Effective January 1, 2008

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

Preferred Provider Organization (PPO)

PORAC Police & Fire Health Plan
Prudent Buyer® Classic Plan

Combined Evidence of Coverage and Disclosure Form
for the Basic Plan

CalPERS

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

COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM

Blue Cross of California
21555 Oxnard Street
Woodland Hills, California 91367

Your health care coverage is provided by Blue Cross of California (Blue Cross). 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 BLUE CROSS. THE FACT THAT A PHYSICIAN PRESCRIBES OR ORDERS THE SERVICE DOES NOT, IN ITSELF, MAKE IT MEDICALLY NECESSARY OR A COVERED EXPENSE.

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

1-800-288-6928

TABLE OF CONTENTS

ADMINISTRATIVE AND BENEFIT CHANGES 1

PRUDENT BUYER PLAN SUMMARY OF BENEFITS: INTRODUCTION 2

PORAC PRUDENT BUYER PLAN: SUMMARY OF BENEFITS 3

PLAN PROVIDERS 7

HOW TO USE YOUR PLAN 9

PRUDENT BUYER PLAN BENEFITS 11

DEDUCTIBLES 11

CO-PAYMENTS 13

OUT-OF-POCKET EXPENSE AMOUNT 14

DETERMINATION OF COVERED EXPENSE 15

CONDITIONS OF COVERAGE 16

COVERED SERVICES AND SUPPLIES 17

Acupuncture 17
Allergy Testing and Allergy Injections 17
Ambulance 17
Ambulatory Surgical Center Services 18
Bariatric Surgery 18
Biofeedback Procedures 19
Blood 19
Breast Cancer 19
Cancer Clinical Trials 19
Cervical Cancer Screening 20
Contraceptives 21
Dental Care 21
Diabetes Education Program 22
Diagnostic Radiology (X-Rays) and Laboratory Service 22
Durable Medical Equipment 22
Emergency Care 23
Hearing Aid Benefits 23
Home Health Care 24
Home Infusion Therapy 24
Hospice Care 25
Hospital - Inpatient 26
Hospital - Outpatient 27
Infertility Services 27
Mental or Nervous Disorders 27
Nicotine Patches 27
Organ and Tissue Transplants 28
Other Cancer Screening Tests 29
Outpatient Drugs and Medicines 29
Physical Therapy - Physical Medicine 29
Physician / Professional Services 30
Pregnancy, Maternity Care and Family Planning 31
Prostate Cancer Screening 31
Prosthetic Devices 32
Radiation, Chemotherapy and Hemodialysis 32
Reconstructive Surgery 32

TABLE OF CONTENTS

Routine Physical Exam (For Members Age 17 and Over) ... 32
Skilled Nursing Facility ... 32
Smoking Cessation Programs ... 33
Speech Therapy ... 34
Special Duty Nursing Care ... 34
Substance Abuse ... 34
Well-Child Care (For Members Under Age 17) ... 34

UTILIZATION REVIEW PROGRAMS ... 35
The Medical Necessity Review Process ... 39
Questions About or Disagreements with Utilization Review Determinations ... 40
Quality Assurance ... 40

CASE MANAGEMENT ... 41

EXCLUSIONS AND LIMITATIONS ... 42

PRESCRIPTION DRUG BENEFITS ... 46

MENTAL DISORDERS AND SUBSTANCE ABUSE BENEFITS ... 58

COORDINATION OF BENEFITS ... 75

THIRD PARTY LIABILITY ... 75

WORKERS' COMPENSATION INSURANCE ... 76

BENEFITS FOR MEDICARE ELIGIBLE MEMBERS ... 76

ENROLLMENT PROVISIONS ... 77

TERMINATION PROVISIONS ... 78

CONTINUATION OF GROUP COVERAGE ... 79
CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA) ... 79
CALCOBRA CONTINUATION OF COVERAGE ... 83
POST-COBRA CONTINUATION FOR QUALIFYING MEMBERS ... 85

HIPAA COVERAGE AND INDIVIDUAL CONVERSION ... 87

TERMINAL BENEFITS ... 88

BLUE CROSS MONTHLY RATES ... 89

GENERAL PROVISIONS ... 90

GENERAL INFORMATION ... 98

CLAIMS REVIEW / GRIEVANCE PROCEDURES ... 99

GENERAL DEFINITIONS ... 105

SCHEDULES FOR NON-PRUDENT BUYER PLAN PROVIDERS ... 112
NON-PRUDENT BUYER PLAN PROVIDER EXCEPTIONS ... 117

FOR YOUR INFORMATION ... 119

ADMINISTRATIVE AND BENEFIT CHANGES

Effective January 1, 2008, the following changes have been made to your plan.

Administrative Changes

1. **Compound Medications.** Prescription Drug Benefits have been revised to require that Compound Medications (defined on page 56) be obtained from Participating Pharmacies. You are responsible to pay a $45 copayment for each Prescription for a Compound Medication filled at a Participating Pharmacy. If you purchase a Compound Medication at a Non-Participating Pharmacy, you will have to pay the total cost. There is no benefit under this plan for Compound Medications obtained from Non-Participating Pharmacies. See the PRESCRIPTION DRUG BENEFITS section beginning on page 46 for additional information.

2. **Specialty Pharmacy Drugs.** Prescription Drug Benefits have been revised to require that Specialty Pharmacy Drugs (defined on page 57) be obtained through the specialty pharmacy program. You are responsible to pay the applicable copayment ($10, $25 or $45) for each Prescription for a Specialty Pharmacy Drug filled through the specialty pharmacy program. If you purchase a Specialty Pharmacy Drug at a retail Pharmacy, you will have to pay the total cost. There is no benefit under this plan for Specialty Pharmacy Drugs not obtained through the specialty pharmacy program. See the PRESCRIPTION DRUG BENEFITS section beginning on page 46 for additional information.

3. **Payment to Providers.** This provision has been revised to reflect that Blue Cross will issue payment to the Subscriber for covered services provided to the Subscriber or Family Member by non-Contracting Hospitals, Non-Prudent Buyer Plan Providers and Non-BHP Providers. It is the Member's responsibility to forward such payment to the non-participating provider. This procedure will apply regardless of any signed assignment of payment to the non-participating provider. See the GENERAL PROVISIONS sections pages 69 and 90 for additional information.

Benefit Changes

There are no benefit changes to your plan.

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

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

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

PRUDENT BUYER PLAN
SUMMARY OF BENEFITS: INTRODUCTION

The benefits described under the PORAC PRUDENT BUYER PLAN - SUMMARY OF BENEFITS are provided for covered expense incurred for treatment of a covered illness, injury or condition. An expense is incurred on the date the Member receives the service or supply for which the charge is made. These benefits are subject to all provisions of the Agreement, which may limit benefits or result in benefits not being payable.

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 A COVERED EXPENSE. CONSULT THIS BOOKLET OR TELEPHONE 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.

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

Important Note About Covered Expense And Your Co-Payment: Covered expenses 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 COVERED EXPENSE.) You must pay all of this excess amount in addition to your co-payment.

Covered expense and the terms of this section do not include any amount payable under the sections entitled MENTAL DISORDERS AND SUBSTANCE ABUSE BENEFITS and 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	What You Pay: 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%*
	Well-child care, including immunizations and inoculations —**$500 maximum/year** for children ages 7 through 16 years	No charge (No deductible)	No charge* (No deductible)
	Routine physical exam for members age 17 and over , including pap smears and mammograms—**$500 maximum/year**	No charge (No deductible)	No charge* (No deductible)

*The Members 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 COVERED EXPENSE on page 15 and SCHEDULES FOR NON-PRUDENT BUYER PLAN PROVIDERS beginning on page 112 for complete benefit information.

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 Blue Cross payment	50%	50%*
Diagnostic Radiology & Laboratory Services	Outpatient X-ray & lab services	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, up to **$50** maximum Blue Cross payment for each exam	20% (No deductible)	20%* (No deductible)
	Hearing aids, limited to one hearing aid per ear in any 36 month period and **$450** maximum Blue Cross payment for each hearing aid	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%
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 Blue Cross Centers of Expertise	10%	10%

*The Members 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 COVERED EXPENSE on page 15 and SCHEDULES FOR NON-PRUDENT BUYER PLAN PROVIDERS beginning on page 112 for complete benefit information.

Type of Services	Description of Services	What You Pay	
		Prudent Buyer Plan Providers	Non-Prudent Buyer Plan Providers*
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%* (maximum Blue Cross payment of $35 per visit)
	For all other service	10%	10%* (maximum Blue Cross payment of $700 per year for all services combined)
Speech Therapy	Inpatient or outpatient treatment when following surgery, injury or for non-congenital organic disease	10%	10%*
Biofeedback	If in conjunction with mental health treatment, see “Mental Disorders and Substance Abuse Benefits”. For all other conditions:	10%	10%*
Mental Disorders and Substance Abuse	Refer to the section entitled MENTAL DISORDERS AND SUBSTANCE ABUSE BENEFITS for information on these benefits.		
Other Benefits	--Unreplaced Blood --Blood Administration	20% 10%	20% 10%*

*The Members 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 COVERED EXPENSE on page 15 and SCHEDULES FOR NON-PRUDENT BUYER PLAN PROVIDERS beginning on page 112 for complete benefit information.

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
		$45 copay - Compound Medication	Not Covered - Compound Medication
	Drugs purchased through the mail service program (drugs include insulin and authorized diabetic supplies)	$20 copay-generic	$20 copay-generic
		$40 copay-formulary brand name	$40 copay-formulary brand name
		$75 copay-non-formulary brand name	$75 copay-non-formulary brand name
	Specialty Pharmacy Drugs purchased through specialty pharmacy program	$10 copay - generic	Not Covered - generic
		$25 copay - formulary brand name	Not Covered - formulary brand name
		$45 copay - non-formulary brand name	Not Covered - non-formulary brand name

**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.

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

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 accept a reduced rate for the services they provide to plan Members.

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 COVERED EXPENSE on page 15 and SCHEDULES FOR NON-PRUDENT BUYER PLAN PROVIDERS beginning on page 112. 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.

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 Blue Cross at 1-800-288-6928 or you may write to 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 Blue Cross of California website at **www.bluecrossca.com**.

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 expense will be based on the Customary and Reasonable Charge or Reasonable Charge 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 Customary and Reasonable Charge or Reasonable Charge for the services of a Non-Prudent Buyer Plan Provider.

CENTERS OF EXPERTISE

Blue Cross has established a Centers of Expertise (COE) network for bariatric surgical procedures such as gastric bypass and other surgical procedures for weight loss programs. **These procedures are covered only at a COE.** A Prudent Buyer Plan Provider is not necessarily a Centers of Expertise facility.

BEHAVIORAL HEALTH PROGRAM PROVIDERS (BHP PROVIDERS)

(See MENTAL DISORDERS AND SUBSTANCE ABUSE BENEFITS section beginning on page 58)

Blue Cross has also established a Behavioral Health Program (BHP) network of Mental Health Professionals, Outpatient Day Treatment Centers and Inpatient Treatment Facilities to provide care for Mental Disorders, Severe Mental Disorders and Substance Abuse. These "BHP Providers" agree to accept the BHP Negotiated Rate as payment in full for covered services. A provider participating in the Prudent Buyer Plan network is not necessarily a provider participating in the BHP network with Blue Cross.

Non-Participating Behavioral Health Program Providers (Non-BHP Providers)

These providers do not have a Behavioral Health Program Provider Agreement in effect with us at the time services are rendered. A Non-BHP Provider may be a provider participating in the Prudent Buyer Plan network.

PARTICIPATING AND NON-PARTICIPATING PHARMACIES

(See PRESCRIPTION DRUG BENEFITS section beginning on page 46)

"Participating Pharmacies" agree to charge Members only the Prescription Drug Negotiated Rate in effect with Blue Cross 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 Negotiated Rate. The amount covered as Prescription Drug expense may be significantly lower than what these providers customarily charge.

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 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 Blue Cross will pay your provider directly.)
- Prudent Buyer Plan Providers will bill 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 Blue Cross is required for services provided by Non-Prudent Buyer Plan Providers. You or your Physician must call 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 COVERED EXPENSE 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 Blue Cross card should be shown on the first visit to a Physicians 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 - 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 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, 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 Routine Physical Exam.

   d. Services under Well-Child Care.

   e. Services under Smoking Cessation Programs and Nicotine Patches.

   f. Services under Hearing Aid Benefits.

   g. Covered travel expense in connection with an authorized bariatric surgical procedure provided at an approved Centers of Expertise.

DEDUCTIBLES

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 expense 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, and
6. Approved Centers of Expertise for authorized bariatric surgery.

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 expense 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 Expense 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 amount of covered expense remaining. Co-payments are shown under each benefit listed in the section entitled PRUDENT BUYER PLAN - COVERED SERVICES AND SUPPLIES on pages 17 through 34.

If your co-payment is a percentage, we will multiply the applicable percentage by the amount of covered expense 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 covered expense 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 amount of covered expense, is the Members responsibility.

All co-payments are subject to the any maximum benefits listed under PRUDENT BUYER PLAN BENEFITS - COVERED SERVICES AND SUPPLIES on pages 17 through 34.

Important Note: Any covered expense 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 COVERED EXPENSE to see how covered expense is determined for these providers, and please read the definitions of Customary and Reasonable Charge, Reasonable Charge, and Scheduled Amount. Any amount in excess of covered expense 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 Blue Cross **before** services are rendered, we will provide whatever benefits are appropriate for Prudent Buyer Plan Providers (see GENERAL DEFINITIONS for additional information).

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

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

Bariatric Surgery. For bariatric surgical procedures authorized by us and performed at a designated Centers of Expertise (COE), 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 COE. 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 expense 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 covered expense for covered services provided by Non-Prudent Buyer Plan Providers and Related Health Providers.

- **Per Member** .... **$3,000 ***
- **Two or more Members of the same family** .... **$6,000 *** †

† Not to exceed $3,000 for any one Member.

***Exceptions:**

– Any co-payments made for the non-Emergency use of a Hospital emergency room or for Nicotine Patches will not be applied toward satisfaction of your Out-of-Pocket Expense Amount. In addition, you are required to continue to pay the co-payment for such treatment even after you have reached that amount.

– Any co-payments made for office visits to a Physician who is a Prudent Buyer Plan Provider will not be applied toward the satisfaction of the your Out-of-Pocket Expense Amount. In addition, you will be required to continue to pay the co-payment for such visits even after you have reached that amount.

– Any co-payments made for diabetes education program services provided by a Physician who is a Prudent Buyer Plan Provider will not be applied toward the satisfaction of your Out-of-Pocket Expense Amount. In addition, you will be required to continue to pay the co-payment for such services even after you have reached that amount.

– Expenses which are applied toward any deductible, incurred for non-covered services or supplies, or in excess of the amount of the covered expense, 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 COVERED EXPENSE to see how covered expense is determined.

DETERMINATION OF COVERED EXPENSE

Subject to the remaining paragraphs of this section, covered expense is the expense incurred for a covered service or supply. An expense is incurred on the date the Member receives the service or supply for which the charge is made. Please read the definitions of Negotiated Rate, Reasonable Charge, Customary and Reasonable Charge, and Scheduled Amount to better understand this section.

Covered expense does not include:

1. Any charge in excess of the Negotiated Rate for services provided by a Prudent Buyer Plan Provider or Centers of Expertise.
2. Any charge in excess of a Reasonable Charge for services provided by:
   a. a Non-Prudent Buyer Plan Hospital for outpatient care, Emergency Care or an Authorized Referral, or a Non-Prudent Buyer Plan Ambulatory Surgical Center for Emergency Care or an Authorized Referral, or
   b. a Non-Prudent Buyer Plan Home Health Agency, or
   c. a facility which provides diagnostic imaging services, or
   d. a clinical laboratory, or
   e. a Related Health Provider, or
   f. a Home Infusion Therapy provider.
3. The maximum covered expense for services provided by non-Prudent Buyer Plan Providers 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.

