In-Area Health Savings Account (HSA) Medical Plan

The Health Savings Account (HSA) Medical Plans are qualified high-deductible health plans that come with a tax-advantaged Health Savings Account (HSA). When you enroll in the In-Area HSA Medical Plan, you will receive a Health Savings Account. For information about the Health Savings Account itself, refer to "Health Savings Account" in the *Reimbursement Accounts* section.

Under the HSA Medical Plans, Anthem Blue Cross administers alcohol and drug care benefits while Medco Health administers the prescription drug benefit. Like other plans administered by Anthem Blue Cross and Medco Health, the HSA Medical plans are welfare benefit plans subject to the Employee Retirement Income Security Act of 1974 (ERISA). Anthem Blue Cross and Medco Health coordinate benefits so that both medical and prescription drug out-of-pocket expenses apply to the deductible and the out-of-pocket maximum. The Health Savings Account is administered separately by ConnectYourCare and is not subject to ERISA. When you enroll in the In-Area HSA Medical Plan, PG&E will set up and contribute to an HSA for you. The mechanism for this account is described in "Health Savings Account" in the *Reimbursement Accounts* section.)

There are two separate HSA Medical plans:

- the In-Area HSA Medical Plan (a Preferred Provider Organization (PPO) plan) and
- the Out-of-Area HSA Medical Plan (a fee for service plan).

Your eligibility will depend on your home address and network availability. Unlike the NAP and CAP plans, Anthem Blue Cross administers the mental health and substance abuse care benefits. Medco administers the prescription drug benefit, which is described in this section.

In general, the In-Area HSA Medical Plan is similar to the Network Access Plan (NAP). The In-Area HSA Medical Plan, however, covers preventive care at 100%. There are also different deductibles, calendar year out-of-pocket maximums and coinsurance amounts. The higher HSA deductible is required by federal law in order to allow federally tax-exempt contributions to the HSA, which is an essential part of the HSA Medical Plan

In This Section

Eligibility

Eligibility for the **In-Area Health Savings Account (HSA) Medical Plan —** a Preferred Provider Organization (PPO) plan — is dependent upon where you live. Anthem Blue Cross on behalf of Anthem Blue Cross Life & Health Insurance Company (Anthem Blue Cross Life & Health) is the Claims Administrator. The Claims Administrator for medical benefits is referred to as "Anthem Blue Cross" in this document. Medco Health is the Claims Administrator for outpatient prescription drug benefits.

If your home ZIP code meets the following access criteria and you are not otherwise ineligible, you are eligible to enroll in the In-Area HSA Medical Plan. If your home ZIP code does not meet the criteria and you are not otherwise ineligible, you are instead eligible to enroll in the Out-of-Area HSA Medical Plan. See the *Out-of-Area HSA Medical Plan* section.

Area	Plan Network Access Standards
Urban	▪ One hospital within 10 miles ▪ Two primary care physicians within 8 miles ▪ Two OB/GYNs within 8 miles ▪ Two pediatricians within 8 miles
Suburban	▪ One hospital within 15 miles ▪ Two primary care physicians within 15 miles ▪ Two OB/GYNs within 15 miles ▪ Two pediatricians within 15 miles
Rural	▪ One hospital within 30 miles ▪ Two primary care physicians within 30 miles ▪ Two OB/GYNs within 30 miles ▪ Two pediatricians within 30 miles

For assistance in locating a network provider in your area or to obtain a Prudent Buyer Plan PPO network provider directory, contact Anthem Blue Cross Member Services at 800-964-0530. You may also visit the Anthem Blue Cross Web site at **www.anthem.com/ca/pge** or **www.anthem.com/ca**, and select the Prudent Buyer Network option.

You are not eligible for the In-Area HSA Medical Plan if:

- You don't have a physical U.S. address (required to enroll in an HSA Medical Plan and to open an HSA account).
- You're covered as a subscriber or as a dependent by another medical pan, unless it's also a qualified high-deductible health plan.
- You're being claimed as a dependent on another person's income tax return.
- You have TRICARE.
- You've received Veterans' benefits in the last three months.
- You're eligible for Medicare.
- You live in an area that does not meet the network access criteria. (If you meet all of the other eligibility criteria for the In-Area HSA Medical Plan except the network access criteria, you will be eligible for the Out-of-Area HSA Medical Plan).

