENT BUYER PLAN BENEFITS - COVERED SERVICES AND SUPPLIES.

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

27. **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.

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

29. **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.

30. **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.

EXCLUSIONS AND LIMITATIONS

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

32. **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.

33. **Routine Exams or Tests.** Routine physical exams or tests which do not directly treat an actual illness, injury or condition, including those required by employment or government authority, except as specifically stated under Preventive Care Services under PRUDENT BUYER PLAN BENEFITS - COVERED SERVICES AND SUPPLIES.

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

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

36. **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.

37. **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).

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

39. **Transgender Services.** Services and supplies in connection with transgender services, except as specifically stated in the "Transgender Services" provision under the section PRUDENT BUYER PLAN BENEFITS - COVERED SERVICES AND SUPPLIES.

40. **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 Anthem. 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.

41. **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.

42. **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.

EXCLUSIONS AND LIMITATIONS

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

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

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 Anthem Blue Cross' 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 1-800-700-2541 (or TTY/TDD 1-800-905-9821) 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 plastic Anthem Blue Cross Identification Card to a Participating Pharmacy, the Member will only pay the applicable copayment amount for each covered Prescription and each refill (see pages 73-74 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 customer service are available by calling 1-800-700-2541 (or TTY/TDD 1-800-905-9821). 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.

PRESCRIPTION DRUG BENEFITS

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 customer service are available by calling 1-800-700-2541 (or TTY/TDD 1-800-905-9821). 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 1-800-700-2541 (or TTY/TDD 1-800-905-9821). The order form is also available on-line at www.anthem.com/ca.

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.

PRESCRIPTION DRUG BENEFITS

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 75 through 77 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 Anthem Blue Cross).

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 1-800-700-2541. 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.

With few exceptions, most orally administered anti-cancer medications are considered specialty drugs. For orally administered anti-cancer medications, the prescription drug deductible, if any, will not apply and the copayment will not exceed the lesser of the applicable copayment shown in the PORAC PRUDENT BUYER PLAN - SUMMARY OF BENEFITS or $200 for a 30-day supply for medications obtained at a retail pharmacy or $600 for a 90-day supply for medications obtained through home delivery.

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 or accessing the website at www.anthem.com/ca.

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.

PRESCRIPTION DRUG BENEFITS

- 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 Drugs or Single Source Brand Name Drugs.
- Shingles, seasonal flu and pneumonia vaccinations.
- Prescription Drugs to eliminate or reduce dependency on, or addiction to, tobacco and tobacco products.
- FDA-approved smoking cessation products including over-the-counter nicotine replacement products when obtained with a Physician's prescription and the Member is at least 18 years old.
- Aspirin to reduce the risk of heart attack or stroke, for men ages 45-79 and women ages 55-79.
- Folic acid supplementation for women age 55 years and younger (folic acid supplement or a multivitamin).
- Vitamin D for women over age 65.
- 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.
- Iron supplements for children from birth through 12 months old.
- Fluoride supplements for children from birth through 6 years old (drops or tablets).

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 76 for more information.

PRESCRIPTION DRUG BENEFITS

COPAYMENTS THROUGH THE HOME DELIVERY PROGRAM

A. The Member is responsible for a **$40.00** copayment for each Brand Name Prescription Drug or refill listed on the Prescription Drug Formulary, plus the difference in Prescription Drug Covered Expense between the cost of the Brand Name Drug and its Generic 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 76 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 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 BENEFITS

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 1-800-700-2541 (or TTY/TDD 1-800-905-9821) to find out where to take the Member's Prescription for an approved Compound Medication to be filled. (You can also find a 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 72 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 1-800-700-2541 (or TTY/TDD 1-800-905-9821) to request one. The Member can also get the form on-line at www.anthem.com/ca. If Anthem Blue Cross has 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 Anthem Blue Cross denies 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, Anthem Blue Cross 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 8 and under COPAYMENTS AT A RETAIL PHARMACY or COPAYMENTS THROUGH THE HOME DELIVERY PROGRAM on pages 73-74 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, Anthem Blue Cross 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, sanitorium, convalescent hospital, or similar facility. Also, it must not be dispensed in or administered by a Hospital, Skilled Nursing Facility, rest home, sanitorium, 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 for the treatment of attention deficit disorder must not exceed a 60-day supply. If the Physician prescribes a 60-day supply for Drugs classified as Schedule II for the treatment of attention deficit disorders, the Member has to pay double the amount of copayment for retail Pharmacies. If the Drugs are obtained through the home delivery program, the copayment will remain the same as for any other Prescription Drug.

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

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.

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 Anthem Blue Cross for review.

L. Certain Drugs have specific quantity supply limits based on Anthem Blue Cross' 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.

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

E. Prescription Drugs, vaccinations, 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.

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

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

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

I. 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 approves, a prescription to dispense is required, and the compound Drug is 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 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 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.

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. 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 Anthem Blue Cross determines that the Drug is Experimental or Investigational, the Member may ask that the denial be reviewed by an external independent medical review organization. See CLAIMS REVIEW / GRIEVANCE PROCEDURES 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. 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. Compound Medication unless all the ingredients are FDA-approved and require a prescription to dispense, and the compound medication 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. Compound Medications must be obtained from a Participating Pharmacy.

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 with Anthem Blue Cross by following the procedures described in the section entitled CLAIMS REVIEW / GRIEVANCE PROCEDURES.

V. 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.

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, Anthem Blue Cross' medical consultant will notify both the Member's personal Physician and pharmacist. Anthem Blue Cross reserves the right to limit benefits to prevent over-utilization of Drugs.

PRESCRIPTION DRUG FORMULARY

Anthem Blue Cross uses a Prescription Drug Formulary to help the Member's Physician make prescribing decisions. 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 Anthem Blue Cross' Formulary Drug list or requires prior authorization, please call Anthem Blue Cross at 1-800-700-2541 (or TTY/TDD 1-800-905-9821). Information about the Drugs on Anthem Blue Cross' Formulary Drug list is also available on the Anthem Blue Cross website at www.anthem.com/ca.

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

In order for the Member to get a Drug that requires prior authorization, the Member's Physician must send a written request to Anthem Blue Cross for the Drug. The request can be sent to Anthem Blue Cross by mail, facsimile, or it may be submitted electronically. The Physician may call Anthem Blue Cross toll-free at 1-800-700-2541 (or

TTY/TDD 1-800-905-9821) to request a copy of the form. This form is also available on-line at www.anthem.com/ca.