   The maximum covered expense for non-Prudent Buyer Plan Providers for services and supplies provided in connection with Cancer 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.

Exception:

If Medicare is the primary payer for a Member, covered expense 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 covered expense stated on pages 112 through 118, 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.

CONDITIONS OF COVERAGE

The following conditions of coverage must be met before expenses incurred for services or supplies will be considered a covered expense.

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 expenses 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 considered covered expense.
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 covered expense which is strictly limited as shown on pages 112 through 118.

Subject to the Calendar Year Deductible and applies toward the Out-of-Pocket Expense Amount, except for office visit provided by a Prudent Buyer Plan Physician. After the Out-of-Pocket Expense Amount is reached, the Member will be required to continue to pay the office visit co-pay for Prudent Buyer Plan Providers.

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.

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 covered expense which is strictly limited as shown on pages 112 through 118.

Subject to the Calendar Year Deductible and applies toward the Out-of-Pocket Expense Amount, except for office visit provided by a Prudent Buyer Plan Physician. After the Out-of-Pocket Expense Amount is reached the Member will be required to continue to pay the office visit co-pay for Prudent Buyer Plan Providers.

AMBULANCE

20% Co-Pay PLUS any amount in excess of covered expense.

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

The following ambulance services are considered covered expense:

1. Base charge, mileage and non-reusable supplies of a licensed ambulance company for ground service to transport a Member to and/or from a Hospital or Skilled Nursing Facility.
2. Emergency services or transportation services that are provided to a Member by a licensed ambulance company as a result of a “911” emergency response system* request for assistance if the Member believes they have an Emergency medical condition requiring such assistance.
3. Base charge, mileage and non-reusable supplies of an air ambulance from the area where the Member is first disabled to transport a Member to the nearest Hospital or Skilled Nursing Facility where appropriate treatment is provided, and only if, such services are Medically Necessary and ground ambulance service is inadequate.

4. Monitoring, electrocardiograms (EKGs or ECGs), cardiac defibrillation, cardiopulmonary resuscitation (CPR) and administration of oxygen and intravenous (IV) solutions in connection with ambulance service. An appropriately licensed person must render the services.

∗ If 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 covered expense which is strictly limited as shown on pages 112 through 118.

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 Expertise (COE).

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 COE facility. **Charges for services provided for or in connection with a bariatric surgical procedure performed at a facility other than a COE will not be considered covered expense.**

Bariatric surgical procedures are subject to pre-service review. Please refer to the PRUDENT BUYER PLAN BENEFITS - UTILIZATION REVIEW PROGRAMS section beginning on page 35 for information on how to obtain the proper reviews.

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

1. Transportation for the Member to and from the COE 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 COE 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 and drug expenses are excluded from coverage.

COVERED SERVICES AND SUPPLIES

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

All travel expenses must be approved by 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 COE. 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 (except for services listed under MENTAL DISORDERS AND SUBSTANCE ABUSE BENEFITS).

10% Co-Pay for Prudent Buyer Plan Providers.

10% Co-Pay for Non-Prudent Buyer Plan Providers PLUS any amount in excess of covered expense which is strictly limited as shown on pages 112 through 118.

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 covered expense.

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

Covered expense includes transfusions (including blood processing) and the cost of unreplaced blood and blood products.

BREAST CANCER. See Hospital benefits on pages 26 & 27 as well as Physician/Professional Services on pages 30 & 31 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, including:

1. Diagnostic mammogram examinations.
2. Routine mammogram examinations after the maximum benefits under the Routine Physical Exam provision have been paid.
3. Mastectomy and lymph node dissection; complications from a mastectomy including lymphedema.
4. Reconstructive surgery performed to restore and achieve symmetry following a Medically Necessary mastectomy.
5. Breast prostheses following a mastectomy (see Prosthetic Devices).

CANCER CLINICAL TRIALS. See Hospital benefits on pages 26 & 27 as well as Physician/Professional Services on pages 30 & 31 for specific Co-Pay, Deductible and Out-of-Pocket Expense Amount Information. We will provide whatever benefits would be appropriate if the services and supplies were provided by a Prudent Buyer Plan Provider for charges by Non-Prudent Buyer Plan Providers for services and supplies provided in connection with Cancer Clinical Trials.

Benefits are provided for services and supplies for routine patient care costs, as defined below, in connection with phase I, phase II, phase III and phase IV cancer clinical trials, if all the following conditions are met:

1. The treatment provided in a clinical trial must either:
   a. Involve a drug that is exempt under federal regulations from a new drug application, or

b. Be approved by (i) one of the National Institutes of Health, (ii) the federal Food and Drug Administration (FDA) in the form of an investigational new drug application, (iii) the United States Department of Defense, or (iv) the United States Veteran's Administration.

2. The Member must be diagnosed with cancer to be eligible for participation in these clinical trials.
3. Participation in such clinical trials must be recommended by the Member's Physician after determining participation has a meaningful potential to benefit the Member.
4. For the purpose of this provision, a clinical trial must have a therapeutic intent. Clinical trials to just test toxicity are not included in this coverage.

Routine patient care costs means the costs associated with the provision of services, including drugs, items, devices and services which would otherwise be covered under the plan, including health care services which are:

1. Typically provided absent a clinical trial.
2. Required solely for the provision of the investigational drug, item, device or service.
3. Clinically appropriate monitoring of the investigational item or service.
4. Prevention of complications arising from the provision of the investigational drug, item, device, or service.
5. Reasonable and necessary care arising from the provision of the investigational drug, item, device, or service, including the diagnosis or treatment of the complications.

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

1. Drugs or devices not approved by the FDA that are associated with the clinical trial.
2. Services other than health care services, such as travel, housing, companion expenses and other nonclinical expenses that the Member may require as a result of the treatment provided for the purposes of the clinical trial.
3. Any item or service provided solely to satisfy data collection and analysis needs not used in the clinical management of the patient.
4. Health care services that, except for the fact they are provided in a clinical trial, are otherwise specifically excluded from the plan.
5. Health care services customarily provided by the research sponsors free of charge to members enrolled in the trial.

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

Disagreements regarding the coverage or medical necessity of possible clinical trial services may be subject to Special Independent Medical Reviews as described in CLAIMS REVIEW / GRIEVANCE PROCEDURES.

CERVICAL CANCER SCREENING. See Diagnostic Radiology and Laboratory Services benefits on page 22 for specific Co-Pay, Deductible and Out-of-Pocket Expense Amount information.

After the maximum benefits under the Routine Physical Exam provision have been paid, services and supplies provided in connection with a routine test to detect cervical cancer, including pap smears human papillomavirus (HPV) screening, and any cervical cancer screening test approved by the FDA, will be covered upon referral by the Member's Physician.

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 covered expense which is strictly limited as shown on pages 112 through 118.

Subject to the Calendar Year Deductible and applies toward the Out-of-Pocket Expense Amount, except for office visit provided by a Prudent Buyer Plan Physician. After the Out-of-Pocket Expense Amount is reached, the Member will be required to continue to pay the office visit co-pay for Prudent Buyer Plan Providers.

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.

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 covered expense which is strictly limited as shown on pages 112 through 118.

Subject to the Calendar Year Deductible and applies toward the Out-of-Pocket Expense Amount, except for office visit provided by a Prudent Buyer Plan Physician. After the Out-of-Pocket Expense Amount is reached, the Member will be required to continue to pay the office visit co-pay for Prudent Buyer Plan Providers.

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.

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 covered expense which is strictly limited as shown on pages 112 through 118.

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 35 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

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.). 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.

DIABETES EDUCATION PROGRAM

$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 covered expense which is strictly limited as shown on pages 112 through 118.

Subject to the Calendar Year Deductible and applies toward the Out-of-Pocket Expense Amount, except for diabetes education program services provided by a Prudent Buyer Plan Physician. After the Out-of-Pocket Expense Amount is reached, the Member will be required to continue to pay the office visit co-pay for Prudent Buyer Plan Providers.

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.

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 covered expense which is strictly limited as shown on pages 112 through 118.

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

Benefits include outpatient diagnostic imaging and laboratory services. Certain 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) and Nuclear Cardiac Imaging are subject to pre-service review to determine medical necessity. See the PRUDENT BUYER PLAN BENEFITS - UTILIZATION REVIEW PROGRAM section beginning on page 35 for details.

DURABLE MEDICAL EQUIPMENT

20% Co-Pay PLUS any amount in excess of covered expense.

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. Therapeutic shoes and inserts for the prevention and treatment of diabetes-related foot complications. Nebulizers, including face masks and tubing, when required for the Medically Necessary treatment of 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. Blue Cross determines whether the item meets the above conditions.

EMERGENCY CARE

10% Co-Pay PLUS any amount in excess of covered expense 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 covered expense.

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 35 for information on how to obtain the proper reviews.

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

Services for the treatment of serious and unexpected acute illness, injury or condition (including without limitation sudden and unexpected severe pain) 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 Blue Cross.

See page 27 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 covered expense 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. Benefits are further limited to a maximum Blue Cross payment of **$450** for each hearing aid.

2. Evaluation and audio-metric examinations in conjunction with the purchase of a hearing aid, up to a maximum Blue Cross payment of **$50** per visit.

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 covered expense.

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 35 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.

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 covered expense.

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 35 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 pages 22 & 23); 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 covered expense.

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 an approved Hospice for the palliative treatment of pain and other symptoms associated with a terminal 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 Blue Cross. Covered services are available on a 24-hour basis for the management of the condition.

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 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 covered expense which is strictly limited as shown on pages 112 through 118.

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 35 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 a covered expense, 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 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 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.

COVERED SERVICES AND SUPPLIES

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 covered expense.

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

Subject to the Calendar Year Deductible. All co-payments, except the 50% co-pay for non-Emergency use of a Hospital emergency room, apply toward the Out-of-Pocket Expense Amount. After the Out-of-Pocket Expense Amount is reached the Member will be required to continue to pay the 50% co-pay for non-Emergency use of a Hospital emergency room.

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 covered expense.

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 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 OR NERVOUS DISORDERS - See the section entitled MENTAL DISORDERS AND SUBSTANCE ABUSE BENEFITS for benefit information.

NICOTINE PATCHES

50% Co-Pay PLUS any amount in excess of covered expense.

Not subject to the Calendar Year Deductible and does not apply toward the Out-of-Pocket Expense Amount. After the Out-of-Pocket Expense Amount is reached the Member will be required to continue to pay the 50% co-pay for nicotine patches.

After successfully completing one of the approved Smoking Cessation Programs specified on page 33 and submitting a Certificate of Completion, benefits are provided for one 90-day supply of nicotine patches per lifetime. Benefits are further limited to a maximum of **$175.00** per Member 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- Blue Cross Claims Unit.

ORGAN AND TISSUE TRANSPLANTS

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 covered expense which is strictly limited as shown on pages 112 through 118.

Subject to the Calendar Year Deductible and applies toward the Out-of-Pocket Expense Amount, except for office visit provided by a Prudent Buyer Plan Physician. After the Out-of-Pocket Expense Amount is reached the Member will be required to continue to pay the office visit co-pay for Prudent Buyer Plan Providers.

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 covered expense which is strictly limited as shown on pages 112 through 118.

Inpatient Hospital services are subject to pre-service review to determine medical necessity. Please refer to the UTLIZATION REVIEW PROGRAMS section beginning on page 35 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 are provided for covered expense incurred for or in connection with non-Investigational human organ or tissue transplants, such as skin, cornea or kidney 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, and
3. an organ or tissue donor who is not a Member, if the organ or tissue recipient is a Member. Benefits are reduced by any amounts paid or payable by the donor's own health plan.

Covered expense does not include human heart, lung, heart-lung, liver or bone marrow transplants received without first obtaining pre-service review according to the provisions stated under PRUDENT BUYER PLAN BENEFITS - UTILIZATION REVIEW PROGRAMS beginning on page 35. Benefits for authorized services are subject to all other conditions, limitations, exclusions and provisions of this plan.

Blue Cross approves certain health care facilities as designated transplant centers. These facilities are recognized as being superior locations where certain difficult or particularly sophisticated medical or surgical procedures are performed.

Blue Cross will advise the Member and his/her Physician whether the facility in which the transplant is to take place is determined by Blue Cross to be a designated transplant center.

No benefits are payable for Experimental or Investigational transplants. If services are denied because 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.

OTHER CANCER SCREENING TESTS. See Hospital benefits on pages 26 & 27 as well as Physician/Professional Services on pages 30 & 31 for specific Co-Pay, Deductible and Out-of-Pocket Expense Amount information.

Benefits are provided for services and supplies provided in connection with all generally medically accepted cancer screening tests. This coverage is provided according to the terms and conditions of this plan that apply to all other medical conditions.

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 covered expense.

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 46 through 57 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 covered expense which is strictly limited as shown on pages 112 through 118.

Subject to the Calendar Year Deductible and applies toward the Out-of-Pocket Expense Amount, except for office visit provided by a Prudent Buyer Plan Physician. After the Out-of-Pocket Expense Amount is reached, the Member will be required to continue to pay the office visit co-pay for Prudent Buyer Plan Providers.

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 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. But, if Blue Cross determines that an additional period of physical therapy, physical medicine or occupational therapy is Medically Necessary, 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 35.)

For the services of Non-Prudent Buyer Plan Providers only, the maximum payment is limited to **$35** for each visit and **$700** per Member per Year. 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.

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 covered expense which is strictly limited as shown on pages 112 through 118.

Subject to the Calendar Year Deductible and applies toward the Out-of-Pocket Expense Amount, except for office visit provided by a Prudent Buyer Plan Physician. After the Out-of-Pocket Expense Amount is reached, the Member will be required to continue to pay the office visit co-pay for Prudent Buyer Plan Providers.

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.

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 covered expense which is strictly limited as shown on pages 112 through 118.

Subject to the Calendar Year Deductible and applies toward the Out-of-Pocket Expense Amount, except for office visit provided by a Prudent Buyer Plan Physician. After the Out-of-Pocket Expense Amount is reached, the Member will be required to continue to pay the office visit co-pay for Prudent Buyer Plan Providers.

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 covered expense which is strictly limited as shown on pages 112 through 118.

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.

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 when provided for pregnancy, maternity care and abortion.
2. Services listed under Hospital for routine nursery care of a newborn child if the child's natural mother is an enrolled Member.
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).

PROSTATE CANCER SCREENING

10% Co-Pay for Prudent Buyer Plan Providers.

10% Co-Pay for Non-Prudent Buyer Plan Providers PLUS any amount in excess of covered expense which is strictly limited as shown on pages 112 through 118.

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

Benefits include services and supplies provided in connection with routine tests to detect prostate cancer. These benefits are available after the maximum benefits under the Routine Physical Exam provision have been paid.

PROSTHETIC DEVICES

20% Co-Pay PLUS any amount in excess of covered expense.

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

Covered expense includes:

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.

RADIATION therapy, **CHEMOTHERAPY** and **HEMODIALYSIS** treatment. See Hospital - Outpatient on page 27 for benefit information.

RECONSTRUCTIVE SURGERY. See Hospital benefits on pages 26 & 27 as well as Physician/Professional Services on pages 30 & 31 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.

ROUTINE PHYSICAL EXAM (FOR MEMBERS AGE 17 AND OVER)

No Co-Pay except any amount in excess of covered expense for services provided by Non-Prudent Buyer Plan Providers.