In-Area HSA Medical Plan at a Glance

This is a summary of the In-Area HSA Medical Plan benefits. Please refer to In-Area HSA Medical Plan Covered Services in this section for more information on covered services and exclusions.

The information in this chart is intended to be a summary of the benefits provided by the In-Area HSA Medical Plan as of January 1, 2011. The information contained in the applicable service provider agreement between Pacific Gas and Electric Company and Anthem Blue Cross shall govern in case of conflict between this chart and the service provider agreement. Please refer to the most recent information about your medical plan benefit options, which are updated annually in the Open Enrollment materials.

In-Area HSA Medical Plan (Administered by Anthem Blue Cross)		
Provisions	**Network** *Care provided by network providers*	**Non-Network** *Care provided by non-network providers*
General	Annual Deductible: $1,250 per person; $2,500 for two of more people Same deductible applies to eligible network and non-network expenses	
	Annual out-of-pocket maximum (includes deductible): ▪ $1,750/person, no more than $3,500/family No lifetime benefits maximum No pre-existing condition exclusions	Annual out-of-pocket maximum (includes deductible): ▪ $2,750/person, no more than $5,500/family No lifetime benefits maximum. No pre-existing condition exclusions
	All plan benefits and out-of-pocket maximums are based on Eligible Expenses only. For the definition of "Eligible Expenses," see the **Definitions** section. ▪ Network benefits and limits may not be combined with non-network benefits and limits	
Hospital Stay	90% for semi private room (private if Medically Necessary); includes intensive care; pre-authorization required for non-emergency care.	70% for semi- private room (private if Medically Necessary); includes intensive care; pre-authorization required for non-emergency care.
Skilled Nursing Facility (For more information on "custodial care," see "**What the In-Area HSA Medical Plan Does Not Cover**" in the **In-Area HSA** section)	90% for semi-private room after 3 days in hospital; pre-authorization required. Excludes custodial care.	70% for semi-private room after 3 days in hospital; pre-authorization required. Excludes custodial care.
Emergency Room Care	90% for medical emergency	90% for medical emergency. Non-emergencies covered at 70%.
Outpatient Hospital Care	90% (100% if part of preventive care). ▪ See "**Preventive Health Guidelines**" in **In-Area HSA Medical** section.	70%.
Maternity Care	90%. Pre-authorization required for delivery stays beyond 48 hours for normal delivery (96 hours for cesarean section).	70%. Pre-authorization required for delivery stays beyond 48 hours for normal delivery (96 hours for cesarean section.
Well-Baby Care	100% for preventive care ▪ See "**Preventive Health Guidelines**" in **In-Area HSA Medical** section.	70%. ▪ See "**Preventive Health Guidelines**" in **In-Area HSA Medical** section.

In-Area HSA Medical Plan (Administered by Anthem Blue Cross)		
Provisions	**Network** *Care provided by network providers*	**Non-Network** *Care provided by non-network providers*
Office Visits	90% for primary, specialist, and urgent care visits, subject to deductible. (100%, not subject to deductible, if part of preventive care.) ▪ See "**Preventive Health Guidelines**" in **In-Area HSA Medical** section.	70% for primary, specialist, and urgent care visits, subject to deductible.
Routine Physical Examinations	100%, not subject to deductible ▪ See "**Preventive Health Guidelines**" in **In-Area HSA Medical** section.	70% ▪ See "**Preventive Health Guidelines**" in **In-Area HSA Medical** section.
Immunizations and Injections	90% (100%, not subject to deductible for disease prevention immunizations). ▪ See "**Preventive Health Guidelines**" in **In-Area HSA Medical** section.	70%, except immunizations for disease prevention, are covered under preventive care benefit at 90% ▪ See "**Preventive Health Guidelines**" in **In-Area HSA Medical** section.
Eye Examinations	Not covered.	Not covered.
X-rays and Lab Tests	90% (100% not subject to deductible if part of preventive care) ▪ See "**Preventive Health Guidelines**" in **In-Area HSA Medical** section.	70%, unless as part of preventive care; then covered under preventive care benefit at 90% ▪ See "**Preventive Health Guidelines**" in **In-Area HSA Medical** section.
Pre-Admission Testing	90%	70%
Home Health Care and Home Hospice Care (For more information on "custodial care," see "**What the In-Area HSA Medical Plan Does Not Cover**" in the **In-Area HSA** section)	90%; requires prior authorization. Excludes custodial care.	70%; requires prior authorization. Excludes custodial care.
Outpatient Physical Therapy	90%	70%