Anthem Blue Cross will review the request and respond within two business days of receiving the completed authorization request form. If material information necessary to approve or disapprove the request is missing, Anthem Blue Cross will tell the Member's Physician within two business days.

While Anthem Blue Cross is 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 8 and under COPAYMENTS AT A RETAIL PHARMACY of this section on page 73, 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 1-800-700-2541 (or TTY/TDD 1-800-905-9821). Information about the Drugs on Anthem Blue Cross' Formulary Drug list is also available on the Anthem Blue Cross 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 Anthem Blue Cross at 1-800-700-2541 (or TTY/TDD 1-800-905-9821). If the Member is not satisfied with the resolution based on such an inquiry, the Member may file a grievance with Anthem Blue Cross by following the procedures described in the section entitled CLAIMS REVIEW / GRIEVANCE PROCEDURES.

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 Anthem Blue Cross 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 Anthem Blue Cross 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.

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.

THIRD PARTY LIABILITY

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

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

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

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

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

WORKERS' COMPENSATION INSURANCE

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

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) in accordance with Section 22844 of the Act. CalPERS will provide the Member with information regarding his or her eligibility for a supplement to original Medicare plan.

Exception: For treatment of end-stage renal disease after the first 30 months, a Member who is enrolled in Medicare will remain enrolled in the Basic Plan, but the benefits of this plan will be reduced. When the Member incurs covered charges under this plan, Anthem Blue Cross 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 CalPERS at **888 CalPERS** (or **888**-225-7377).

COORDINATING BENEFITS WITH MEDICARE

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

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

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

3. If the Member elects to enroll in Medicare voluntary outpatient Prescription Drug benefits (Part D), the Member will **not** receive any benefits under the PRESCRIPTION DRUG BENEFITS section of this plan.
4. For any given claim, the combination of benefits provided by Medicare and the benefits provided under this plan will not exceed the Maximum Allowed Amount for the covered services.

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

ENROLLMENT PROVISIONS

ELIGIBILITY FOR ENROLLMENT

A. All Members who are eligible in accordance with the Act may enroll hereunder. Enrollment is restricted to members of the Peace Officers Research Association of California (PORAC) and their eligible Family Members.

   Family Member means the spouse or Domestic Partner and children of an Employee or Annuitant who qualify under Articles 1 and 5 of the Act and Sections 599.500, 599.501 and 599.502 of the Regulations. Such children include: (1) the Employee's or Annuitant's adopted, step or recognized natural child up to age 26, and (2) any other child up to age 26 for whom the Employee or Annuitant has intentionally assumed a parent-child relationship or assumed parental duties, except for a foster child, as certified by the Employee or Annuitant at the time of the child's enrollment, and annually thereafter.

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

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

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

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

ENROLLMENT PROVISIONS

CONDITIONS OF ENROLLMENT

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

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

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

COMMENCEMENT OF COVERAGE

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

TERMINATION PROVISIONS

TERMINATION OF AGREEMENT

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

TERMINATION OF COVERAGE

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

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

IMPORTANT NOTE: The Subscriber may be held liable retroactively for any services provided to ineligible Dependents. It is the Subscriber's responsibility to report any changes in a Family Member's status to his or her employer 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 Anthem Blue Cross may apply for reenrollment during the Open Enrollment Period.

UNFAIR TERMINATION OF COVERAGE

If the Member believes that his or her coverage has been or will be improperly terminated, the Member may file a grievance with Anthem Blue Cross in accordance with the procedures described in the section entitled CLAIMS REVIEW / GRIEVANCE PROCEDURES. The Member should file his or her grievance as soon as possible after the Member receives notice that his or her coverage will end. The Member may also request a review of the matter by the Director of the Department of Managed Health Care. If the Member's coverage is still in effect when he or she submits a grievance, Anthem Blue Cross will continue to provide coverage to the Member under the terms of this plan until a final determination of the Member's request for review has been made, including any review by the Director of the Department of Managed Health Care (this does not apply if the Member's coverage is cancelled for non-payment of subscription charges). If the Member's coverage is maintained in force pending outcome of the review, subscription charges must still be paid to Anthem Blue Cross on the Member's behalf.

CONTINUATION OF GROUP COVERAGE

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

A. Eligibility for Continuation - Qualifying Events

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

For Subscriber and Family Members . . .

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

For Family Members . . .

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

B. Requirements for Continuation

1. Notice

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

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

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

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 employee or annuitant shall be deemed notice to all other eligible Family Members residing with such employee, annuitant or Spouse at the time such notification is made.

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

Once a Subscriber and/or Family Member elects the COBRA continuation, Anthem Blue Cross shall provide written notice to each covered employee or annuitant 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. The standard enrollment provisions of the Act and Regulations apply to enrollees during the continuation period. A Family Member acquired and enrolled during the period of continuation coverage which resulted from the original qualifying event is not eligible for a separate continuation if a subsequent qualifying event results in the person's loss of coverage*.

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

3. Cost of Coverage

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

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

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

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

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

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

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

4. Subsequent Qualifying Events

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

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

5. When Continuation Coverage Begins

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

C. When The Continuation Ends

This continuation will end on the earliest of:

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

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

   a. the Member whose COBRA continuation under this plan began on or after January 1, 2003, and ends in accordance with item 1, elects to continue coverage for medical benefits only under CalCOBRA for the balance of 36 months (COBRA and CalCOBRA combined). All COBRA eligibility must be exhausted before the Member is eligible to further continue coverage under CalCOBRA. Please see CalCOBRA Continuation of Coverage in this booklet for more information.

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

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

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

2. The end of 36 months from the date the Member's coverage terminates, if the qualifying event was the death of the 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 Agreement 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.

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

CALCOBRA CONTINUATION OF COVERAGE

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

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

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

TERMS OF CALCOBRA CONTINUATION

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

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

CONTINUATION OF GROUP COVERAGE

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

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

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

You must make payment to Anthem Blue Cross within the timeframes specified below. Anthem Blue Cross must receive payment of your subscription charge each month to maintain your coverage in force.

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

If subscription charges are not received when due, your coverage will be cancelled. Anthem Blue Cross will cancel your coverage only upon sending you written notice of cancellation at least 30 days prior to cancelling your coverage (or any longer period of time required by applicable federal law, rule or regulation). If you make payment in full within this time period, your coverage will not be cancelled. If you do not make the required payment in full within this time period, your coverage will be cancelled as of 12:00 midnight on the thirtieth day after the date on which the notice of cancellation is sent (or any longer period of time required by applicable federal law, rule or regulation) and will not be reinstated. Any payment Anthem Blue Cross receives after this time period runs out will be refunded to you within 20 business days. Note: You are still responsible for any unpaid subscription charges that you owe to Anthem Blue Cross, including subscription charges that apply during any grace period.