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

Physician services and diagnostic radiology and laboratory services in connection with a routine physical exam, including pap smears and mammograms, subject to a maximum payment of **$500** per Year. Electron Beam Tomography (ETB) diagnostic services and self-referred colonoscopy are covered for the Subscriber ONLY and are subject to the same $500 per Year maximum. After the maximum payment under this Routine Physical Exam benefit has been paid, certain cancer screenings will be covered, according to the terms and conditions of this plan that apply to all other medical conditions, under the provisions described in Breast Cancer, Cervical Cancer Screening and Prostate Cancer Screening.

Note: The Member must always inform the Physician that the purpose of the visit is to receive a routine physical examination. This will insure that the benefits for routine physical examinations are correctly provided.

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 covered expense.

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

COVERED SERVICES AND SUPPLIES

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 35 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 covered expense.

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

Benefits are provided for covered expense incurred up to a maximum of **$100** per lifetime 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 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. 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 - 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 - 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 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 covered expense.

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

Covered expense includes Medically Necessary outpatient speech therapy following injury or organic disease.

SPECIAL DUTY NURSING CARE

20% Co-Pay PLUS any amount in excess of covered expense.

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

SUBSTANCE ABUSE - See the section entitled MENTAL DISORDERS AND SUBSTANCE ABUSE BENEFITS for benefit information.

WELL-CHILD CARE (FOR MEMBERS UNDER AGE 17)

No Co-Pay except any amount in excess of covered expense for services provided by Non-Prudent Buyer Plan Providers.

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

The following services are covered when rendered to a Member under age 17:

1. Physician services for routine physical exams, including newborn well-baby exams (both in and out of a Hospital),
2. Immunizations given as standard medical practice,
3. Radiology and laboratory services in connection with routine physical exams.

For children ages 7 through 16 years, benefits are subject to a maximum payment of **$500** per Year.

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 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 Blue Cross and monitored so that Members know when it is no longer Medically Necessary and appropriate to continue those services.

It is 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 HOW BENEFITS ARE AFFECTED BY UTILIZATION REVIEWS.

Utilization Review Requirements

Utilization reviews are conducted for the following services:

— All inpatient Hospital Stays.

— Organ and tissue transplants.

— 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.

— Home infusion therapy.

— Home health care.

— Admissions to a Skilled Nursing Facility.

— Bariatric surgical services performed at a Centers of Expertise.

— Select 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) 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.

Exceptions: Utilization review is not required for inpatient Hospital Stays for the following services:

— Maternity care of 48 hours or less following a normal delivery or 96 hours or less following a cesarean section; and

— Mastectomy and lymph node dissection.

UTILIZATION REVIEW PROGRAMS

The stages of utilization review are:

1. **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 following services:

   — Scheduled, non-Emergency inpatient Hospital Stays, except inpatient Stays for maternity care or mastectomy and lymph node dissection.

   — Organ and tissue transplants.

   — 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.

   — Home infusion therapy.

   — Home health care.

   — Admissions to a Skilled Nursing Facility.

   — Bariatric surgical services performed at a Centers of Expertise.

   — Select 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) and Nuclear Cardiac Imaging.

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

3. **Retrospective review** is performed to review services that have already been provided. This applies in cases when pre-service or concurrent 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.

How Benefits Are Affected By Utilization Reviews

In order for the full benefits of this plan to be payable, all of the following criteria must be met:

A. 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. 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.

B. 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:

   — Organ and tissue transplants, as follows:

   - For kidney, 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 Blue Cross for the transplant requested.

   - For transplantation of liver, heart, heart-lung, lung, kidney-pancreas or bone marrow, including autologous bone marrow transplant, peripheral stem cell replacement 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 Expertise.

— A specified number of additional visits for physical therapy, physical medicine and occupational therapy if the Member needs more visits than is provided under the “Physical Therapy – Physical Medicine” provision of PRUDENT BUYER PLAN BENEFITS: COVERED SERVICES AND SUPPLIES.

— 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.

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

— Bariatric surgical procedures, 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 Expertise.

— Select 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) and Nuclear Cardiac Imaging.

C. 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 paid 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.

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 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.

UTILIZATION REVIEW PROGRAMS

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 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.

Blue Cross will certify services that are Medically Necessary and appropriate. For inpatient Hospital Stays, 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. Concurrent Reviews

If pre-service review was not performed, the Member, the Member's Physician or the provider of service must contact Blue Cross for concurrent review. **For an Emergency Hospital admission or procedure, 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 Blue Cross directly.

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

If 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 Blue Cross' decision. Written notice will be sent to the Member and the Member's Physician within two business days following 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", Blue Cross may take into account whether or not the Member's condition was severe enough to prevent him or her from notifying Blue Cross, or whether or not someone from the Member's family was available to notify 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

Retrospective review is performed when Blue Cross has not been notified of the services the Member received and therefore is unable to perform the appropriate review prior to the Member's discharge from the Hospital or completion of outpatient treatment. It is also performed when pre-service or concurrent 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 concurrent review was performed.

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

UTILIZATION REVIEW PROGRAMS

THE MEDICAL NECESSITY REVIEW PROCESS

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, Blue Cross is committed to ensuring that reviews are performed in a timely and professional manner. The following information explains 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.
2. A decision on the medical necessity of a concurrent 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 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 Blue Cross is unsuccessful and a delay is anticipated, Blue Cross will notify the Member or the Member's Physician of the delay and what is needed to make a decision. Blue Cross will also inform the Member of when a decision can be expected following receipt of the needed information.
5. All pre-service, concurrent and retrospective reviews for medical necessity are screened by clinically experienced, licensed personnel (called "Review Coordinators") using pre-established criteria and Blue Cross' medical policy. These criteria and policies are developed and approved by practicing providers not employed by 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. A 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 concurrent 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 Blue Cross chooses at 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. 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.

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 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.

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. 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 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. 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 Blue Cross have an obligation to provide it; Blue Cross provides these services at its sole and absolute discretion.

How Case Management Works

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 Blue Cross claims reports. The Member or the Member's family may also call 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. 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 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 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 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. A 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.

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. Any alternative benefits are accumulated toward any lifetime maximums.
2. Benefits are provided for an alternative treatment plan on a case-by-case basis only. 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.
3. Blue Cross' authorization of services in lieu of benefits in a particular case in no way commits Blue Cross to do so in another case or for another Member.
4. The personal case management program does not prevent Blue Cross from strictly applying the expressed benefits, exclusions and limitations of this plan at any other time or for any other Member.

Note: 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 Cancer Clinical Trials under the section PRUDENT BUYER PLAN BENEFITS - COVERED SERVICES AND SUPPLIES.

5. **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.

6. **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.

7. **Dental Care.** Dental plates, bridges, crowns, caps or other dental prostheses, dental services, extraction of teeth or treatment to the teeth or gums, except as specifically stated in Dental Care under PRUDENT BUYER PLAN BENEFITS - COVERED SERVICES AND SUPPLIES. Cosmetic dental surgery or other services for beautification.

8. **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.

9. **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 COVERED EXPENSE.

10. **Excess Amounts for BHP Providers.** Any expense incurred for the services of a Behavioral Health Program Provider (BHP Provider) or a Non-Behavioral Health Program Provider (Non-BHP Provider) in excess of the amounts described under MENTAL DISORDERS AND SUBSTANCE ABUSE BENEFITS.

EXCLUSIONS AND LIMITATIONS

11. **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.

12. **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.

13. **Government Services.** Any services actually given to the Member by a local, state or federal government agency, 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.

14. **Hearing Aids or Tests.** Hearing aids or routine hearing tests, except as specifically stated under the Hearing Aid Benefits provision of PRUDENT BUYER PLAN BENEFITS - COVERED SERVICES AND SUPPLIES.

15. **Mental Disorders or Substance Abuse.** Services for conditions attributable to Substance Abuse or to a Mental Disorder, except as specifically stated under MENTAL DISORDERS AND SUBSTANCE ABUSE BENEFITS.

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

17. **Nicotine Addiction.** Services for smoking cessation or reduction; nicotine use or addiction, except as specifically stated in the Smoking Cessation Programs and Nicotine Patches provisions of PRUDENT BUYER PLAN BENEFITS - COVERED SERVICES AND SUPPLIES.

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

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

20. **Nuclear Energy.** Conditions caused by release of nuclear energy, whether or not the result of war when government funds are available for treatment of illness or injury arising from such release of nuclear energy.

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

EXCLUSIONS AND LIMITATIONS

22. **Orthopedics.** Orthopedic shoes (other than shoes joined to braces) or non-custom molded and cast shoe inserts, except for therapeutic shoes and inserts for the prevention and treatment of diabetes-related foot complications as specifically stated under the Durable Medical Equipment provision of PRUDENT BUYER PLAN BENEFITS - COVERED SERVICES AND SUPPLIES.

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

24. **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.

25. **Over Negotiated Rate.** Any expense incurred for services of a Prudent Buyer Plan Provider in excess of the Negotiated Rate.

26. **Personal Items and Services.** Air purifiers, air conditioners, humidifiers, exercise equipment and supplies for comfort, hygiene or beautification. Educational services and nutritional counseling (except as stated under Diabetes Education Program benefits). Food or nutritional supplements (other than for the treatment of phenylketonuria). Formulas and food products approved by the FDA and prescribed by a Physician for the treatment of phenylketonuria are covered under this plan.

27. **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.

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

29. **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.

30. **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 Well-Child Care, Routine Physical Exam, Breast Cancer, Cervical Cancer Screening and Prostate Cancer Screening under PRUDENT BUYER PLAN BENEFITS - COVERED SERVICES AND SUPPLIES.

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

32. **Sex Change.** Procedures or treatments to change characteristics of the body to those of the opposite sex.

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

34. **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.

EXCLUSIONS AND LIMITATIONS

35. **Telephone and Facsimile Machine Consultations.** Consultations provided by telephone or facsimile machine.

36. **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.

37. **Weight Alteration Programs (Inpatient and Outpatient).** Weight loss or weight gain programs including, but not limited to, dietary evaluations and counseling, exercise programs, behavioral modification programs, surgery, laboratory tests, food and food supplements, vitamins and other nutritional supplements associated with weight loss or weight gain, unless it is 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.

37. **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 mail service program. The Member can also choose between Generic Drugs, Brand Name Drugs on 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

Many Participating Pharmacies display an "Rx" decal with Blue Cross logo in their window. 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 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 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 page 48 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 Blue Cross at the address shown below:

Blue Cross of California Prescription Drug Program
P.O. Box 4165
Woodland Hills, CA 91365-4165

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. Mail your claim, with the appropriate portion completed by the pharmacist, to Blue Cross 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.

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 Blue Cross at the address below:

Blue Cross of California Prescription Drug Program
P.O. Box 4165
Woodland Hills, CA 91365-4165

Non-Participating Pharmacies do not have Blue Cross 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.

PRESCRIPTION DRUG BENEFITS

Claim forms and customer service are available by calling 1-800-700-2541. The Member must mail the claim form with the appropriate portion completed by the pharmacist to Blue Cross 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.

MAIL SERVICE PROGRAM

Members can order Prescriptions through the mail service Prescription Drug program; however, not all medications are available through the mail service pharmacy. For any available Prescription Drug ordered through the mail service program, the Member will only pay the applicable copayment amount. Prescriptions can be filled through the mail service program for up to a 90-day supply or 100 units, 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 mail service Prescription must also include a completed patient profile questionnaire. The patient profile questionnaire can be obtained by calling the toll-free number below. The Member need only enclose the Prescription or refill notice and the appropriate payment for any subsequent mail service Prescriptions, or call the toll-free number. Copayments can be paid by check, money order or credit card.

To obtain order forms or verify whether the Drug is available through the mail service program, contact Blue Cross of California Prescription Drug Program - Mail Service at the following address or telephone number:

Blue Cross of California Prescription Drug Program - Mail Service
P.O. Box 961025
Fort Worth, TX 76161-9863
1-866-274-6825

Generic Drugs will be dispensed through the mail service 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 mail service program when the Prescription specifies a Brand Name and states "dispense as written" or no Generic Drug equivalent exists.

SPECIALTY PHARMACY PROGRAM

Members can only order Prescriptions for Specialty Pharmacy Drugs through the specialty pharmacy program unless they are given an exception from the specialty pharmacy program (See PRESCRIPTION DRUG CONDITIONS OF SERVICE on pages 50 & 51 of this section). Blue Cross of California – Specialty Pharmacy Program only fills Prescriptions for Specialty Pharmacy Drugs and will ship medication to the Member by mail or common carrier (Members cannot pick up their medications at Blue Cross of California).

The Prescription for the Specialty Pharmacy 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 Pharmacy Drug by calling 1-800-870-6419. When the Member calls Blue Cross of California – Specialty Pharmacy Program, a dedicated care coordinator will guide the Member through the process up to and including actual delivery of the Member's Specialty Pharmacy Drug to the Member. (If you order your Specialty Pharmacy 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 Pharmacy 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 Blue Cross of California – Specialty Pharmacy Program at the address shown below. The Member will only have to pay the cost of the applicable copayment (**$10**, **$25** or **$45**).

The first time the Member gets a Prescription for a Specialty Pharmacy 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 Pharmacy 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 a list of Specialty Pharmacy Drugs available through the specialty pharmacy program or order forms either by calling the toll-free number shown below or accessing the website at www.bluecrossca.com.

Blue Cross of California – Specialty Pharmacy Program
8900 Duke Blvd, Ste 100
Mason, OH 45040-8943
phone 1-800-870-6419
fax 1-800-824-2642

If the Member does not get Specialty Pharmacy Drugs through the specialty pharmacy program, the Member will not receive any benefits under this plan for such Drugs.

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 or 100 unit supply. See page 51 for more information.

COPAYMENTS THROUGH THE MAIL SERVICE 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 or 100 unit supply (see page 51 for more information).

COPAYMENTS THROUGH THE SPECIALTY PHARMACY PROGRAM

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 **$10.00** copayment for each Generic Prescription Drug or refill.

D. The copayments specified in A., B. and C. above will apply to each 30-day supply. See page 51 for more information.

REIMBURSEMENT

A. When the Member has a Prescription filled at a Participating Pharmacy or through the specialty pharmacy 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. We determine the amount of covered expense using the Drug Limited Fee Schedule; then,

   2. We then subtract the Member's applicable copayment from 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 covered expense as well as the cost of any non-covered items.

PRESCRIPTION DRUG BENEFITS

DETERMINATION OF COVERED EXPENSE

Covered expense for Prescription Drugs is determined as follows. Expense is incurred on the date the Member receives the Drug for which the charge is made.

A. For Prescription Drugs dispensed by a Participating Pharmacy and the mail service program, the amount we consider covered expense is the Prescription Drug Negotiated Rate.

B. For Prescription Drugs dispensed by a Non-Participating Pharmacy, the amount we consider covered expense is derived from the Drug Limited Fee Schedule. The Member is responsible for any amount exceeding the schedule.

PRESCRIPTION DRUG CONDITIONS OF SERVICE

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

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

B. It must be approved for general use by the State of California Department of Health Services or the federal Food and Drug Administration (FDA).

C. It must be for the direct care and treatment of the Member's illness, injury or condition. Dietary supplements, health aids or drugs prescribed for cosmetic purposes are not included. However formulas prescribed by a Physician for the treatment of phenylketonuria are covered.

D. It must be dispensed from a licensed retail Pharmacy, a Home Health Agency, the mail service program or through the specialty pharmacy program.