In-Area HSA Medical Plan (Administered by Anthem Blue Cross)		
Provisions	**Network** *Care provided by network providers*	**Non-Network** *Care provided by non-network providers*
Retail Outpatient Prescription Drugs (Administered by Medco Health)	Prescription drug benefit combined with medical for purposes of deductible and out-of-pocket maximum; 100% (not subject to deductible) for preventive prescriptions*. Preventive drugs are determined by Medco Health Solutions; 90% after deductible for non-preventive prescriptions;* * Drugs filled at non-network pharmacies will be filled based on average network negotiated rate; 15% cost penalty for retail refills of maintenance drugs on the 4th fill; Generic Incentive Provision applies. ▪ Generic Incentive Provision: If you purchase a brand-name drug when a generic is available, you'll be responsible for paying the price difference plus any required coinsurance. Note: Charges above average negotiated rate, or any refill or generic/brand penalties you pay are non-covered expenses and therefore do not count toward your deductible or out-of-pocket maximum.	
Mail-Order Prescription Drugs	Prescription drug benefit combined with medical for purposes of deductible and out-of-pocket maximum; 100% (not subject to deductible) for preventive prescriptions; 90% after deductible for non-preventive prescriptions; Generic Incentive Provision applies; ▪ Generic Incentive Provision: If you purchase a brand-name drug when a generic is available, you'll be responsible for paying the price difference plus any required coinsurance. Note: Any generic/brand penalties you pay are non-covered expenses and therefore do not count toward your deductible or out-of-pocket maximum.	
Outpatient Mental Health or Substance Abuse	90%	70%
Intensive Outpatient Mental Health or Substance Abuse (or other alternative levels of care)	90%. Requires pre-authorization from Anthem Blue Cross.	70%; requires pre-authorization from Anthem Blue Cross.
Inpatient Mental Health or Inpatient Substance Abuse	90%. Requires pre-authorization by Anthem Blue Cross.	70%; requires pre-authorization by Anthem Blue Cross.
Durable Medical Equipment	90%; pre-authorization required for purchase or cumulative rental over $1,000.	70%; pre-authorization required for purchase or cumulative rental over $1,000.
Chiropractic Care	90% up to 20 visits per plan year (includes all services provided by a chiropractor); no coverage after visit maximum has been reached.	70% up to 15 visits per plan year (includes all services provided by a chiropractor); no coverage after visit maximum has been reached.

In-Area HSA Medical Plan (Administered by Anthem Blue Cross)		
Provisions	**Network** *Care provided by network providers*	**Non-Network** *Care provided by non-network providers*
Acupuncture	90% for up to 20 visits per year from licensed acupuncturist or M.D.	70% for up to 15 visits per year from licensed acupuncturist or M.D.
Other Benefits	Infertility— 90% $7,000 lifetime maximum for all infertility treatment. Balances from prior plans carry forward. Transplant Services—90% when performed at a Center of Medical Excellence (CME). Pre-certification required; no coverage when performed at a non-CME Network facility.	Infertility—90%; $7,000 lifetime maximum for all infertility treatment. Balances from prior plans carry forward. Transplant Services—Not covered.

How the In-Area HSA Medical Plan Works

Anthem Blue Cross is the Claims Administrator for the medical benefits of the In-Area HSA Medical Plan, including mental health and substance abuse benefits. The In-Area HSA Medical Plan offers you a choice each time you seek medical care. You may:

- obtain medical care through an In-Area HSA Medical Plan network provider and receive network benefits, or
- obtain medical care through any provider you choose and receive lower non-network benefits if the provider does not participate in the network.

Medco Health is the Claims Administrator for the outpatient prescription drug benefit in the In-Area HSA Medical Plan. You have the choice of filling prescriptions by mail order or at retail pharmacies.