Change of Subscription Charge. The amounts of the subscription charges may be changed by Anthem Blue Cross as of any subscription charge due date. Anthem Blue Cross will provide you with written notice at least 60 days prior to the date any subscription charge increase goes into effect.

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

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

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

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

CONTINUATION OF GROUP COVERAGE

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

1. The date that is 36 months after the date of your qualifying event under federal COBRA*;
2. The date the Agreement terminates;
3. The end of the period for which subscription charges are last paid (your coverage will be cancelled upon written notification, as explained under "Payment Dates" above);
4. The date you become covered under any other health plan;
5. The date you become entitled to Medicare; or
6. The date you become covered under a federal COBRA continuation.

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

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

TERMINAL BENEFITS

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

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

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

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

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

   1. The Member is no longer Totally Disabled, or
   2. The maximum benefits of the Agreement are paid, or
   3. The Member becomes covered under another group health plan that provides coverage without limitation for disabling illness or injury, or
   4. A period of 12 consecutive months has passed since the date coverage ended.

ANTHEM BLUE CROSS MONTHLY RATES

Type of Enrollment	Enrollment Code	Gross Rate
Self Only	2071	$699.00
Self and One Dependent	2072	$1,399.00
Self and Two or More Dependents	2073	$1,789.00

State Employees and Annuitants

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

Public Agency Employees and Annuitants

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

Rate Change

The plan rates may be changed as of January 1, 2017, following at least sixty (60) days' written notice to the Board prior to such change.

GENERAL PROVISIONS

Evidence of Coverage

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

Identification Cards

Anthem Blue Cross shall issue to the Subscriber an identification card to which the Subscriber and Family Members are entitled. Possession of an Anthem Blue Cross identification card confers no right to services or other benefits of 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 Anthem Blue Cross. The services must be ordered by the attending Physician for the direct care and treatment of a covered illness, injury or condition, except for routine care, dental care and lenses following surgery as specifically stated. They must be standard medical practice where received for the illness, injury or condition being treated and must be legal in the United States. When an Inpatient Hospital Stay is necessary, services are limited to those which could not have been performed before admission. The process used to authorize or deny health care services under this plan is available to you upon request.

Expense in Excess of Benefits

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

Payment to Providers

Anthem Blue Cross pays the benefits of this plan directly to Contracting Hospitals, Centers of Medical Excellence, Prudent Buyer Plan Providers and medical transportation providers. If the Subscriber or Family Member receives services from non-contracting Hospitals or Non-Prudent Buyer Plan Providers, payment will be made directly to the Subscriber, and the Member will be responsible for payment to the provider. Any assignment of benefits, even if assignment includes the provider's right to receive payment, is void. Anthem Blue Cross will pay non-contracting Hospitals and other providers of service directly when Emergency services and care are provided to the Member. Anthem Blue Cross will continue such direct payment until the Emergency Care results in stabilization. If the Member is a Medi-Cal beneficiary and assigns benefits in writing to the State Department of Health Services, Anthem Blue Cross will pay the benefits of this plan to the State Department of Health Services. These payments fulfill the obligation of Anthem Blue Cross to the Member for those services.

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 Anthem Blue Cross, 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.

Public Policy Participation

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

Claims Procedures

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 Anthem Blue Cross by the Member or the provider of service. These claim forms must be received by Anthem Blue Cross 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. Anthem Blue Cross is not liable for the benefits of the Agreement 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 customer service phone number shown on the Member's ID Card or go to Anthem Blue Cross' website at www.anthem.com/ca and download and print one.

Members using Non-Prudent Buyer Plan Providers or Non-BHP Provider must submit bills attached to a claim form to:

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

If you have any questions regarding the status of a claim, please call the PORAC claims and customer service telephone number: 1-800-288-6928.

Right of Recovery

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

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

GENERAL PROVISIONS

Anthem Blue Cross has oversight responsibility for compliance with provider and vendor and subcontractor contracts. Anthem Blue Cross 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.

Anthem Blue Cross has 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. Anthem Blue Cross will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. Anthem Blue Cross may not provide you with notice of overpayments made by Anthem Blue Cross or you if the recovery method makes providing such notice administratively burdensome.

Free Choice of Hospital and Physician

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

Workers' Compensation Insurance

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

Non-Regulation of Providers

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

Area of Service

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

Benefits Non-Transferable

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

Independent Contractors

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

Clerical Error

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

Grievance Procedure

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

GENERAL PROVISIONS

Right to Receive and Release Information

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

Member Cooperation

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

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

Protection of Coverage

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

A. The Agreement is still in effect, and

B. The Member is still eligible, and

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

Providing of Care

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

Terms of Coverage

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

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

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

Right to Receive Benefit

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

GENERAL PROVISIONS

Inter-Plan Programs

- **Out of Area Services (For Members Traveling Outside of California)**

  Anthem Blue Cross has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs". Whenever you obtain healthcare services outside of Anthem Blue Cross' service area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program and may include negotiated National Account arrangements available between Anthem Blue Cross and other Blue Cross and Blue Shield Licensees.

  Typically, when accessing care outside Anthem Blue Cross' service area, you may obtain care from healthcare providers that have a contractual agreement (i.e., are "participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, you may obtain care from non-participating healthcare providers. Anthem Blue Cross' payment practices in both instances are described below.

- **BlueCard® Program.** Under the BlueCard® Program, when you access covered healthcare services within the geographic area served by a Host Blue, Anthem Blue Cross will remain responsible for fulfilling its contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers.

  Whenever you access covered healthcare services outside Anthem Blue Cross' service area and the claims is processed through the BlueCard® Program, the amount you pay for covered healthcare services, is usually calculated based on the lower of the:

  - The billed covered charges for your covered services, or
  - The negotiated price that the Host Blue makes available to Anthem Blue Cross.

  Often, the "negotiated price," will consist of a simple discount which reflects the actual price paid by the Host Blue to your healthcare provider. But sometimes it is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments, and other credits or charges. Occasionally it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

  Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However such adjustments will not affect the price Anthem Blue Cross uses for your claim because they will not be applied retroactively to claims already paid.

  Federal law or the law in a small number of states may require the Host Blue to add a surcharge to the calculation. If any federal law or any state law mandates other liability calculation methods, including a surcharge, Anthem would then calculate your liability for any covered healthcare services according to applicable law.