E. **An approved Compound Medication must be dispensed by a Participating Pharmacy.** Call 1-800-700-2541 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.bluecrossca.com.) **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 Specialty Pharmacy Drug must be obtained by using the specialty pharmacy program.** See SPECIALTY PHARMACY PROGRAM on pages 47 & 58 of this section for information on how to get the Member's Drugs by using the specialty pharmacy program. **The Member will have to pay the full cost of any Prescription for a Specialty Pharmacy Drug which the Member fills at a retail Pharmacy that should have obtained through the specialty pharmacy program.**

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

   1. The first two months supply of a Specialty Pharmacy Drug which is available through a Participating Pharmacy; or
   2. Drugs which, due to medical necessity, must be obtained immediately; or
   3. A Member who is unable to pay for delivery of their medication (i.e., no credit card).

   How to obtain an exception to the specialty pharmacy program. If you believe that you should not be required to get your medication through the specialty pharmacy program for any of the reasons listed above, you must complete an Exception to Specialty Drug Program form to request an exception and send this form to Blue Cross by either facsimile or mail (See page 48 for facsimile number and address for specialty pharmacy program). If you need a copy of the form, you may call us at 1-800-700-2541 to request one. You can also get the form on-line at www.bluecrossca.com. If we have given you an exception, it will be in writing and will be good

for 12 months from the time it is given. After this 12-month period, if you believe that you should still not be required to get your medication through the specialty pharmacy program, you must again request an exception. If we deny your request for an exception, it will be in writing and will tell you why we did not approve the exception.

Urgent or emergency need of a Specialty Pharmacy Drug subject to the specialty pharmacy program. If you are out of a Specialty Pharmacy Drug which must be obtained through the specialty pharmacy program, we will authorize an override of the specialty pharmacy program requirement for 72 hours, or until the next business day following a holiday or weekend, to allow you to get an emergency supply of medication if your Physician decides that it is appropriate and Medically Necessary. You may have to pay the applicable copayment, shown in PORAC PRUDENT BUYER PLAN: SUMMARY OF BENEFITS on page 6 and under COPAYMENTS THROUGH THE SPECIALTY PHARMACY PROGRAM on page 49 of this section, for the 72-hour supply of your Drug.

If you order your Specialty Pharmacy Drug through the specialty pharmacy program and it does not arrive, if your Physician decides that it is Medically Necessary for you to have the Drug immediately, we will authorize an override of the specialty pharmacy program requirement for a 30-day supply or less, to allow you to get an emergency supply of medication from a Participating Pharmacy near you. A dedicated care coordinator from the specialty pharmacy program will coordinate the exception, and you 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 or 100 units.

   Drugs federally-classified as Schedule II which are FDA-approved for the treatment of attention deficit disorder must not exceed a 60-day supply or 100 units. 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 mail service program, the copayment will remain the same as for any other Prescription Drug.

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

J. For the mail service program, the Prescription must not exceed the greater of a 90-day supply or 100 units.

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 Blue Cross for review.

L. Certain Drugs have specific quantity supply limits based on 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. 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 oral contraceptives; contraceptive diaphragms. Contraceptive diaphragms are limited to one per Year and are subject to the copayment for Brand Name Drugs.

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 which contain at least one covered Prescription ingredient.

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 Well-Child Care 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, sanatorium, 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 lowering cholesterol.

G. Durable medical equipment, devices, appliances and supplies, even if prescribed by a Physician, except Prescription contraceptive diaphragms as specified under PRESCRIPTION DRUG SERVICES AND SUPPLIES THAT ARE COVERED. 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.

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 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. Over-the-counter smoking cessation Drugs. This exclusion does not apply to Medically Necessary Drugs that can only be obtained with a Prescription under state and federal law. While not covered under prescription drug benefits, nicotine patches are covered as specified under the Nicotine Patches provision of the PRUDENT BUYER PLAN BENEFITS, subject to all terms of this plan that apply to those benefits.

M. 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.

N. Any expense incurred for a Drug or medication in excess of: (a) the Drug Limited Fee Schedule for Drugs dispensed by Non-Participating Pharmacies, or (b) the Prescription Drug Negotiated Rate for Drugs dispensed by Participating Pharmacies or through the mail service program.

O. Any Drug which has not been approved for general use by the State of California Department of Health Services or the FDA. This does not apply to Drugs that are Medically Necessary for a covered condition.

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

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

R. 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.

S. 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.

T. 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.

U. 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.

V. Compound Medication obtained from other than a Participating Pharmacy. **The Member will have to pay the full cost of the Compound Medications the Member gets from a Non-Participating Pharmacy**.

W. Specialty Pharmacy Drugs that must be obtained from the specialty pharmacy program but which are obtained from a retail Pharmacy are not covered by this plan. **The Member will have to pay the full cost of the Specialty Pharmacy Drugs the Member gets from a retail Pharmacy that the Member should have gotten through the specialty pharmacy program**.

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

PRESCRIPTION DRUG FORMULARY

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 Blue Cross' Formulary Drug list or requires prior authorization, please call Blue Cross at 1-800-700-2541.

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 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 make a written request to Blue Cross for the Member to get it using an Outpatient Prescription Drug Prior Authorization of Benefits form. The form can be sent by facsimile or mailed to Blue Cross. The Physician may call Blue Cross toll-free at 1-800-700-2541 to request a copy of the form. This form is also available on-line at www.bluecrossca.com.

If the request is for urgently needed Drugs, after Blue Cross receives the Outpatient Prescription Drug Prior Authorization of Benefits form:

- Blue Cross will, within 72 hours, review the form and decide if benefits are approved. (As soon as Blue Cross can, based on your medical condition, as Medically Necessary, Blue Cross may take less than 72 hours to decide if benefits will be approved.) Blue Cross will notify the Member and Member's Physician in writing of the decision - by facsimile to the Physician and by mail to the Member.
- If more information is needed to make a decision or Blue Cross, for any reason, cannot make a decision, Blue Cross will tell the Member's Physician, within 24 hours after Blue Cross receives the form, what information is missing and why Blue Cross cannot make a decision. If, for reasons beyond its control, Blue Cross cannot tell the Member's Physician within 24 hours what information is missing, Blue Cross will tell the Physician that there is a problem as soon as Blue Cross knows that it cannot respond within 24 hours. In either event, Blue Cross will tell the Member and Member's Physician that there is a problem – always in writing by facsimile and, when appropriate, by telephone call to the Member's Physician and in writing by mail to the Member.
- As soon as Blue Cross can, based on the Member's medical condition, as Medically Necessary, but not more than 48 hours after it has all the information it needs to decide if benefits will be approved, Blue Cross will notify the Member and Member's Physician in writing of the decision - by facsimile to the Physician and by mail to the Member.

If the request is not for urgently needed Drugs, after Blue Cross receives the Outpatient Prescription Drug Prior Authorization of Benefits form:

- Based on the Member's medical condition, as Medically Necessary, Blue Cross will, within 5 business days, review the form and decide if benefits will be approved. Blue Cross will tell the Member and Member's Physician in writing what was decided - by facsimile to the Physician and by mail to the Member.
- If more information is needed to make a decision, Blue Cross will tell the Member's Physician, in writing within 5 business days after Blue Cross gets the request, what information is missing and why Blue Cross cannot make a decision. If, for reasons beyond Blue Cross' control, it cannot tell the Member's Physician within 5 business days what information is missing, Blue Cross will tell the Physician that there is a problem as soon as Blue Cross knows that it cannot respond within 5 business days. In any event, Blue Cross will tell the Member and Member's Physician that there is a problem – in writing by facsimile and, when appropriate, by telephone call to the Physician, and in writing by mail to the Member.
- As soon as Blue Cross can, based on the Member's medical condition, as Medically Necessary, within 5 business days after Blue Cross has all the information it needs to decide if benefits will be approved, it will tell the Member and Member's Physician in writing what was decided - by facsimile to the Physician and by mail to the Member.

While Blue Cross is reviewing the Outpatient Prescription Drug Prior Authorization of Benefits form, 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 6 and under COPAYMENTS AT A RETAIL PHARMACY of this section on page 48, for the 72-hour supply of the Drug. If the request for the Specialty Pharmacy Drug is approved after the Member has received a 72-hour supply, the Member will receive the remainder of the 30-day supply of the Drug with no additional copayment.

If you have any questions regarding whether a Drug in on the Prescription Drug Formulary or requires prior authorization, please call 1-800-700-2541.

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 Blue Cross at 1-800-700-2541. If the Member is not satisfied with the resolution based on such an inquiry, the Member may file a grievance with Blue Cross by following the procedures described in the section entitled CLAIMS REVIEW / GRIEVANCE PROCEDURES.

The outpatient Prescription Drugs included on the list of Formulary Drugs covered by the Plan is decided by Blue Cross' Pharmacy and Therapeutics Committee which is comprised of independent Physicians and pharmacists. The Pharmacy and Therapeutics Committee meets quarterly and decides on changes to make in the Formulary Drug list based on recommendations from 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.

DEFINITIONS

Average Wholesale Price. Average Wholesale Price is an accepted term in the pharmaceutical industry as a benchmark for pricing by pharmaceutical manufacturers.

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

Compound Medication. A Compound Medication is a mixture of Prescription Drugs and other ingredients, of which at least one of the components is commercially available as a Prescription product. Compound Medications do not include:

1. Duplicates of existing products and supplies that are mass-produced by a manufacturer for consumers; or
2. Products lacking an NDC number.

All claims for reimbursement for Compound Medications must be submitted electronically by the Pharmacy and will be paid at the Prescription Drug Negotiated Rate. Compound Medications may be limited to distribution at designated Pharmacies.

Drug. Drug means a prescribed Drug approved by the State of California Department of Health Services or the federal Food and Drug Administration (FDA) for general use by the public. For the purpose of this plan, insulin and niacin, for lowering cholesterol, will be considered Prescription Drugs.

Drug Limited Fee Schedule. The Drug Limited Fee Schedule represents the maximum amounts Blue Cross will allow as covered expense for Prescriptions filled at Non-Participating Pharmacies. These amounts are the lesser of billed charges or the Average Wholesale Price.

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

PRESCRIPTION DRUG BENEFITS

Generic Prescription Drug (Generic Drug). A Generic Prescription 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.

Non-Participating Pharmacy. A Non-Participating Pharmacy is a Pharmacy which does not have a Participating Pharmacy Agreement in effect with Blue Cross 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.

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

Pharmacy. A Pharmacy is a licensed retail pharmacy.

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

Prescription drug covered expense. Prescription Drug Covered Expense is the expense the Member incurs for a covered Prescription Drug, but not more than the maximum amounts described in items 1 and 2 below. Expense is incurred on the date the Member receives the service or supply.

Prescription Drug Covered Expense does not include any expense in excess of: (1) the Drug Limited Fee Schedule for Drugs dispensed by Non-Participating Pharmacies; or (2) the Prescription Drug Negotiated Rate, for Drugs dispensed by Participating Pharmacies or by the mail service program.

Prescription Drug Formulary (Formulary). The Prescription Drug Formulary is a list which 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.

Prescription Drug Negotiated Rate. The rate that Blue Cross has negotiated with Participating Pharmacies under a Participating Pharmacy Agreement for Prescription Drug Covered Expense. Participating Pharmacies have agreed to charge Members no more than the Prescription Drug Negotiated Rate. It is also the rate which Blue Cross of California Prescription Drug Program - Mail Service has agreed to accept as payment in full for Prescription Drugs filled through the mail service program.

Specialty pharmacy drugs. Specialty Pharmacy Drugs are high-cost, injectable, infused, oral or inhaled medications that generally require close supervision and monitoring of their effect on the patient by a medical professional. These Drugs often require special handling, such as temperature controlled packaging and overnight delivery, and are often unavailable at retail Pharmacies.

MENTAL DISORDERS AND SUBSTANCE ABUSE BENEFITS

Blue Cross has developed a Behavioral Health Program (BHP) which provides confidential, professional, and affordable services for the broad range of personal, family, mental health, and Substance Abuse problems that affect the general well-being of Members. The plan is designed to assure that the services you receive are Medically Necessary and appropriate, and that your benefits are used to your best advantage. This plan features services provided through the Behavioral Health Program provider network. How these services are coordinated is explained in **HOW THE PLAN WORKS**, later in this section.

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED. THE MEANINGS OF WORDS AND PHRASES WHICH ARE CAPITALIZED ARE DESCRIBED IN THE SECTIONS OF YOUR EVIDENCE OF COVERAGE FORM, AND IN THIS SECTION, ENTITLED DEFINITIONS.

SUMMARY OF BENEFITS

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

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

MENTAL DISORDERS AND SUBSTANCE ABUSE BENEFITS

Benefits for Covered Expense incurred for Mental Disorders (other than Severe Mental Disorders) and Substance Abuse will be paid as shown on the following pages, subject to the conditions, limitations and exclusions of this plan.

SEVERE MENTAL DISORDER BENEFITS

Covered services for the treatment of Severe Mental Disorders will not be subject to any of the co-payments or limitations applicable to Mental Disorders shown on pages 59 & 60 which apply to all other Mental Disorders. Benefits for the treatment of Severe Mental Disorders (see definition on pages 73 & 74) will be provided the same as they would for any other medical illness or condition. However, in order for the highest level of benefits to be payable under this plan, the **UTILIZATION REVIEW AND CARE MANAGEMENT REQUIREMENTS** shown on pages 64 & 65 must be followed.

Benefits for services provided by BHP Providers or Non-BHP providers, when the appropriate approval is received, shall be provided according to the benefit levels and all other conditions applicable to Prudent Buyer Plan Providers as listed under the **PRUDENT BUYER PLAN BENEFITS** section. Benefits for services provided by Non-BHP Providers when the appropriate approval is not received, shall be provided according to the benefit levels and all other conditions applicable to Non-Prudent Buyer Plan Providers as listed under the **PRUDENT BUYER PLAN BENEFITS** section.

Benefits for Severe Mental Disorders will be subject to all other medical terms, conditions, limitations and exclusions. This includes any applicable medical benefit maximums, Deductible, co-payments, Out-of-Pocket Expense Amount, Determination of Covered Expense and any other provisions listed under the **PRUDENT BUYER PLAN BENEFITS** section.

Important Note: See HOW THE PLAN WORKS for information on the approval process for treatment plans, and how to obtain the necessary reviews and authorizations.

MENTAL DISORDERS AND SUBSTANCE ABUSE BENEFITS

CO-PAYMENTS

The following is a list of amounts for which you are responsible for each covered Mental Disorder and Substance Abuse service or supply.

Note: In addition to the co-payment shown below, you will be required to pay any amount in excess of Covered Expense for the services of a Non-BHP Provider.

For Each Inpatient or Outpatient Visit for Psychotherapy and Psychological Testing:

- BHP Providers (with authorization) .... **20%** of Covered Expense limited to one visit per day
- BHP Providers (without authorization) .... **50%** of Covered Expense limited to one visit per day
- Non-BHP Providers .... **50%** of Covered Expense limited to one visit per day

For Inpatient Treatment Facility Services:

- BHP Providers (with authorization) .... **$150** per Course of Treatment plus **20%** of remaining Covered Expense
- BHP Providers(without authorization) .... **$300** per Course of Treatment plus **50%** of remaining Covered Expense
- Non-BHP Providers .... **$500** per Course of Treatment plus **50%** of remaining Covered Expense

For Outpatient Treatment Center or Intensive Structured Outpatient Services:

- BHP Providers .... **20%** of Covered Expense
- BHP Providers(without authorization) .... **50%** of Covered Expense
- Non-BHP Providers .... **50%** of Covered Expense

NOTE: These co-payments will not apply to services for the treatment of a Severe Mental Disorder. See page 58 for Severe Mental Disorder Benefits information.