- **Non-Participating Health Care Providers Outside Anthem Service Area**

  Member Liability Calculation. When covered health care services are provided outside of California by non-participating health care providers, the amount you pay for such services will generally be based on either the Host Blue's non-participating health care provider local payment or the pricing arrangements required by

applicable state law. In these situations, you may be liable for the difference between the amount that the non-participating health care provider bills and the payment we will make for the covered services as set forth in this paragraph.

Exceptions. In certain situations, Anthem may use other payment bases, such as billed covered charges, the payment Anthem would make if the health care services had been obtained within California, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount Anthem will pay for services rendered by non-participating health care providers. In these situations, you may be liable for the difference between the amount that the non-participating health care provider bills and the payment Anthem will make for the covered services as set forth in this paragraph.

If you obtain services in a state with more than one Blue Plan network, an exclusive network arrangement may be in place. If you see a provider who is not part of an exclusive network arrangement, that provider's services will be considered non-network care, and you may be billed the difference between the charge and the maximum allowable amount. You may call the customer service number on your ID card or go to www.anthem.com/ca for more information about such arrangements.

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

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 Anthem Blue Cross 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 Anthem Blue Cross.
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 Anthem Blue Cross.

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 Anthem Blue Cross.

Please contact customer service 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, Anthem Blue Cross 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 Anthem Blue Cross 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 Anthem Blue Cross prior to termination. The provider must also agree in writing to accept the terms and reimbursement rates under his or her agreement with Anthem Blue Cross prior to termination. If the provider does not agree with these contractual terms and conditions, Anthem Blue Cross is not required to continue the provider's services beyond the contract termination date.

Anthem Blue Cross 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 Anthem Blue Cross 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 time the Member enrolls with Anthem Blue Cross.

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 Anthem Blue Cross.
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 the Member enrolls with Anthem Blue Cross.

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 customer service 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.

Anthem Blue Cross will notify the Member 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. Anthem Blue Cross 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, Anthem Blue Cross is not required to continue that provider's services. If the Member disagrees with Anthem Blue Cross' determination regarding continuity of care, the Member may file a grievance with Anthem Blue Cross by following the procedures described in the section entitled CLAIMS REVIEW / GRIEVANCE PROCEDURES.

Financial Arrangements with Providers

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

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

Also, under arrangements with some Providers certain discounts, payments, rebates, settlements, incentives, adjustments and/or allowances, including, but not limited to, pharmacy rebates, may be based on aggregate

payments made by Anthem Blue Cross or an affiliate in respect to all health care services rendered to all persons who have coverage through a program provided or administered by Anthem Blue Cross or an affiliate. They are not attributed to specific claims or plans and do not inure to the benefit of any covered individual or group, but may be considered by Anthem Blue Cross or an affiliate in determining its fees or subscription charges or premiums.

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

Confidentiality and Release of Medical Information

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

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

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

Medical Policy and Technology Assessment

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

Liability of Subscriber to Pay Providers

In accordance with California law, a Member will not be required to pay any Prudent Buyer Plan Provider or Related Health Provider any amounts Anthem Blue Cross owes to that provider (not including Co-Payments or deductibles), even in the unlikely event that Anthem Blue Cross fails to pay that provider. The Member may be liable, however, to pay Non-Prudent Buyer Plan Providers any amounts not paid to them by Anthem Blue Cross.

Voluntary Clinical Quality Programs. Anthem Blue Cross 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) within a specific 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. Anthem Blue Cross 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. 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. 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. If the Member receives a gift card 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.

Voluntary Wellness Incentive Programs. Anthem Blue Cross 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 employees, 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 customer service number on their ID card and Anthem Blue Cross 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.

GENERAL INFORMATION

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

Remember, it is your responsibility to stay informed about your health plan coverage. If you have any questions, consult your Health Benefits Officer in your agency or the retirement system from which you receive your allowance, or write to CalPERS Member Account Management Division at P.O. Box 942715, Sacramento, CA 94229-2715, or telephone the appropriate number shown below.

CalPERS Customer Service

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

Direct Payment of Dues

If you arrange for direct payment of premiums, send your payment, together with Form HBD 21 to Anthem Blue Cross, Attn: CalPERS Prudent Buyer Membership & Billing, P.O. Box 629, Woodland Hills, CA 91365. Be sure to include your Subscriber number with your payment. For further details, see the CalPERS Health Program Guide.

CLAIMS REVIEW / GRIEVANCE PROCEDURES

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

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

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

NOTE: You should use the following Anthem Blue Cross grievance procedures for disputes over coverage and/or benefits, or if you are dissatisfied with the quality of care or your access to care. For matters of eligibility, you should contact CalPERS Member Account Management Division, P.O. Box 942715, Sacramento, CA, 94229-2715.

The following procedures shall be used to resolve a dispute:

1. Objection to Claims Processing or Denial

If you do not agree with the action Anthem Blue Cross has taken on your claim, either you or your attending Physician, acting as your authorized representative, may request reconsideration. To request a reconsideration, you may telephone Anthem Blue Cross at 1-800-288-6928 or send a written request to Anthem Blue Cross at P.O. Box 60007, Los Angeles, CA 90060-0007 Attn: PORAC Unit. Anthem Blue Cross' customer service staff will answer your questions or assist you in resolving your issue.

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

All grievances received by Anthem Blue Cross will be acknowledged in writing, together with a description of how Anthem Blue Cross proposes to resolve the grievance. After Anthem Blue Cross has reviewed your grievance, you will be sent a written statement on its resolution within 30 days. If your case is urgent and involves an imminent threat to your health, including, but not limited to, the potential loss of life, limb, or major bodily function, review of your grievance will be expedited and resolved within three days. You have the right to review all documents that are part of your grievance file and to present evidence and testimony as part of the grievance process.