MENTAL DISORDERS AND SUBSTANCE ABUSE BENEFITS

BENEFIT MAXIMUMS

We will pay up to the following maximum amounts and number of visits, for Covered Expense incurred:

- **For Mental Disorders or Substance Abuse**

  Outpatient visits for psychotherapy and psychological testing are limited to **25 visits** per Calendar Year for BHP Providers without authorization and Non-BHP Providers combined. Outpatient visits for psychotherapy and psychological testing are further limited to a combined maximum of **50 visits** per Calendar Year for ALL providers.

- **Treatment facility services for Mental Disorders**
  (inpatient and outpatient) .... **30 days** per Calendar Year*

  * Two treatment sessions at an Outpatient Treatment Center are equivalent to one day at an Inpatient Treatment Facility.

- **Substance Abuse**†
  (for all covered services) .... **$15,000** per Calendar Year

  (for all covered services) .... **$30,000** during your lifetime

  † All Substance Abuse benefits for inpatient and outpatient services rendered by all providers are limited to a maximum lifetime payment of $30,000.00 of covered expense incurred by each Member while covered under any Blue Cross group benefit plan sponsored by PORAC on or after August 1, 1988. This lifetime maximum does not apply to services for the treatment of Mental Disorders.

  For all Inpatient Treatment Facility or Outpatient Day Treatment Center services for Substance Abuse, no more than a combined maximum of one Course Of Treatment a Year and a maximum aggregate of two Courses Of Treatment while the Member is covered under any Blue Cross group benefit plan sponsored by PORAC on or after August 1, 1988.

  A Course Of Treatment is limited as follows:

  — For BHP Providers, a Course Of Treatment is limited to the number of days prescribed for the Member by the medical director of the Inpatient Treatment Facility or Outpatient Day Treatment Center and accepted by the BHP Care Manager.

  — For Non-BHP Providers, a Course Of Treatment is limited to a maximum of (1) 30 consecutive days for inpatient services provided by an Inpatient Treatment Facility or (2) 60 days in a Year for services provided by an Outpatient Day Treatment Center.

  When the Member begins a Course Of Treatment, that Member's available benefits will be reduced the same as for a Completed Course Of Treatment, even if the Member does not complete it.

NOTE: These Benefit Maximums will not apply to services for the treatment of a Severe Mental Disorder. See page 58 for Severe Mental Disorder Benefits information.

ADDITIONAL EXCEPTIONS TO THE ABOVE CO-PAYMENTS AND BENEFIT MAXIMUMS

Subject to the conditions and limitations of AUTHORIZED REFERRALS TO NON-BHP PROVIDERS and EMERGENCY CARE, your co-payments and Maximums for Non-BHP Provider services will be the same as for the services of a BHP Provider (with authorization) for an Emergency or an Authorized Referral.

However, Covered Expense will never exceed the amount shown in HOW COVERED EXPENSE IS DETERMINED. This amount may be significantly lower than what providers customarily charge. You must pay all of this excess amount in addition to your co-payments.

HOW THE PLAN WORKS

The Behavioral Health Program (BHP) combines a selected network of health care providers specializing in the treatment of Mental Disorders, Severe Mental Disorders and Substance Abuse with specially designed benefits and a care management service that coordinates the delivery of needed services. The extent of your benefits for services received is determined by whether you obtain prior authorization for benefits from a Behavioral Health Care Manager and receive services from a provider who participates in the BHP network (Behavioral Health Program Provider or BHP Provider).

When you choose a BHP Provider and follow the procedures for authorizations by the Care Manager as described in this section, you will be entitled to the maximum benefits payable under this plan.

For treatment of Mental Disorders and Substance Abuse, if the procedures for prior authorization and concurrent review are not followed, and you do not choose a BHP Provider, you may be entitled only to the minimum level of benefits stated for Non-BHP Providers, in the SUMMARY OF BENEFITS.

For treatment of Severe Mental Disorders, if the procedures for prior authorization and concurrent review are not followed, and you do not choose a BHP Provider, you may be entitled only to the minimum level of benefits stated for Non-Prudent Buyer Plan Providers, in the section entitled PRUDENT BUYER PLAN BENEFITS (pages 11 through 45). If the procedures for prior authorization and concurrent review are followed, and you choose a BHP Provider, you will be entitled to the level of benefits stated for Prudent Buyer Plan Providers, in the section entitled PRUDENT BUYER PLAN BENEFITS.

No benefits are payable unless your coverage is in force at the time services are received, and the payment of benefits is also subject to all terms and requirements that may be listed elsewhere in this plan.

Your Behavioral Health Program provides benefits for services and treatment for problems related to Mental Disorders, Severe Mental Disorders and Substance Abuse. The maximum benefits are provided only when all the necessary reviews and authorizations are obtained, and (1) a referral was received from a Care Manager; (2) a Care Manager had been notified in advance; or (3) a Care Manager has been notified within 24 hours following the onset of an Emergency, unless extraordinary circumstances prevent such notification within that time period.

A care manager is available 24 hours a day by calling the toll-free telephone number listed below:

1-800-399-2421

Verification of Eligibility and Referral. When you call, a Behavioral Health Program representative will verify your eligibility and obtain demographic information. This verification does not assure that benefits are payable, only that you are eligible under the plan. The representative will evaluate whether you need to speak immediately with a Care Manager or, if appropriate, may authorize initial visits to a Mental Health Professional.

MENTAL DISORDERS AND SUBSTANCE ABUSE BENEFITS

If your apparent needs cannot be met by a BHP Provider, the Care Manager will give you an Authorized Referral to a Non-BHP Provider (see AUTHORIZED REFERRALS TO NON-BHP PROVIDERS).

If you choose to use a Non-BHP Provider for the treatment of Mental Disorders or Substance Abuse, even though the Care Manager has referred you to a BHP Provider, your benefits will be reduced to those described in the SUMMARY OF BENEFITS for Non-BHP Providers. If you choose to use a Non-BHP Provider for the treatment of Severe Mental Disorders, even though the Care Manager has referred you to a BHP Provider, your benefits will be reduced to those described for Non-Prudent Buyer Plan Providers, in the section entitled PRUDENT BUYER PLAN BENEFITS.

Treatment Plan Review. The BHP Provider will notify the Care Manager of the treatment plan proposed for you. The Care Manager will conduct the required utilization reviews. If the Care Manager confirms the medical necessity of the services and accepts the treatment plan, the Care Manager will authorize the BHP Provider to implement the accepted treatment plan. A specific number of visits, days, or treatments will be authorized.

The BHP Provider will notify the Care Manager of any changes or exceptions to your treatment plan. The Care Manager will review the revised treatment plan and authorize benefits if it is accepted.

Authorization. The Care Manager will authorize benefits for your treatment plan after it is reviewed and accepted, and after your eligibility has been verified. For treatment plans reviewed after normal business hours, the Care Manager will verify your eligibility for benefits on the next business day, after which any benefits for approved covered services will be authorized.

Prior Coverage Under a Behavioral Health Program Plan. If the prior plan is a Blue Cross health plan with Mental Disorder and Substance Abuse benefits provided under the behavioral health program, benefits will continue to be provided according to the original authorizations, subject to continuing utilization review.

Important Note: Benefits provided for the services of Non-BHP Providers (or Non-Prudent Buyer Plan Providers can be significantly lower than those provided for BHP Providers. Please read the SUMMARY OF BENEFITS carefully for details.

AUTHORIZED REFERRALS TO NON-BHP PROVIDERS

Prior to services being rendered, you may receive an Authorized Referral from the Care Manager for services from a Non-BHP Provider. This will be done as part of the assessment and referral process.

Maximum benefits will be provided for Authorized Referrals as though the services had been rendered by a BHP Provider-with authorization (or Prudent Buyer Plan Provider for treatment of a Severe Mental Disorder) **only** when all of the following criteria are met:

1. There is no BHP Provider who can provide the required services within a 30-mile radius of your residence;
2. The referral is authorized before you receive the services; **and**
3. The Non-BHP Provider cooperates with all aspects of behavioral health care management, including: (a) submission of the treatment plan prior to services being rendered; (b) disclosure of your status and progress to substantiate quality of care, medical necessity and the appropriateness of the treatment; and (c) referral to other providers and facilities which are BHP Providers, unless prior approval is otherwise obtained.

MENTAL DISORDERS AND SUBSTANCE ABUSE BENEFITS

For Mental Disorders or Substance Abuse, if you obtained services from a Non-BHP Provider without first obtaining an Authorized Referral, any benefits provided for those services will be paid at the Non-BHP Provider payment level shown in the SUMMARY OF BENEFITS after the services have been documented and approved as Medically Necessary. For Severe Mental Disorders, if you obtained services from a Non-BHP Provider without first obtaining an Authorized Referral, any benefits provided for those services will be paid at the Non-Prudent Buyer Plan Provider payment level shown in the section entitled PRUDENT BUYER PLAN BENEFITS, after the services have been documented and approved as Medically Necessary.

If, after first obtaining an Authorized Referral, you receive services from that provider in excess of those authorized by the Care Manager, those excess services for Mental Disorders or Substance Abuse will be provided at the Non-BHP Provider payment level after the services have been documented and approved as Medically Necessary. For Severe Mental Disorders those excess services will be provided at the Non-Prudent Buyer Plan Provider payment level shown in the section entitled PRUDENT BUYER PLAN BENEFITS, after the services have been documented and approved as Medically Necessary.

EMERGENCY CARE

Please read the definition of Emergency in the DEFINITIONS section carefully. This definition will be strictly interpreted.

When Emergency Care is provided by a BHP Provider, the BHP Provider will contact the Care Manager on your behalf.

You may seek Emergency Care from any licensed mental health provider, but you (or a member of your family or your provider acting on your behalf) must contact a Care Manager within 24 hours of receiving the initial Emergency Care, unless you demonstrate that extraordinary circumstances* prevented you or another person from notifying a Care Manager within 24 hours and that you, in fact, made such notification as soon as reasonably possible.

If it is determined that the admission or treatment could not have safely been delayed until prior authorization was obtained:

1. Emergency Care benefits will be provided as though the services had been rendered by a BHP Provider-with authorization (or Prudent Buyer Plan Provider for treatment of a Severe Mental Disorder);
2. The Care Manager will assist you in arranging a transfer to a BHP Provider; and
3. If a BHP Provider is not available, you will receive an Authorized Referral to a Non-BHP Provider, selected by the Care Manager and appropriate for your needs. This provider may or may not be the same provider who rendered the initial Emergency Care.

Benefits will be provided at the Non-BHP Provider payment levels (or Non-Prudent Buyer Plan Provider payment level for treatment of a Severe Mental Disorder) under the following circumstances:

1. It is determined that the admission or treatment could have been safely delayed until after prior authorization was obtained;
2. Emergency Care services are provided in excess of those authorized by the Care Manager; and
3. For continued care after your condition has stabilized, if you refuse transfer to a BHP Provider or an Authorized Referral to another Non-BHP Provider, and choose to continue treatment with the Non-BHP Provider who rendered Emergency Care.

MENTAL DISORDERS AND SUBSTANCE ABUSE BENEFITS

Whenever possible, you should call the Care Manager to speak to a licensed counselor before seeking treatment on your own. Care Managers are available 24 hours a day, seven days a week by telephone for emergency or urgent situations.

*__Extraordinary Circumstances.__ In determining "extraordinary circumstances", we may take into account whether or not your condition was severe enough to prevent you from notifying the Care Manager, or whether or not a member of your family was available to notify the Care Manager for you. You may have to prove that such "extraordinary circumstances" were present at the time of the Emergency.

UTILIZATION REVIEW AND CARE MANAGEMENT REQUIREMENTS

Utilization review is performed for all services you receive for the treatment of Mental Disorders, Severe Mental Disorders and Substance Abuse. The Care Manager will initiate the required reviews for approved treatment plans.

Utilization Review Requirements

1. **Pre-service review** determines whether the services are Medically Necessary prior to the services being rendered. Pre-service review is required for all elective inpatient admissions and elective outpatient services. It is not required for Emergency Care, as described in EMERGENCY CARE.

2. **Concurrent review** determines whether services continue to be Medically Necessary. Concurrent review includes reviews performed: (a) to evaluate the medical necessity of services when pre-service review was not performed; and (b) to determine the medical necessity of ongoing treatment.

   Concurrent review may include onsite review of clinical records and progress notes. When such onsite review is required, benefits will not be payable unless the review is completed to the Care Manager's satisfaction.

   Concurrent review may also require a direct interview of the Member by a Mental Health Professional chosen by us. Such an interview would be applied as a visit under this benefit.

   The requirements of concurrent review are determined at the sole option of the Care Manager.

3. **Retrospective review** is performed when the Care Manager was not informed of services you received or was otherwise not able to perform the appropriate pre-service or concurrent reviews prior to the end of the Stay or the completion of outpatient services. If the retrospective review determines that all or part of the services you received were not Medically Necessary or otherwise not covered, you are responsible for payment of the charges for services determined to be not Medically Necessary, or otherwise not covered.

   Exception: If services rendered by a BHP Provider are retrospectively determined to be not Medically Necessary or otherwise not covered, you will not be responsible for those charges, unless you so agreed in writing prior to the provision of those services.

   Only the minimum benefits may be approved on a retrospective basis. Retrospective review will require clear and adequate documentation of medical necessity.

Important: Utilization review requirements apply in all cases, even when your coverage under this plan is secondary to another plan providing benefits for you or your Family Members.

How to obtain utilization reviews. Utilization reviews may be obtained by calling the Care Manager at:

1-800-399-2421

MENTAL DISORDERS AND SUBSTANCE ABUSE BENEFITS

When the Care Manager is contacted prior to your receiving services from a Non-BHP Provider, the required pre-service and concurrent reviews will be conducted by the Care Manager. You, or an individual representing you, or the Non-BHP Provider (on your behalf) must contact the Care Manager in advance of receiving services.

When the Care Manager has not been contacted prior to your receiving services from a Non-BHP Provider, the services will be retrospectively reviewed when the bill is submitted for payment. If that retrospective review results in the determination that any or part of those services are not medically necessary, benefits for any such services will be denied. For services determined to have been Medically Necessary, benefits will be those described for Non-BHP Provider levels (or Non-Prudent Buyer Plan Provider levels for treatment of a Severe Mental Disorder).

You and your provider will be required to document that any services you receive are Medically Necessary. If you or your provider fail to comply with the documentation requirement, benefits for any such services received will be denied.

DISAGREEMENTS WITH UTILIZATION REVIEW DECISIONS

If you or your provider disagree with our determination, such as a denial of authorization, or question how it was reached, reconsideration may be requested. The request may be made by you, someone chosen to represent you or your provider. Requests for reconsideration must be directed, in writing, to the Care Manager, and must include medical information that supports the medical necessity of the treatment and a copy of the original determination by the Care Manager.

If you are dissatisfied with the reconsidered decision, you may appeal by writing to us, to the office of the Medical Director. The appeal may be made by you, your representative or your provider.

In the event that our decision regarding the appeal is unsatisfactory to you, then your remedy is binding arbitration. (See the section entitled CLAIMS REVIEW/GRIEVANCE PROCEDURES beginning on page 99.)

If you elect to utilize a Non-BHP Provider, it will always be your responsibility to determine that you and your provider are complying with all the terms and conditions of the plan.

HOW COVERED EXPENSE IS DETERMINED

Benefits for Mental Disorders and Substance Abuse are payable for Covered Expense incurred, subject to the co-payments and Benefit Maximums shown on pages 59 & 60. Expense is incurred on the date you receive the service or supply for which the charge is made. For the treatment of Severe Mental Disorders, Covered Expense will not exceed either the Negotiated Rate, Reasonable Charge or the Scheduled Amount as described under the section entitled DETERMINATION OF COVERED EXPENSE under PRUDENT BUYER PLAN BENEFITS (see page 15).

Covered Expense is the expense incurred for a covered service or supply. Covered Expense will not exceed the lesser of the billed charge or the amount shown below for Mental Disorders and Substance Abuse:

For ALL BHP Providers:
The Maximum Covered Expense is the BHP Negotiated Rate.

For Non-BHP Providers:
Maximum Covered Expense for Mental Health Professionals is the Customary and Reasonable Charge*.

Maximum Covered Expense for ALL OTHER ELIGIBLE PROVIDERS is a Reasonable Charge*.

You are responsible for any amount exceeding Covered Expense for the services received from a Non-BHP Provider.

MENTAL DISORDERS AND SUBSTANCE ABUSE BENEFITS

***Exception:** If Medicare is the primary payer, Covered Expense does not include any charge:

1. By a Hospital, in excess of the approved amount as determined by Medicare; or
2. By a Mental Health Professional, in excess of the lesser of the maximum Covered Expense stated above, or:
   a. For providers who accept Medicare assignment, the approved amount as determined by Medicare; or
   b. For providers who do not accept Medicare assignment, the limiting charge as determined by Medicare.

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

CO-PAYMENTS AND BENEFIT MAXIMUMS

Benefits paid for all inpatient or outpatient services rendered by all providers for treatment of Mental Disorders or Substance Abuse are subject to the co-payments and Benefit Maximums shown on pages 59 & 60. Covered services for the treatment of Severe Mental Disorders will not be subject to any of the co-payments or Benefit Maximums applicable to Mental Disorders shown on pages 59 & 60 which apply to all other Mental Disorders. Benefits for the treatment of Severe Mental Disorders (see definition on pages 73 & 74) will be provided the same as they would for any other medical illness or condition listed under the PRUDENT BUYER PLAN BENEFITS section.

CO-PAYMENTS

We will subtract your co-payment from the amount of Covered Expense. If your co-payment is a percentage, we will apply the applicable percentage to the amount of Covered Expense incurred. This will determine the dollar amount of your co-payment.

BENEFIT MAXIMUMS

For Mental Disorders or Substance Abuse, the maximum amounts payable for all Covered Expense for behavioral health benefits are shown on pages 59 & 60.

Prior Plan Benefit Maximums. If this plan replaces a prior plan, then the amount of any benefits paid to you under the prior plan will reduce any maximum amounts you are eligible for under this plan which apply to the same benefit.

SERVICES AND SUPPLIES THAT ARE COVERED

Subject to the exclusions and limitations listed under SERVICES AND SUPPLIES THAT ARE NOT COVERED, we will provide benefits for the following services as well as any services listed under PRUDENT BUYER PLAN BENEFITS - COVERED SERVICES AND SUPPLIES for the treatment of Severe Mental Disorders. All services require a diagnostic code within the range 290-319 or a DSM-IV diagnosis.

Mental Health Professionals. Inpatient or outpatient services of Mental Health Professionals, including the services of a Mental Health Professional who is on the staff of the Inpatient Treatment Facility or Outpatient Treatment Center, for evaluation, individual counseling, group and family therapy, biofeedback, stress management training and psychological testing.

Inpatient Treatment Facility. The following services and supplies provided by an Inpatient Treatment Facility:

1. Accommodations in a room of two or more beds, or the prevailing charge for two-bed room accommodations in an Inpatient Treatment Facility if a private room is used. However, if your Physician certifies that a private room is needed because of your medical condition and prior authorization for a private room has been obtained from a Care Manager, private room accommodations are provided.

2. Supplies and ancillary services normally provided by an Inpatient Treatment Facility, including any professional component of those services.
3. Detoxification services.
4. Dietary services.
5. Physical conditioning.
6. X-ray or laboratory services.
7. Medication management services and drugs and medicines approved for general use by the federal Food and Drug Administration (FDA) or the State of California Department of Health Services which are supplied by the Inpatient Treatment Facility for use during your Stay.
8. An outpatient aftercare program at that Inpatient Treatment Facility following an inpatient stay for rehabilitation.

Outpatient Treatment Center or Intensive Structured Outpatient Services. Approved programs providing services and supplies to patients on a full day (patient returns home each night) or a partial day basis. Covered expense will include services normally provided by an Outpatient Treatment Center, including any professional component of those services.

SERVICES AND SUPPLIES THAT ARE NOT COVERED

In addition to the exclusions and limitations in PRUDENT BUYER PLAN BENEFITS - EXCLUSIONS AND LIMITATIONS, no benefits will be provided under this plan in connection with any of the items below. (The titles given to these exclusions and limitations are for ease of reference only; they are not meant to be an integral part of the exclusions and limitations and do not modify their meaning.)

BHP Providers. For services provided by a BHP Provider, any charge in excess of the BHP Negotiated Rate.

Non-BHP Providers. For services provided by a Non-BHP Provider, any charge in excess of the Maximum Covered Expense.

Excess Services. Any amounts in excess of any benefit maximums.

Legal Proceedings. Evaluations or reports for legal proceedings.

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.

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.

Unapproved Drugs. Any drug which has not been approved for general use by the FDA or by the State of California Department of Health Services.

Self-Administered Drugs. Outpatient drugs and medications prescribed for self-administration by the Member.

Ambulance. Ground or air ambulance transportation services, except when necessary to transfer you to a BHP Provider, and when prior authorization has been properly obtained.

Not Defined. Treatment for any condition other than a Mental Disorder, Severe Mental Disorder or Substance Abuse as defined in this plan. Services for conditions not attributable to Substance Abuse or to a Mental Disorder (V code) in the International Classification of Diseases.

Nicotine Dependency. Services for smoking cessation or reduction; nicotine use or addiction.

Educational Services. Academic or educational testing, counseling, and remediation.

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

Caffeine Addiction.

Bulimia or Weight Reduction. Inpatient services primarily for the treatment of bulimia and/or bulimia nervosa (binge-purge) syndrome unless necessary to treat a Severe Mental Disorder. Services for weight reduction or the treatment of obesity.

Chronic Conditions. Chronic conditions not reasonably expected to improve with short-term, intensive symptom-focused treatment. Personality restructuring, self-discovery, self-realization, or psychoanalysis.

Surgery.

Gambling. Services or programs for treatment of pathological gambling.

Codependency. Services or programs for treatment of codependency.

Misrepresentation. Any service provided in connection with an attempt to commit fraud, or a material misrepresentation of the facts.

Telephone and Facsimile Machine Consultations. Consultations provided by telephone or facsimile machine, except as provided under HOW THE PLAN WORKS.

GENERAL PROVISIONS

Non-Regulation of Providers. The benefits of this plan do not regulate the amounts charged by providers of medical care, except to the extent that rates for covered services are regulated with BHP Providers.

Provider Reimbursement. Physicians and other professional providers are paid on a fee-for-service basis, according to an agreed schedule. Hospitals and other health care facilities may be paid either a fixed fee or on a discounted fee-for-service basis.

Notice of Claim. You or the provider of service must send properly and fully completed claim forms to us within 90 days of the date you receive the service or supply for which a claim is made. Services received and charges for the services must be itemized, and clearly and accurately described. If it is not reasonably possible to submit the claim within that time frame, an extension of up to 12 months will be allowed. We are not liable for the benefits of the Agreement if you do not file claims within the required time period. Claim forms must be used; canceled checks or receipts are not acceptable. Claims must be submitted to us in care of the Behavioral Health Program at the address below:

Blue Cross of California
Behavioral Health Program
P. O. Box 4137
Woodland Hills, California 91365-4137

MENTAL DISORDERS AND SUBSTANCE ABUSE BENEFITS

Payment to Providers. Blue Cross will pay the benefits of this plan directly to Contracting Hospitals, BHP Providers and medical transportation providers. If the Subscriber or Family Member receives services from non-contracting Hospitals and Non-BHP 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 unless an Authorized Referral has been approved by Blue Cross. Blue Cross will pay non-contracting Hospitals and other providers of service directly when Emergency Services and Emergency Care are provided to the Member. Blue Cross will continue such direct payment until the Emergency Services and 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, Blue Cross will pay the benefits of this plan to the State Department of Health Services. These payments will fulfill Blue Cross' obligation to the Member for those covered services.

Liability of Subscriber to Pay Providers. In accordance with California law, you will not be required to pay any BHP Provider any amounts we owe to that provider (not including co-payments or deductibles), even in the unlikely event that we fail to pay that provider. You may be liable, however, to pay Non-BHP Providers any amounts not paid to them by us.

Transition Assistance for a New Member. Transition Assistance is a process that allows for completion of covered services for a new Member receiving services from a Non-BHP Provider. 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 Blue Cross in consultation with you and the Non-BHP Provider and consistent with good professional practice. Completion of covered services shall not exceed twelve (12) months from the time you enroll with Blue Cross.
3. 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.
4. 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 Blue Cross.

Please contact the Care Manager at 1-800-399-2421 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.

You will be notified 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-BHP Providers are negotiated on a case-by-case basis. We will request that the Non-BHP Provider agree to accept reimbursement and contractual requirements that apply to BHP Providers, including payment terms. If the Non-BHP 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, Blue Cross will provide benefits to a Member at the BHP Provider level for covered services (subject to applicable co-payments, coinsurance, deductibles and other terms) received from a provider at the time the provider's contract with us terminates (unless the provider's contract terminates for reasons of medical disciplinary cause or reason, fraud, or other criminal activity).

The Member must be under the care of the BHP 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 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 Blue Cross prior to termination. If the provider does not agree with these contractual terms and conditions, we are not required to continue the provider's services beyond the contract termination date.

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 Blue Cross in consultation with you and the terminated provider and consistent with good professional practice. Completion of covered services shall not exceed twelve (12) months from the time you enroll with Blue Cross.
3. 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.
4. 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 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.

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

We will notify you by telephone, and the provider by telephone and facsimile, as to whether or not your request for continuity of care is approved. If approved, you will be financially responsible only for applicable deductibles, coinsurance, and co-payments under the plan. Financial arrangements with terminated providers are negotiated on a case-by-case basis. We will request that the terminated provider agree to accept reimbursement and contractual requirements that apply to BHP Providers, including payment terms. If the terminated provider does not agree to accept the same reimbursement and contractual requirements, we are not required to continue that provider's

services. If you disagree with our determination regarding continuity of care, you may file a grievance with us by following the procedures described in the section entitled CLAIMS REVIEW / GRIEVANCE PROCEDURES.

DEFINITIONS

The meanings of key terms used in this section are shown below. Whenever any of the key terms shown below appear, they will be capitalized. When any of the terms below are capitalized in this section, you should refer to this section.

Acute Psychiatric Facility is a Hospital specializing in psychiatric treatment or a designated psychiatric unit of a Hospital licensed by the state to provide 24-hour acute inpatient care for persons with psychiatric disorders. For the purposes of this plan, the term acute psychiatric facility also includes psychiatric health facilities.

Authorized Referral occurs when you, because of your medical needs, are referred by the Care Manager to a Non-BHP Provider, but only when the requirements specified under AUTHORIZED REFERRAL TO NON-BHP PROVIDERS or EMERGENCY CARE are met.

Behavioral Health Care Manager (Care Manager) is an individual licensed by the State of California as a nurse, clinical social worker or other Mental Health Professional and who is employed by or under contract to us for the purpose of assessing an individual's medical needs for the treatment of Mental Disorders, Severe Mental Disorders or Substance Abuse. A care manager refers you to a Mental Health Professional, Outpatient Treatment Center, or Inpatient Treatment Facility for a treatment plan and/or treatment and conducts the required utilization reviews on your behalf with the cooperation of the provider.

Behavioral Health Program Negotiated Rate (BHP Negotiated Rate) is the fee BHP Providers agree to accept as payment for covered services. It is always lower than the Customary and Reasonable Charge or the Reasonable Charge for that service in the same geographic area. BHP negotiated rates are determined by the Behavioral Health Program Provider Agreement.

Behavioral Health Program Providers (BHP Providers) are Mental Health Professionals, Outpatient Treatment Centers and Inpatient Treatment Facilities which have a Behavioral Health Program Provider Agreement in effect with us at the time services are rendered. BHP providers agree to accept the BHP Negotiated Rate as payment in full for covered services.

Chemical Dependency Rehabilitation Facility is a health facility which provides 24-hour inpatient care and other appropriate Substance Abuse rehabilitation services for drug or alcohol dependence. The facility must have a medical director who is a Physician (M.D.). The facility must be licensed to provide Substance Abuse rehabilitation services according to state and local laws.

Course of Treatment is the period of time during which you are receiving therapeutic or rehabilitative treatment for a Mental Disorder or Substance Abuse. A course of treatment: (1) begins when you call the Care Manager and receive referral for behavioral health services; (2) runs continuously through the day you are discharged from or voluntarily leave an Inpatient Treatment Facility or Outpatient Treatment Center; or are no longer receiving treatment from a Mental Health Professional; and (3) will be considered completed provided treatment has continued for the number of days, sessions, or visits authorized by the Care Manager.

Covered Expense is the expense you incur for a covered service or supply, but not more than the maximum amounts described in HOW COVERED EXPENSE IS DETERMINED. Expense is incurred on the date you receive the service or supply.

MENTAL DISORDERS AND SUBSTANCE ABUSE BENEFITS

Customary and Reasonable Charge, as determined annually by us, is a charge which falls within the common range of fees billed by a majority of Mental Health Professionals for a service in a given geographic region. If it exceeds that range, the expense must be justified based on the complexity or severity of treatment for a specific case.

Emergency For the treatment of Mental Disorders or Substance Abuse, emergency means a sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity which could result in your actions causing harm to yourself or placing others in danger, unless immediate transport, supervision, or intervention by a public safety representative or licensed medical professional is obtained.

Emergency Care is the services received during treatment of an emergency.

Emergency Services are services provided in connection with the initial treatment of an Emergency.

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

For the limited purpose of inpatient care for the acute phase of a Mental Disorder, the term “hospital” includes Psychiatric Health Facilities.

Inpatient Treatment Facility is one of the following:

1. An Acute Psychiatric Facility;
2. A Psychiatric Health Facility;
3. A Chemical Dependency Rehabilitation Facility;
4. A Residential Treatment Center; and
5. A Hospital.

Mental Disorders, for the purposes of this plan, are conditions that affect thinking and the ability to figure things out, perception, mood and behavior. A mental disorder is recognized primarily by symptoms or signs that appear as distortions of normal thinking, distortions of the way things are perceived (e.g., seeing or hearing things that are not there), moodiness, sudden and/or extreme changes in mood, depression, and/or unusual behavior such as depressed behavior or highly agitated or manic behavior.

Any condition meeting this definition is a mental disorder no matter what the cause of the condition may be; but medical conditions that are caused by your behavior that may be associated with these mental conditions (e.g., self-inflicted injuries) and treatment for Severe Mental Disorders are not subject to plan limitations that apply to mental disorders.

Mental Health Professional is one of the following Physicians:

1. A psychiatrist or other Physician (M.D.);
2. A licensed clinical psychologist (Ph.D.);
3. A licensed clinical social worker (L.C.S.W.);

4. A marriage, family and child counselor (M.F.C.C.); or
5. A Psychiatric Mental Health Nurse.

Non-Participating Behavioral Health Program Providers (Non-BHP Providers) are Mental Health Professionals, Outpatient Treatment Centers, and Inpatient Treatment Facilities which do not have a Behavioral Health Program Provider Agreement in effect with us at the time services are rendered.