CLAIMS REVIEW / GRIEVANCE PROCEDURES

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

2. Special Independent Medical Reviews

A. Objection to Denial of Experimental or Investigative Treatment

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

1. You have a life-threatening or seriously debilitating condition, described as follows:
   - A life-threatening condition is a condition or disease where the likelihood of death is high unless the course of the disease is interrupted or a condition or disease with a potentially fatal outcome where the end point of clinical intervention is the patient's survival.
   - A seriously debilitating condition is a disease or condition that causes major, irreversible morbidity.
2. Your physician must certify that either (a) standard treatment has not been effective in improving your condition, (b) standard treatment is not medically appropriate, or (c) there is no more beneficial standard treatment covered by this plan than the proposed treatment.
3. The proposed treatment must be recommended by either (a) a Prudent Buyer Plan Provider or (b) a board certified or board eligible Physician qualified to treat you who certifies in writing that the proposed treatment is more likely to be beneficial than standard treatment. This certification must include a statement of the evidence relied upon.
4. If this review is requested either by you or by a qualified Non-Prudent Buyer Plan Provider (as described above), the requestor must supply two items of acceptable medical and scientific evidence. This evidence consists of the following sources:
   a) Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized standards;
   b) Medical literature meeting the criteria of the National Institutes of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus (EMBASE), Medline, and MEDLARS database of Health Services Technology Assessment Research (HSTAR);
   c) Medical journals recognized by the Secretary of Health and Human Services, under Section 1861(t)(2) of the Social Security Act;

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

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

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

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

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

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

Within three business days of receiving notice from the DMHC of your request for review, Anthem Blue Cross will send the reviewing panel all relevant medical records and documents in their possession, as well as any additional information submitted by you or your Physician. Any newly developed or discovered relevant medical records identified by Anthem Blue Cross or by a Prudent Buyer Plan Provider after the initial documents are sent will be immediately forwarded to the reviewing panel. The external independent review organization will complete its review and render its opinion within 30 days of its receipt of request for review (or within seven days if your Physician determines that the proposed treatment would be significantly less effective if not provided promptly). This timeframe may be extended by up to three days for any delay in receiving necessary records.

Please note: If you have a terminal illness (an incurable or irreversible condition that has a high probability of causing death within one year or less) and proposed treatment is denied because the treatment is determined to be Experimental, you may also meet with Anthem Blue Cross' review committee to discuss your case as part of the grievance process (see Objection to Claims Processing or Denial at the beginning of this section).

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

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

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

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

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

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

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

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

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

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

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

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

For more information regarding the IMR process, or to request an application form, please call Anthem Blue Cross customer service at 1-800-288-6928.

3. Time Limits for Filling an Objection

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

CLAIMS REVIEW / GRIEVANCE PROCEDURES

4. Time Limit for Anthem Blue Cross Review of Objection

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

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

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

Coverage grievances: A coverage grievance concerns the denial or approval of health care services substantially based on a finding that the provision of a particular service is included or excluded as a covered benefit under the Evidence of Coverage booklet. It does not include a plan or contracting provider decision regarding a disputed health care service.

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

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

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

If you are still dissatisfied after you have followed the grievance procedures on pages 108-115 and received a response regarding the grievance filed with the Department of Managed Health Care (see: Independent Medical Review of Grievances Involving a Disputed Health Care Service on pages 110-111), you may proceed to item 6: Administrative Appeal Process or item 7: Binding Arbitration, in the alternative. If your coverage dispute is within the jurisdictional limits of Small Claims Court, you may proceed through that court.

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

Eligibility grievances: These issues should always be referred directly to CalPERS at the address noted on page 108.

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

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

CLAIMS REVIEW / GRIEVANCE PROCEDURES

6. CalPERS Administrative Appeal Process

Only **eligibility grievances** and **coverage grievances** which concern the denial or approval of health care services substantially based on a finding that the provision of a particular service is included or excluded as a covered benefit under this Evidence of Coverage Booklet may be appealed directly to CalPERS. Note: Anthem Blue Cross reserves the right to dispute or challenge CalPERS jurisdiction in particular matters. **Disputed health care service grievances** must be appealed through the Department of Managed Health Care's independent medical review process before they can be appealed to CalPERS (See pages 110-111).

CalPERS staff will conduct an administrative review upon your appeal of Anthem Blue Cross' denial of **coverage grievances** or the denial of a **disputed health care service grievance** by the Department of Managed Health Care. However, your written appeal must be submitted to CalPERS within 30 days of the postmark date of Anthem Blue Cross' letter of denial or the Department of Managed Health Care's determination of findings.

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

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

7. Binding Arbitration (Small Claims Court)

If you do not use item 6, or if it does not apply, binding arbitration is the final step in resolving your grievance. Any dispute or claim, of whatever nature, arising out of, in connection with, or in relation to this plan or the 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 limits of the small claims court. Any dispute regarding a claim for damages within the jurisdictional limits of the small claims court will be resolved in such court. **Note: A small claims court judgment cannot be appealed.**

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

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

CLAIMS REVIEW / GRIEVANCE PROCEDURES

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

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

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

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

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

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

ADDITIONAL DEPARTMENT OF MANAGED HEALTH CARE GRIEVANCE PROCEDURES:

If you are dissatisfied with the resolution of your grievance as described on pages 108 through 113, or if your grievance has not been resolved after at least 30 days (or within three days for urgent care), you may submit your grievance to the California Department of Managed Health Care for review prior to binding arbitration (see DEPARTMENT OF MANAGED HEALTH CARE below). If your case is urgent and involves an imminent threat to your health, including, but not limited to, the potential loss of life, limb, or major bodily function, you are not required to complete our grievance process or to wait at least 30 days, but may immediately submit your grievance to the Department of Managed Health Care (DMHC) for review. If your grievance concerns the termination of your coverage, you may also immediately submit your grievance to the DMHC if the DMHC determines your grievance requires immediate review.

CLAIMS REVIEW / GRIEVANCE PROCEDURES

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

If at the conclusion of review of your grievance by the Department of Managed Health Care you continue to be dissatisfied with its resolution, or prior to and instead of review of your case by the Department of Managed Health Care, your remedy may be item 6. CalPERS Administrative Appeal Process (see page 113) or item 7. Binding Arbitration (see page 113).

DEPARTMENT OF MANAGED HEALTH CARE

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

GENERAL DEFINITIONS

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

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

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

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

An **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 Anthem Blue Cross and licensed according to state and local laws. A list of approved Alternative Birth Centers will be sent on request.

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

Anniversary Date is the first day of each contract term.

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

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

An **Authorized Referral** occurs when a Member, because of his or her medical needs, is referred to a Non-Prudent Buyer Plan Hospital, Non-Prudent Buyer Plan Ambulatory Surgical Center or Non-Prudent Buyer Plan Physician, but only when:

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 which provides the required services or has the necessary facilities within a 30-mile radius of the Member's residence within the county in which the Member's residence is located, whichever is less, and
2. The Member is referred in writing to the Non-Prudent Buyer Plan Hospital, Non-Prudent Buyer Plan Ambulatory Surgical Center or Non-Prudent Buyer Plan Physician by a Prudent Buyer Plan Physician, and
3. The referral has been authorized by Anthem Blue Cross before services are rendered.