Outpatient Treatment Center is an outpatient psychiatric facility, a Chemical Dependency Rehabilitation Facility or other outpatient facility providing an organized, multidisciplinary Course of Treatment program consisting of acute and/or rehabilitative care. The facility must have a medical director who is a Physician (M.D.). It must be licensed by the California Department of Alcohol and Drug Services and all services must be provided by licensed medical or mental health providers.

Participating Providers are licensed health care providers that have a Behavioral Health Program Provider Agreement in effect with us at the time services are rendered.

Physician is a psychiatrist or other doctor of medicine (M.D.).

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.

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 Charge is a charge we consider not to be excessive based on the circumstances of the care provided, including: (1) level of skill; experience involved; (2) the prevailing or common cost of similar services or supplies; and (3) any other factors which determine value.

Residential Treatment Center is an Inpatient Treatment Facility where the Member 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.

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

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

1. As a result of the mental disorder, the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community and is at risk of being

removed from the home or has already been removed from the home or the mental disorder has been present for more than six months or is likely to continue for more than one year without treatment.

2. The child is psychotic, suicidal, or potentially violent.

3. The child meets special education eligibility requirements under California law (Government Code Section 7570).

Benefits for severe mental disorders will be provided according to the plan's benefits for medical conditions, and will not be subject to plan provisions for Mental Disorders.

Substance Abuse means those conditions, not including those covered as Mental Disorders, in the International Classification of Diseases as diagnostic codes 290-319. These conditions include, but are not limited to: (1) psychoactive substance induced mental disorders; (2) psychoactive substance use dependence; and (3) psychoactive substance use abuse. Substance abuse does not include addiction to, or dependency on, tobacco or food substances (or dependency on items not ingested).

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

A. 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 Blue Cross under the Agreement for the treatment of the illness, disease, injury or condition for which the third party is liable.

   1. If 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 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, 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, 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, Blue Cross' lien will be reduced by the same comparative fault percentage by which your recovery was reduced.
   6. 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 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 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 Blue Cross under the Agreement. Failure of the Member to give such notice to Blue Cross or cooperate with Blue Cross, or actions of the Member that prejudice the rights or interests of Blue Cross, will be a material breach of the Agreement and will result in the Member being personally responsible for reimbursing Blue Cross.

C. 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 Blue Cross, and such third party disputes that responsibility, then Blue Cross shall provide the benefits of the Agreement and Blue Cross shall automatically acquire thereby, by operation of law, a lien to the extent of benefits paid by Blue Cross. The Member agrees to take no action that may prejudice Blue Cross' rights under such lien. The lien may be filed with the responsible third party, his or her agent, or the court, and 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 expense under this plan, 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, covered expense for covered services is determined as stated under Exception in the section PRUDENT BUYER PLAN BENEFITS - DETERMINATION OF COVERED EXPENSE.

If you have questions about your eligibility for a Basic or Supplement to Original Medicare Plan, please contact the CalPERS Customer Service and Education Division (CSED) at **888 CalPERS** (or **888**-225-7377).

COORDINATING BENEFITS WITH MEDICARE

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 covered expense 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.

   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 Blue Cross while enrolled under any of the Board's alternative medical and hospital benefit programs.

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 the CalPERS Customer Service and Education Division (CSED) 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 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, HIPAA COVERAGE AND INDIVIDUAL CONVERSION and TERMINAL BENEFITS:

1. By the Board's termination of the Memorandum of Agreement.

2. By the 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 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 Blue Cross may apply for reenrollment during the Open Enrollment Period.

UNFAIR TERMINATION OF COVERAGE

A Member’s coverage may not be terminated because of his or her health status or requirements for health care services. If the Member believes that his or her coverage has been terminated for either of these reasons, the Member may request a review of the matter by the Commissioner of Corporations.

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

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

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

Once a Subscriber and/or Family Member elects the COBRA continuation, 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 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, 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, 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, Blue Cross shall charge 150 percent of the Subscriber's subscription charge prior to the disability. 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, except that if the Member's coverage under a group health plan contains any exclusion or limitation relating to a pre-existing condition, the Member's coverage will remain effective until the exclusions or limitations of the group health plan for pre-existing conditions no longer apply to the Member.

CONTINUATION OF GROUP COVERAGE

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

Subject to the Agreement remaining in effect, a retired Subscriber whose coverage began due to a Chapter 11 bankruptcy may continue coverage for the remainder of his life; that Subscriber's covered Family Members may continue coverage for 36 months after their coverage terminates due to the Subscriber's death. However, coverage could terminate prior to such time for either the Subscriber or Family Member in accordance with items 4, 5, 6, or 7 above.

If a Member's continuation under this plan ends in accordance with items 1, 2, or 3, the Member may be eligible for Individual Conversion coverage. If a Member's continuation under this plan ends in accordance with items 1, 2, 3 or 4, the Member may be eligible for HIPAA coverage. The Employer will provide notice of these options within 180 days prior to the Member's COBRA termination date.

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, as long as you are not subject to a pre-existing condition limitation under that coverage; 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, Blue Cross will notify you of your right to further elect coverage under CalCOBRA. If you choose to elect CalCOBRA coverage, you must notify 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 Blue Cross written notification within this time period, you will not be able to continue your 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:

1. 110% of the applicable group rate if your coverage under federal COBRA ended after 18 months; or
2. 150% of the applicable group rate if your coverage under federal COBRA ended after 29 months.

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

CONTINUATION OF GROUP COVERAGE

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. Blue Cross will cancel your coverage only upon sending you written notice of cancellation at least 15 days prior to cancelling your coverage. If you make payment in full within 15 days after Blue Cross issues this notice of cancellation, your coverage will not be cancelled. If you do not make the required payment in full within this 15 day period, your coverage will be cancelled as of 12:00 midnight on the fifteenth day after the date on which the notice of cancellation is sent and will not be reinstated. Any payment Blue Cross receives more than 15 days after it issues the notice of cancellation will be refunded to you within 20 business days.

Change of Subscription Charge. The amounts of the subscription charges may be changed by Blue Cross as of any subscription charge due date. Blue Cross will provide you with written notice at least 30 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. 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.

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, unless the other health plan contains an exclusion or limitation relating to a pre-existing condition that you have. In this case, this continuation will end at the end of the period for which the pre-existing condition exclusion or limitation applied;
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.

CONTINUATION OF GROUP COVERAGE

*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.

If your CalCOBRA continuation under this plan ends in accordance with items 1, 2 or 3, you may be eligible for HIPAA coverage or Individual Conversion coverage. You will receive notice of these options within 180 days prior to your CalCOBRA termination date. Please see the HIPAA COVERAGE AND INDIVIDUAL CONVERSION section for more information.

POST-COBRA CONTINUATION FOR QUALIFYING MEMBERS

This section does not apply to any individual who is not eligible for this continuation prior to January 1, 2005. Subject to payment of subscription charges as stated in the Agreement, coverage under this plan may be continued for the Subscriber, the Subscriber's Spouse, and the Subscriber's former Spouse (if any) under Section 1373.621 of the Health and Safety Code and Section 2800.2 of the Labor Code, in accordance with the following provisions. This continuation may be elected following the CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA) (the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), or Title X of P.L. 99-272) and the CALCOBRA CONTINUATION OF COVERAGE shown above.

For the purposes of this section, "former Spouse" means: (a) an individual who is divorced from the Subscriber; or (b) an individual who was married to the Subscriber at the time of the Subscriber's death.

Requirements. The Subscriber and Spouse may continue coverage under this plan if:

1. The Subscriber, or the Subscriber on behalf of himself or herself and the Spouse, was entitled to, and had elected to continue coverage under, COBRA or CalCOBRA, as described in the preceding sections;
2. The Subscriber or Spouse has not elected to continue coverage under any other available continuation;
3. The Subscriber has worked for the employer for at least the prior five years; and
4. The Subscriber is at least 60 years old on the date employment with the employer ended.

The former Spouse may continue coverage under this plan in accordance with this section if he or she was covered as a qualified beneficiary under COBRA or CalCOBRA, as described in the preceding sections.

Notice and Election. The employer will notify the Subscriber or Spouse and the former spouse of the right to continue coverage at least 180 days prior to the date continuation of coverage under COBRA or CalCOBRA is scheduled to end.

For the Subscriber and Spouse, this continuation may be chosen for both, for the Subscriber only, or for the Spouse only. The former Spouse may elect this continuation for himself or herself only.

To elect this continuation, you must notify the Board in writing within 30 days prior to the date continuation coverage under COBRA or CalCOBRA is scheduled to end. If you fail to elect this continuation when first eligible, you may not elect this continuation at a later date. Notice of continued coverage, along with the initial subscription charge, must be delivered to us within 45 days after you elect this continuation.

Cost of Coverage. This continuation is subject to payment of subscription charges to Blue Cross at the time subscription charges are due. The Employer may require that you pay the entire cost of your continuation coverage. The Employer is responsible to us for the timely payment of subscription charges due for the continuation of your coverage under this Agreement. The rate for continuation coverage under this section shall be 213% of the applicable prepayment fees. For the purpose of determining subscription charges payable, the Spouse or former spouse continuing coverage alone will be considered to be a Subscriber.

CONTINUATION OF GROUP COVERAGE

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

1. The end of the period for which subscription charges are last paid;
2. The date the Agreement terminates;
3. The date after the date of election, the Subscriber, Spouse, or former Spouse first becomes covered under any group health plan not maintained by the employer;
4. The date after the date of election, the Subscriber, Spouse, or former Spouse first becomes entitled to Medicare;
5. The date the Subscriber, Spouse, or former Spouse reaches age 65; or
6. For the Spouse or former Spouse, five years from the date the Spouse's or former Spouse's COBRA or CalCOBRA continuation coverage ended.

If your continuation under this plan ends in accordance with item 6, you are eligible for Individual Conversion coverage. If your continuation under this plan ends in accordance with items 2 or 6, you may be eligible for HIPAA coverage. See the following INDIVIDUAL CONVERSION AND HIPAA COVERAGE section for more information.

HIPAA COVERAGE AND INDIVIDUAL CONVERSION

If coverage for medical benefits under this plan ends, the Member may be eligible to enroll for coverage with any carrier or health plan that offers individual medical coverage. HIPAA Coverage and Individual Conversion are available upon request if the Member meets the requirements stated below. Both HIPAA Coverage and Individual Conversion are available for medical benefits only. Please note that the benefits and cost of these plans will differ from the Employer's plan.

HIPAA COVERAGE

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law that provides an option for individual coverage when coverage under the employer's group plan ends. To be eligible for HIPAA coverage, the Member must meet all of the following requirements:

1. The Member must have a minimum of 18 months of continuous health coverage, most recently under an employer-sponsored health plan, and have had coverage within the last 63 days.
2. The Member's most recent coverage was not terminated due to nonpayment of subscription charges or fraud.
3. If continuation of coverage under the employer plan was available under COBRA, CalCOBRA, or a similar state program including Post-COBRA, such coverage must have been elected and exhausted.
4. The Member must not be eligible for Medicare, Medi-Cal, or any group medical coverage and cannot have other medical coverage.

The Member must apply for HIPAA coverage within 63 days of the date their coverage under the employer's plan ends. If a Member decides to enroll in HIPAA coverage, he or she will no longer qualify for Individual Conversion.

INDIVIDUAL CONVERSION

A. A Subscriber whose coverage under the employer's plan is terminated, other than by voluntary cancellation, termination of the Memorandum of Agreement by the Board, termination of the Group Benefit Agreement by Blue Cross, withdrawal of his or her Employer from participation in the Act, or failure to continue enrollment or to make contributions during continuation of enrollment in a non-pay status according to the Act, may apply on behalf of himself or herself and all enrolled Family Members for an Individual Membership Agreement that may be in effect at the time of application for individual coverage.

B. A Family Member whose coverage under the employer's plan terminates because of termination of enrollment of a Subscriber, or because of loss of Family Member status, may apply for an Individual Membership Agreement that may be in effect at the time of application for individual coverage.

C. A Member, eligible for an individual conversion plan as specified in A. and B. above, must submit a written application and make the first subscription charge payment to Blue Cross within 63 days following the date coverage under the employer's plan ends. In such event, individual coverage shall become effective at 12:01 a.m. on the day following termination of coverage through the Employer.

If you decide to enroll in an Individual Conversion plan, you will no longer qualify for HIPAA Coverage.

The intention of conversion coverage is not to replace the coverage a Member has under this plan, but to make available a specified amount of coverage for medical benefits until the Member can find a replacement. The conversion plan provides lesser benefits than this plan, and the provisions and rates differ.

When coverage under the employer's group plan ends, the Member will receive more information about how to apply for HIPAA coverage or Individual Conversion, including a postcard for requesting an application and a telephone number to call if the Member has any questions. Any carrier or health plan that offers individual medical coverage must make HIPAA coverage available to qualified persons without regard to health status.

TERMINAL BENEFITS

In the event the Agreement is terminated by Blue Cross, 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. 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, 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.

BLUE CROSS MONTHLY RATES

Type of Enrollment	Enrollment Code	Gross Rate
Self Only	2071	$ 452.00
Self and One Dependent	2072	$ 847.00
Self and Two or More Dependents	2073	$ 1,076.00

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, 2009, following at least sixty (60) days' written notice to the Board prior to such change.

GENERAL PROVISIONS

Evidence of Coverage

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

Blue Cross shall issue to the Subscriber an identification card to which the Subscriber and Family Members are entitled. Possession of a 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 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

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

Payment to Providers

Blue Cross pays the benefits of this plan directly to Contracting Hospitals, Centers of Expertise, 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 unless an Authorized Referral has been approved by Blue Cross. Blue Cross will pay non-contracting Hospitals and other providers of service directly when Emergency services and care are provided to the Member. 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, Blue Cross will pay the benefits of this plan to the State Department of Health Services. These payments fulfill the obligation of Blue Cross to the Member for those services.

Provider Reimbursement

Physicians and other professional providers are paid on a fee-for-service basis, according to an agreed schedule. A Prudent Buyer Plan Provider Physician may, after notice from us, be subject to a reduced Negotiated Rate 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.

GENERAL PROVISIONS

Public Policy Participation

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 Blue Cross by the Member or the provider of service. These claim forms must be received by 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. 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.

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

Blue Cross of California
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

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

Free Choice of Hospital and Physician

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.

GENERAL PROVISIONS

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. 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 Blue Cross shall operate to defeat any of the rights, privileges or benefits of any Member.

Grievance Procedure

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

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

Protection of Coverage

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

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.

Out-of-California Providers (For Members Traveling Outside of California)

The Blue Cross Blue Shield Association, of which Blue Cross is a member, has a program (called the "BlueCard Program") which allows our Members to have the reciprocal use of participating providers contracted under other states' Blue Cross and/or Blue Shield Licensees. If you are outside of California and require medical care or treatment, you may use a local Blue Cross and/or Blue Shield provider. If you use one of these providers, your out-of-pocket expenses may be lower than those incurred when using a provider which does not participate in the BlueCard Program. The rules for the BlueCard Program, including those described below, are set by The Blue Cross and Blue Shield Association. In order for you to receive access to whatever discounts may be available, we must abide by those rules.

When you obtain covered health care services through the BlueCard Program outside of California, your co-payment for such services, if it is not a flat dollar amount, is usually calculated on the lower of the:

- Billed charges for your covered services, or
- Negotiated price that the on-site Blue Cross and/or Blue Shield Licensee ("Host Blue") passes on to us.

Often, the "negotiated price," referred to above, will consist of a simple discount, which reflects the actual price paid by the Host Blue. But, sometimes it is an estimated price that factors in expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect **average** expected savings with your health care provider or with a specified group of providers. If the negotiated price reflects average expected savings, it may result in greater variation (more or less) from the actual price paid than will the estimated price. The estimated or average price may be adjusted in the future to correct for over- or underestimation of past prices. Regardless of how the negotiated price is determined, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating Member liability for covered services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state statutes mandate Member liability calculation methods that differ from the usual BlueCard Program method noted above in the second paragraph of this section, or require a surcharge, we would then calculate your co-payment for any covered health care services using the methods outlined by the applicable state statute in effect at the time you received your care.

Providers available to you through the BlueCard Program have not entered into contracts with Blue Cross of California. If you have any questions or complaints about the BlueCard Program, please call 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 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 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 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 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, 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 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 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 Blue Cross prior to termination. If the provider does not agree with these contractual terms and conditions, Blue Cross is not required to continue the provider's services beyond the contract termination date.

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

GENERAL PROVISIONS

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 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 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 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 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.

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

Financial Arrangements with Providers

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 Blue Cross or an affiliate is a party, including all persons covered under the Agreement.

Under the above-referenced contracts between Providers and 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 Blue Cross or an affiliate for the same medical services. In negotiating the terms of the Agreement, PORAC was aware that 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 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 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 Blue Cross or an affiliate in determining its fees or subscription charges or premiums.

Confidentiality and Release of Medical Information

Blue Cross will use reasonable efforts, and take the same care to preserve the confidentiality of the Member's medical information. 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.

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 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

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 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 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 Blue Cross owes to that provider (not including co-payments or deductibles), even in the unlikely event that 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 Blue Cross.

Certificate of Creditable Coverage

Certificates of creditable coverage are issued automatically when a Member's coverage under this plan ends. Blue Cross will also provide a certificate of creditable coverage in response to a Member's request, or to a request made on a Member's behalf, at any time while the Member is covered under this plan and up to 24 months after the Member's coverage under this plan ends. The certificate of creditable coverage documents the Member's coverage

under this plan. To request a certificate of creditable coverage, please call PORAC – Blue Cross customer service toll-free at 1-800-288-6928.

GENERAL INFORMATION

Information pertaining to eligibility, enrollment, cancellation or termination of insurance, conversion rights, etc., is found in the informational pamphlet entitled *CalPERS Health Program Handbook*. 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 Customer Service and Education Division (CSED) 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 Office of Employer and Member Health Services at P.O. Box 942714, Sacramento, CA 94229-2714, or telephone the appropriate number shown below.

CalPERS Office of Employer and Member Health Services

Toll free number ---	**888 CalPERS** (or **888**-225-7377)
Fax number ---	(916) 795-1277
TTY ---	(800) 735-2929; (916) 795-3240

Direct Payment of Dues

If you arrange for direct payment of premiums, send your payment, together with Form HBD 21 to Blue Cross of California, 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 Handbook.

CLAIMS REVIEW / GRIEVANCE PROCEDURES

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. Blue Cross has the responsibility for determining whether claims are payable. A practicing physician-consultant retained by 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 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 Office of Employer and Member Health Services at P.O. Box 942714, Sacramento, Ca. 94229-2714.

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 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 Blue Cross at 1-800-288-6928 or send a written request to Blue Cross at P.O. Box 60007, Los Angeles, CA 90060-0007 Attn: PORAC Unit. 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 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 Blue Cross of California website at **www.bluecrossca.com**. You must submit your grievance to Blue Cross no later than 180 days following the date you receive a denial notice from Blue Cross or any other incident or action with which you are dissatisfied. Your issue will then become part of Blue Cross' formal grievance process and will be resolved accordingly.

All grievances received by Blue Cross will be acknowledged in writing, together with a description of how Blue Cross proposes to resolve the grievance. After Blue Cross has reviewed your grievance, you will be sent a written statement on its resolution within 30 days. If your case involves an imminent threat to your health, including, but not limited to, the potential loss of life, limb, or major bodily function, review of your grievance will be expedited and resolved within three days.

If 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 us 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 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. To request an application form, please call or write to us 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. 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.

3. 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 medical journals with nationally recognized standards;

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

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

   d) The American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluation, the American Dental Association Accepted Dental Therapeutics, and the United States Pharmacopoeia-Drug Information;

   e) Findings, studies or research conducted by or under the auspices of federal governmental agencies and nationally recognized federal research institutes; and

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

Within three business days of receiving notice from the DMHC of your request for review, we will send the reviewing panel all relevant medical records and documents in our possession, as well as any additional information submitted by you or your Physician. Information we receive subsequently will be sent to the review panel within three business days. Any newly developed or discovered relevant medical records identified by us 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 in the case of an expedited review). 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 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 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 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. 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 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 us, based in whole or in part on a decision that the health care service is not Medically Necessary; and
3. You have filed a grievance with 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.

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, 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 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.

4. Time Limit for Blue Cross Review of Objection

Blue Cross will acknowledge receipt of a complaint by written notice to the complainant within 20 days. 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 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 99 & 100 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 page 101), 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 99.

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.

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: 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 page 101).

CalPERS staff will conduct an administrative review upon your appeal of 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 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 Office of Employer and Member Health Services, P.O. Box 942714, Sacramento, CA, 94229-2714, or call CalPERS Customer Service and Education Division (CSED) 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, except any dispute or claim within the jurisdictional limits of the small claims court must be resolved in such court. **Note: A small claims court judgement cannot be appealed.**

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

By enrolling in this plan, the Member is agreeing to have certain disputes (coverage grievance and bad faith grievance as described above) decided by neutral binding arbitration. Both Blue Cross and the plan Member waive their right to a jury or court trial for these disputes.

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

The steps for binding arbitration are as follows:

A. Binding arbitration is begun by the Member making written demand on Blue Cross.

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

C. The arbitration will be conducted by Judicial Arbitration and Mediation Services (JAMS). If, for any reason, JAMS is unavailable to conduct the arbitration, the arbitration will be conducted by another neutral arbitration entity, by mutual agreement of the Member and Blue Cross, or by order of the court, if the Member and Blue Cross cannot agree. Copies of such arbitration rules are available from Blue Cross.

D. Blue Cross and the Member will each be responsible for paying their own shares of the fees and expenses of the arbitration; however Blue Cross may pay the Member's share of these fees in cases of extreme hardship, as determined by JAMS. An application to claim extreme hardship under this section may be obtained from JAMS.

E. **THE ARBITRATION FINDINGS ARE FINAL AND BINDING,** except to the extent that California or Federal law provides for the judicial review of arbitration proceedings.

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 Blue Cross of California, 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 99 through 102, or if your grievance has not been resolved after at least 30 days, you may submit your grievance to the California Department of Managed Health Care for review prior to binding arbitration (see DEPARTMENT OF MANAGED HEALTH CARE below). If your case involves an imminent threat to your health, including, but not limited to, the potential loss of life, limb, or major bodily function, you are not required to complete our grievance process or to wait at least 30 days, but may immediately submit your grievance to the Department of Managed Health Care for review.

If at the conclusion of review of your grievance by the Department of Managed Health Care you continue to be dissatisfied with its resolution, or prior to and instead of review of your case by the Department of Managed Health Care, your remedy may be item 6. CalPERS Administrative Appeal Process (see page 103) or item 7. Binding Arbitration (see pages 103 & 104).

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 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 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.

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, or 30 minutes normal travel time from, the Member's residence or place of work, 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 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 Expertise. 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.

GENERAL DEFINITIONS

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

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

Centers of Expertise (COE) are health care providers which have a Centers of Expertise Agreement in effect with Blue Cross at the time services are rendered. A provider participating in the Prudent Buyer Plan Provider network is not necessarily a COE. A provider's participation in the Prudent Buyer Plan Provider network or other agreement with Blue Cross is not a substitute for a Centers of Expertise Agreement.

A **Contracting Hospital** is a Hospital which has a contract with 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.

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, preparation of special diets, and supervision over self-administration of medication not requiring the constant attention of trained medical personnel.

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

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) 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 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.

GENERAL DEFINITIONS

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

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

Home Infusion Therapy Provider is a provider licensed according to state and local laws as a pharmacy, and must be either certified as a home health care provider by Medicare, or accredited as a home pharmacy by the Joint Commission 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 Blue Cross. A list of approved Hospices will be sent on request.

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

A **Hospital** is a facility which provides diagnosis, treatment and care of persons who need acute inpatient Hospital care under the supervision of Physicians. It must be licensed as a general acute care Hospital according to state and local laws. It must also be registered as a general Hospital by the American Hospital Association and meet accreditation standards of the Joint Commission on Accreditation of Health Care Organizations. For the limited purpose of inpatient care for the acute phase of a Mental Disorder, the term Hospital will also include Psychiatric Health Facilities, which are defined under MENTAL DISORDERS AND SUBSTANCE ABUSE.

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.

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.

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

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

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

GENERAL DEFINITIONS

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

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

Negotiated Rate is the fee Prudent Buyer Plan Providers agree to accept as payment in full for covered services. It is always lower than the Customary and Reasonable Charge for that service in the same geographical area. Negotiated Rates are determined by the Prudent Buyer Plan Participating Agreement. Because Prudent Buyer Plan Providers agree to accept this special rate, the Member is guaranteed protection against having to pay any covered charges in excess of that amount (other than deductible and co-payment amounts, or amounts in excess of stated maximum benefits). The Negotiated Rate is one of the main advantages of choosing a Prudent Buyer Plan Provider. Note: If Medicare is the primary payer, the negotiated rate may be determined by Medicare's approved amount (see PRUDENT BUYER PLAN BENEFITS - DETERMINATION OF COVERED EXPENSE).

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 Blue Cross but does not have a Prudent Buyer Plan Participating Agreement in effect with Blue Cross at the time services are rendered:

1. A Hospital. A Hospital that is a Non-Prudent Buyer Plan Provider may also be referred to as a Non-Prudent Buyer Plan Hospital.
2. A Physician. A Physician who is a Non-Prudent Buyer Plan Provider may also be referred to as a Non-Prudent Buyer Plan Physician.
3. 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.
4. 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.
5. A facility which provides diagnostic imaging services.
6. A clinical laboratory.
7. A Home Infusion Therapy Provider.

Any of the above providers whose principal place of business is outside the State of California also is a Non-Prudent Buyer Plan Provider.

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.

GENERAL DEFINITIONS

Out-of-Pocket Expense is the difference between covered expense and 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, Customary and Reasonable Charges, or Reasonable Charges, and any other charges which are not considered covered expense. 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, charges covered under MENTAL DISORDERS AND SUBSTANCE ABUSE BENEFITS and 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 **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, is providing a service for which benefits are specified in this Evidence of Coverage, and when benefits would be payable if the services were provided by a Physician as defined in 1. above:

   a. A dentist (D.D.S. or D.M.D.)
   b. An optometrist (O.D.)
   c. A dispensing optician
   d. A podiatrist or chiropodist (D.P.M., D.S.P. or D.S.C.)
   e. A licensed clinical psychologist
   f. A chiropractor (D.C.)
   g. An acupuncturist (A.C.), but only for acupuncture and for no other services
   h. A certified registered nurse anesthetist (C.R.N.A.)
   i. A clinical social worker (C.S.W. or L.C.S.W.)
   j. A marriage and family therapist (M.F.T.)
   k. A physical therapist (P.T. or R.P.T.)*
   l. A speech pathologist*
   m. An audiologist*
   n. An occupational therapist (O.T.R.)*
   o. A respiratory care practitioner (R.C.P)*
   p. A nurse midwife**
   q. A registered dietitian (R.D.)* for the provision of diabetic medical nutrition therapy 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.

GENERAL DEFINITIONS

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

A **Prudent Buyer Plan Provider** is one of the following providers in the State of California which has a Prudent Buyer Plan Participating Agreement in effect with Blue Cross at the time services are rendered. 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 Blue Cross. Those providers alone have undertaken and are responsible for providing medical care:

1. 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.

2. 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.

3. 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.

4. 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.

5. A facility which provides diagnostic imaging services.

6. A clinical laboratory.

7. A Home Infusion Therapy provider.

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

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

1. A licensed ambulance company.
2. A Skilled Nursing Facility.
3. A Hospice.
4. A registered nurse.

5. A durable medical equipment supply outlet.
6. A blood bank.

The **Scheduled Amount** is the amount of covered expense 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 will not be considered covered expense. 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 expense.

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.

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 payment to 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.

A **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 we determine the Scheduled Amount (the maximum amount we will consider covered expense 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

Covered expense 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.

Blue Cross has the right to adjust these Scheduled Amounts in order to maintain the relationship between these amounts and the rates negotiated by 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

Covered expense 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.

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

Exceptions: Covered Expense for a Non-Prudent Buyer Plan Physician will not exceed the Customary and Reasonable Charge when the services are for an Emergency, Authorized Referral, Out-of-Area Member, Cancer 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, the following unit values apply unless otherwise stated in the Unit Value Schedule:

   — Full unit value for the major procedure
   — 50 percent of the unit value for the second procedure
   — 25 percent of the unit value for the third procedure
   — 25 percent of the unit value for the fourth procedure
   — 25 percent of the unit value for the fifth procedure.

b. The unit value for the services of an assistant surgeon is 20 percent of the unit value for the primary surgeon performing that procedure.

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
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

NON-PRUDENT BUYER PLAN PROVIDER EXCEPTIONS

Subject to all other provisions of the plan, the Scheduled Amount described on pages 113 through 117 will not apply to the following services. Covered expense for these services will be subject to either the Customary and Reasonable Charge or a Reasonable Charge as shown below:

a. a Non-Prudent Buyer Plan Hospital for outpatient care, Emergency Care or an Authorized Referral, or a Non-Prudent Buyer Plan Ambulatory Surgical Center for Emergency Care or an Authorized Referral, or

b. a Non-Prudent Buyer Plan Home Health Agency, or

c. a facility which provides diagnostic imaging services, or

d. a clinical laboratory, or

e. a Related Health Provider, or

f. an Out-of-Area Member, or

g. a Home Infusion Therapy provider, or

h. Emergency services provided by other than a Hospital, or

i. Authorized Referral services from a Physician who is a non-Prudent Buyer Plan Provider (See GENERAL DEFINITIONS for details), or

j. Charges of a Physician who has a specialty which is not represented in the Prudent Buyer Plan network; or

k. Cancer Clinical Trials.

Determination of Covered Expense. For these exceptions, covered expense for the services of a non-Prudent Buyer Plan Provider is the lesser of the billed charge or the amount shown below.

Type of Provider	Maximum Covered Expense is...
Physicians	**the Customary and Reasonable Charge**
All Other Non-Prudent Buyer Plan Providers	**a Reasonable Charge**

FOR YOUR INFORMATION

ORGAN DONATION

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

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

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

If you decide to become a donor, please discuss it with your family. Let your Physician know your intentions as well. Obtain 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.

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

IMPORTANT TELEPHONE NUMBER FOR OTHER BENEFITS

Behavioral Health Program - 1-800-399-2421

BLUE CROSS WEB SITE

Information specific to your benefits and claims history are available by calling Blue Cross at 1-800-288-6928 or by logging onto the Blue Cross of California web site at **www.bluecrossca.com**. 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," then "Groups of 51 or More," and then "Member Services." You may also submit a grievance online or print the Plan Grievance Form through the web site. If you do not have a Personal Identification Number (PIN) from Blue Cross, you can request one through the web site and it will be sent to you within seven business days.

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

For claims and customer service, contact:

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

1-800-288-6928
www.bluecrossca.com

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

1-800-937-6722
WWW.PORAC.ORG

(707)

Form No. CB14918-1 (108)

Blue Cross of California is an Independent Licensee of the
Blue Cross Association (BCA). ®Registered Mark of BCA.