Such Authorized Referrals are not available to bariatric surgical services. These services are only covered when performed at a Centers of Medical Excellence. 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.

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

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

Centers of Medical Excellence (CME) are health care providers designated by Anthem Blue Cross as a selected facility for specified medical services. A provider participating in a CME has an agreement in effect with Anthem Blue Cross at the time services are rendered or is available through Anthem Blue Cross' affiliate companies or Anthem Blue Cross' 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 and other ingredients wherein one or more ingredients are FDA-approved, a prescription is required to dispense, and the compound medication is not essentially the same as an FDA-approved product from a drug manufacturer.

A **Contracting Hospital** is a Hospital which has a contract with Anthem Blue Cross 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.

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

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

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 Disorders or substance abuse under the supervision of Physicians.

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.

GENERAL DEFINITIONS

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

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

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

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

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

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

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

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

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.

GENERAL DEFINITIONS

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

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

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

A **Hospital** is a facility which provides diagnosis, treatment and care of persons who need acute Inpatient Hospital care under the supervision of Physicians. It must be licensed as a general acute care Hospital according to state and local laws. It must also be registered as a general Hospital by the American Hospital Association and meet accreditation standards of the Joint Commission on Accreditation of Health Care Organizations. For the limited purpose of Inpatient care, the definition of hospital also includes (1) Psychiatric Health Facilities (only for the acute phase of a Mental Disorder or substance abuse), (2) and Residential Treatment Centers.

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

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

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 Anthem Blue Cross 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 Anthem Blue Cross determines to be:

1. Appropriate and necessary for the diagnosis or treatment of the medical condition;
2. Provided for the diagnosis or direct care and treatment of the medical condition;
3. Within standards of good medical practice within the organized medical community;
4. Not primarily for the convenience of the patient or for the convenience of the Physician or another provider;
5. Not more costly than an equivalent service 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

6. 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; and

   c. For Hospital Stays, acute care as an Inpatient is necessary due to the kind of services you are receiving or the severity of your condition, and safe and adequate care cannot be received by you as an outpatient or in a less intensified medical setting.

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

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

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

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 Anthem Blue Cross but does not have a Prudent Buyer Plan Participating Agreement in effect with Anthem Blue Cross 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.

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

Out-of-Pocket Expense is the difference between the Maximum Allowed Amount and Anthem Blue Cross' 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 applied to deductibles, 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, Nicotine Patches, office visits to Physicians who are Prudent Buyer Plan Providers, diabetes education program services provided by Physicians who are Prudent Buyer Plan Providers, unrelated donor search charges, 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.

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 customer service telephone number.

Pharmacy means a licensed retail pharmacy.

A **Pharmacy Benefits Manager (PBM)** is the entity with which Anthem Blue Cross has contracted to administer its prescription drug benefits. The Pharmacy Benefits Manager is an independent contractor and not affiliated with Anthem Blue Cross.

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 for the provision of 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.)*
- Any agency licensed by the state to provide services for the treatment of Mental Disorders or substance abuse, when the plan is required by law to cover those services.
- A registered dietitian (R.D.)* or another nutritional professional* with a master's or higher degree in a field covering clinical nutrition sciences, from a college or university accredited by a regional accreditation agency, who is deemed qualified to provide these services by the referring M.D. or D.O. A registered dietitian or other nutritional professional as described here are covered for the provision of diabetic medical nutrition therapy and nutritional counseling for the treatment of eating disorders such as anorexia nervosa and bulimia nervosa only.

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 customer service telephone number on your ID card for a referral to an OB/GYN.

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

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

The **Prescription Drug Formulary (Formulary)** is a list which Anthem Blue Cross has 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 1-800-700-2541 (or TTY/TDD 1-800-905-9821) or going to our internet website anthem.com/ca.

The **Prescription Drug Maximum Allowed Amount** is the maximum amount Anthem Blue Cross will allow for any Drug. The amount is determined by Anthem Blue Cross using prescription drug cost information provided to Anthem Blue Cross 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 1-800-700-2541 (or TTY/TDD 1-800-905-9821).

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 customer service 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.

GENERAL DEFINITIONS

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 Anthem Blue Cross 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 agents of Anthem Blue Cross. 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.

GENERAL DEFINITIONS

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 on Accreditation of Health Care Organizations; and
4. Staffed by an organized medical or professional staff which includes a Physician as medical director.

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.

Reasonable and customary value is (1) for professional Non-Prudent Buyer Plan Providers, the reasonable and customary value is determined by using a percentile of billed charges from a database of a third-party that takes into consideration various factors, such as the amounts billed for same or similar services, and the geographic locations in which the services were rendered; and (2) for facility Non-Prudent Buyer Plan Providers, the reasonable and customary value is determined by using a percentile of billed charges from a database of Anthem Blue Cross' actual claims experience, subject to certain thresholds based on each provider's cost-to-charge ratio as reported by the provider to a California governmental agency and the actual claim submitted to Anthem Blue Cross.

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

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 Disorder or substance abuse. The facility must be licensed to provide psychiatric treatment of Mental Disorders or rehabilitative treatment of substance abuse according to state and local laws.

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.

The **Scheduled Amount** is the Maximum Allowed Amount for Non-Prudent Buyer Plan Providers, determined according to the schedules stated under SCHEDULES FOR NON-PRUDENT BUYER PLAN PROVIDERS. Any amount by which a Non-Prudent Buyer Plan Provider's charge exceeds the appropriate schedule, exceeds the Maximum Allowed Amount and is not covered under this plan. Providers charge much more than this amount, and the Member is responsible for paying all of this excess expense, in addition to deductible and Co-Payment amounts, amounts over stated benefit maximums, and any other non-covered charges.

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

GENERAL DEFINITIONS

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

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

Single Source Brand Name Drugs are drugs with no generic substitute.

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

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

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 means the person enrolled hereunder who is responsible for premium payment to Anthem Blue Cross, and whose employment or other status, except family dependency, is the basis for eligibility for enrollment under the Agreement. Subscribers must be members of the Peace Officers Research Association of California.

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

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

GENERAL DEFINITIONS

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

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

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

SCHEDULES FOR NON-PRUDENT BUYER PLAN PROVIDERS

This section explains how Anthem Blue Cross determines the Scheduled Amount (the Maximum Allowed Amount for Non-Prudent Buyer Plan Providers), which is subject to the maximums, conditions, exclusions and limitations of this plan.

As used in this section, a **Service Area** is an area in which the Non-Prudent Buyer Plan Provider's principal place of business is located. The counties encompassed by each Service Area are as follows:

— **Service Area 1**
Counties of Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Inyo, Kings, Lake, Lassen, Madera, Mariposa, Mendocino, Merced, Modoc, Mono, Nevada, Placer, Plumas, Sacramento, San Benito, Shasta, Sierra, Siskiyou, Solano, Sutter, Tehama, Trinity, Tulare, Tuolumne, Yolo and Yuba.

— **Service Area 2**
Counties of Alameda, Contra Costa, Monterey, Napa and Santa Cruz.

— **Service Area 3**
Counties of Marin, San Francisco, San Mateo and Santa Clara.

— **Service Area 4**
Counties of Los Angeles and Riverside (city of Palm Springs only).

— **Service Area 5**
Orange County

— **Service Area 6**
Counties of Kern, Riverside (except city of Palm Springs), San Bernardino, San Luis Obispo, Santa Barbara and Ventura.

— **Service Area 7**
San Diego County

— **Service Area 8**
Counties of Fresno, San Joaquin, Sonoma and Stanislaus.

— **Service Area 9**
Imperial County

— **Service Area 10**
Outside California

SCHEDULES FOR NON-PRUDENT BUYER PLAN PROVIDERS

NON-PRUDENT BUYER PLAN HOSPITALS

The Maximum Allowed Amount does not include any charge in excess of the Scheduled Amount shown below for Inpatient services provided by a Non-Prudent Buyer Plan Hospital, other than Emergency Care or an Authorized Referral.

Anthem Blue Cross has the right to adjust these Scheduled Amounts in order to maintain the relationship between these amounts and the rates negotiated by Anthem Blue Cross with Prudent Buyer Plan Hospitals. Benefits are determined based on the Scheduled Amounts in effect at the time services are rendered.

NON-PRUDENT BUYER PLAN HOSPITAL
TABLE OF INPATIENT ALLOWANCES
(other than Emergency Care or Authorized Referral)

Service Area	Daily Maximum
1	$540.00 for each day
2	540.00 for each day
3	540.00 for each day
4	580.00 for each day
5	540.00 for each day
6	540.00 for each day
7	540.00 for each day
8	540.00 for each day
9	540.00 for each day
10	580.00 for each day

SCHEDULES FOR NON-PRUDENT BUYER PLAN PROVIDERS

NON-PRUDENT BUYER PLAN AMBULATORY SURGICAL CENTERS

The Maximum Allowed Amount does not include any charge in excess of the Scheduled Amount shown below for outpatient surgery provided by a Non-Prudent Buyer Plan Ambulatory Surgical Center, other than Emergency Care or an Authorized Referral.

Anthem Blue Cross has the right to adjust these Scheduled Amounts in order to maintain the relationship between these amounts and the rates negotiated by Anthem Blue Cross with Prudent Buyer Plan Ambulatory Surgical Centers. Benefits are determined based on the Scheduled Amounts in effect at the time services are rendered.

NON-PRUDENT BUYER PLAN
AMBULATORY SURGICAL CENTER
TABLE OF ALLOWANCES (other than Emergency Care or Authorized Referral)

Service Area	Each Session
1	$540.00 for each session
2	540.00 for each session
3	540.00 for each session
4	580.00 for each session
5	540.00 for each session
6	540.00 for each session
7	540.00 for each session
8	540.00 for each session
9	540.00 for each session
10	580.00 for each session

SCHEDULES FOR NON-PRUDENT BUYER PLAN PROVIDERS

NON-PRUDENT BUYER PLAN PHYSICIANS

For services provided by a Non-Prudent Buyer Plan Physician, other than Emergency Care or an Authorized Referral, the Maximum Allowed Amount does not include any charge in excess of the Scheduled Amount, which is the amount obtained by multiplying the unit value of that service (established by the unit value schedule), by the appropriate unit allowance shown below. Anthem Blue Cross has the right to adjust, without notice, both the unit values and the schedule of unit allowances in order to maintain the relationship between this Non-Prudent Buyer Plan Physician Scheduled Amount and the fee schedule negotiated by Anthem Blue Cross with Prudent Buyer Plan Physicians. Benefits are determined based on the schedule in effect at the time services are rendered.

Exceptions: Covered charges for a Non-Prudent Buyer Plan Physician will not exceed the Reasonable and Customary Value when the services are for an Emergency, or the Maximum Allowed Amount when the services are for an Authorized Referral, Out-of-Area Member, Clinical Trial, or when the Non-Prudent Buyer Plan Physician's specialty is not represented in the Prudent Buyer Plan Network.

TABLE OF UNIT ALLOWANCES

Service Area	Surgery	Anesthesia	Medical	Radiology	Pathology
1	$110.00	$25.00	$4.80	$9.50	$1.05
2	110.00	25.00	4.80	9.50	1.05
3	120.00	26.00	5.10	10.50	1.15
4	120.00	26.00	5.10	10.50	1.15
5	120.00	26.00	5.10	10.50	1.15
6	110.00	25.00	4.80	9.50	1.05
7	110.00	25.00	4.80	9.50	1.05
8	110.00	25.00	4.80	9.50	1.05
9	110.00	25.00	4.80	9.50	1.05
10	120.00	26.00	5.10	10.50	1.15

The sample schedule on the following pages shows the unit values of representative services and the basic unit value for anesthesia. For procedures not listed in the schedule, benefits are provided on the basis of comparable service.

a. When two or more surgical procedures are performed during the same operative session, Anthem Blue Cross will calculate the Maximum Allowed Amount for all of the services combined by adding:

   — the Maximum Allowed Amount for the services with the highest Scheduled Amount; plus;

   — a reduced percentage of what the Scheduled Amount would have been for each of the additional surgical services if these services had been performed alone.

b. The unit value for the services of an assistant surgeon will be a reduced percentage of the Scheduled Amount for the primary surgeon.

c. The total unit value for the services of an anesthesiologist or anesthetist is the basic anesthesia value for that procedure and a unit value for the actual time spent administering anesthesia.

SCHEDULES FOR NON-PRUDENT BUYER PLAN PROVIDERS

UNIT VALUE SCHEDULE
(Partial Listing)

PROCEDURE CODE	SURGICAL PROCEDURE (for each single procedure)	UNIT VALUE
Skin		
10060	Incision and drainage of abscess	0.58
11100	Biopsy of skin, including closure	0.43
11770	Excision of pilonidal cyst or sinus	1.59
Breast		
19120	Excision of breast tumor, unilateral	2.80
19200	Radical mastectomy, including pectoral muscles and axillary nodes	7.25
Fractures		
21315	Nasal, simple, closed reduction	1.16
25565	Closed radial and ulnar shafts, manipulative reduction	3.71
27232	Femur and neck, manipulative reduction, including traction	5.63
Heart		
33400	Aortic valvuloplasty, with bypass	14.79
33420	Valvotomy, mitral valve, closed	11.04
Throat		
42650	Dilation, salivary duct	0.42
42820	Tonsillectomy and adenoidectomy, under 12 years	2.64
Digestive		
43620	Total gastrectomy	10.25
44950	Appendectomy	3.96
47600	Cholecystectomy	5.67
Rectum		
46200	Fissurectomy	2.01
46250	Hemorrhoidectomy, external, complete	2.48
Male		
55801	Prostatectomy, perineal (sub-total)	8.16
Female		
58180	Supracervical (sub-total) hysterectomy with or without tubes or ovaries	7.15
Maternity		
59510	Cesarean section, including antepartum and postpartum care	11.98
Thyroid		
60200	Local excision of cyst of thyroid	4.54
60240	Thyroidectomy, total or complete	7.89

SCHEDULES FOR NON-PRUDENT BUYER PLAN PROVIDERS

Ear

69420	Myringotomy	0.75
69501	Transmastoid antrotomy	5.17

SCHEDULES FOR NON-PRUDENT BUYER PLAN PROVIDERS

PROCEDURE CODE	BASIC ANESTHESIA	UNIT VALUE
01400	Knee joint	3.0
01462	Lower leg, ankle, or foot	3.0
00566	Direct coronary artery bypass grafting without pump oxygenator	12.0
00740	Upper gastrointestinal endoscopic	4.0
00940	Vaginal	3.0
01961	Cesarean delivery	5.6

MEDICINE		UNIT VALUE
99205	Office Visit -- initial comprehensive exam	19.44
99212	Office Visit -- problem-focused examination evaluation, and/or treatment	4.61
99231	Hospital Visit -- problem-focused examination, evaluation, and/or treatment, same illness	5.27
99241	Consultation -- problem-focused examination and/or evaluation	10.59

RADIOLOGY		UNIT VALUE
Diagnostic		
70210	Sinuses and paranasal, limited	2.75
70250	Skull, limited	3.03
74241	Upper gastrointestinal tract	7.71
74415	Nephrotomography	8.95
Therapeutic		
77261	Therapeutic radiology treatment planning, simple	6.55
Nuclear Medicine		
78000	Thyroid uptake	4.00
79000	Hyperthyroidism, initial evaluation	15.88

PATHOLOGY		UNIT VALUE
81000	Urinalysis, routine, complete	4.32
87081	Microbiology - culture, bacterial screening	10.58

FOR YOUR INFORMATION

Your Rights and Responsibilities as an Anthem Blue Cross Member

As an Anthem Blue Cross Member you have certain rights and responsibilities when receiving your health care. You also have a responsibility to take an active role in your care. As your health care partner, Anthem is committed to making sure your rights are respected while providing your health benefits. That also means giving you access to Anthem network providers and the information you need to make the best decisions for your health and welfare.

These are your rights and responsibilities:

You have the right to:

- Speak freely and privately with your doctors and other health providers about all health care options and treatment needed for your condition. This is no matter what the cost or whether it's covered under your plan.
- Work with your doctors in making choices about your health care.
- Be treated with respect and dignity.
- Expect Anthem to keep your personal health information private. This is as long as it follows state and Federal laws, and Anthem's privacy policies.
- Get the information you need to help make sure you get the most from your health plan, and share your feedback. This includes information on:
  - Anthem company and services
  - Anthem network of doctors and other health care providers
  - Your rights and responsibilities
  - The rules of your health care plan
  - The way your health plan works
- Make a complaint or file an appeal about:
  - Your health care plan
  - Any care you get
  - Any covered service or benefit ruling that your health care plan makes
- Say no to any care, for any condition, sickness or disease, without it affecting any care you may get in the future. This includes the right to have your doctor tell you how that may affect your health now and in the future.
- Get all of the most up-to-date information from a doctor or other health care professional about the cause of your illness, your treatment and what may result from it. If you don't understand certain information, you can choose another person to be with you to help you to understand.

FOR YOUR INFORMATION

You have the responsibility to:

- Read and understand, to the best of your ability, all information about your health benefits or ask for help if you need it.
- Follow all health care plan rules and policies.
- Choose any primary care physician (doctor), also called a PCP, who is in Anthem's network if your health care plan requires it.
- Treat all doctors, health care providers, and staff with courtesy and respect.
- Keep all scheduled appointments with your health care providers and call their office if you may be late or need to cancel.
- Understand your health problems as well as you can and work with your doctors or other health care providers to make a treatment plan that you all agree on.
- Follow the care plan that you have agreed on with your doctors or health care providers.
- Give Anthem, your doctors and other health care professionals the information needed to help you get the best possible care and all the benefits you are entitled to. This may include information about other health care plans and insurance benefits you have in addition to your coverage with Anthem.
- Let the Customer Service department know if you have any changes to your name, address or family members covered under your plan.

For details about your coverage and benefits, please read your Evidence of Coverage.

Anthem is committed to providing quality benefits and customer service to Members. Benefits and coverage for services provided under the benefit program are governed by the Evidence of Coverage and not by this Member Rights and Responsibilities statement.

If you need more information or would like to contact Anthem, please go to www.anthem.com/ca and select "Customer Support>Contact Us", or you may call the customer service number on your ID card.

ORGAN DONATION

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

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

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

FOR YOUR INFORMATION

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.

ANTHEM BLUE CROSS WEB SITE

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

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 Anthem Blue Cross at 1-800-288-6928 to ensure that you can obtain the health care services that you need.

LANGUAGE ASSISTANCE PROGRAM

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

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

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

- Spanish
- Chinese
- Vietnamese
- Korean
- Tagalog

FOR YOUR INFORMATION

Oral interpretation services are available in additional languages.

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

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

STATEMENT OF RIGHTS UNDER THE NEWBORNS AND MOTHERS HEALTH PROTECTION ACT

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

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

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

For claims and customer service, contact:

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

1-800-288-6928

www.anthem.com/ca

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

1-800-655-6397

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

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