Preventive care is covered at 100%. For all other care, you must satisfy the deductible before the Plan pays any benefit. After you satisfy the deductible, you pay coinsurance for covered services up to the plan's out-of-pocket maximum. If you meet the out-of-pocket maximum, the In-Area HSA Medical Plan will pay 100% of remaining eligible expenses for the rest of the calendar year.

Network Providers

The In-Area HSA Medical Plan provides in-network coverage through a preferred provider organization, or "PPO." A PPO consists of a network of doctors, hospitals, laboratories and other providers who have agreed to provide services at negotiated rates. The In-Area HSA Medical Plan uses the Anthem Blue Cross Prudent Buyer Plan PPO network in California.

Outside of California, the Plan uses the BlueCard PPO network of providers across the country who have agreed to provide services at negotiated rates. These providers participate in one of the local Anthem Blue Cross Blue Shield plan PPO networks and are available to you through the BlueCard Program, but do not contract directly with Anthem Blue Cross. Also available are traditional providers who might not participate in a BlueCard PPO network, but have agreed to provide PPO members with health care services at a discounted rate. To locate BlueCard PPO providers, you may:

- call Anthem Blue Cross Member Services at 800-964-0530; or
- visit the Anthem Blue Cross Web site at **www.anthem.com/ca/pge** or **www.anthem.com/ca**.

Under the Plan, you may go directly to any provider or specialist of your choice without authorization from a primary care physician. The Plan encourages the use of the Anthem Blue Cross Prudent Buyer Plan PPO network by offering a higher level of reimbursement when members use network providers.

Non-Network Providers

Under the Plan, you may also go to any non-network doctor or hospital at any time. However, these doctors and hospitals do not participate in the Prudent Buyer PPO network and have not agreed to negotiated rates. If you seek care from a provider who does not participate in the network, you receive reimbursement at a lower level.

Please remember, you have a responsibility to work together with the physician(s) you select to ensure that all your medical needs are appropriately met, and to notify the appropriate Medical Management Program when pre-authorization is required. (See Medical Management Programs in this section for more information.)

Plan physicians and hospitals who participate in the Anthem Blue Cross Prudent Buyer Plan PPO network have agreed to charge members certain negotiated rates. If you receive care from a network provider who charges more than the negotiated rate, you will be held harmless for those charges above the negotiated rate. The same will be true if a Plan network provider has referred you to a non-network provider. You will not be responsible for fees over the Customary and Reasonable Charge.

If you receive treatment from a doctor who does not participate in the Prudent Buyer Plan PPO network, you may be responsible for any amounts over the Customary and Reasonable (Eligible Expense) limits. These amounts can be substantial. You should discuss this with your physician.

Deductibles

The annual deductible is the amount you must pay before the Plan starts paying for non-preventive benefits. Combined eligible expenses for medical services, mental health/substance abuse treatment, and outpatient prescription drugs apply toward the deductible.

Per Person	$1,250
Couple or Family	$2,500

Charges for non-covered services and amounts over Customary and Reasonable for non-network services do not apply toward the annual deductible.

You must satisfy the entire deductible before the In-Area HSA Medical Plan pays for any non-preventive visits or drugs, diagnostic care or medical treatment. For members enrolled with couple or family coverage, the entire $2,500 must be satisfied before the plan will pay benefits other than preventive care benefits.

Plan Maximums

Out-of-Pocket Maximums

The Plan has an out-of-pocket maximum that limits the amounts you pay for covered services. The out-of-pocket maximum is the maximum amount you pay each calendar year for covered expenses, including deductibles and coinsurance.

	Network Providers	Non-Network Providers
Per Person	$1,750	$2,750
Family	$3,500	$5,500

Amounts apply separately for Network and Non-Network maximums. Coinsurance and deductibles apply towards the out-of-pocket maximum.

Charges for non-covered services and charges above Customary and Reasonable Charges (Eligible Expenses) for non-network services do not apply toward the annual out-of-pocket maximum.

Outpatient prescription drug claims apply to the in-network maximum.

Lifetime Maximums

The Plan does not have an overall lifetime maximum benefit, but there are lifetime maximums for the following services or supplies:

Service or Supply	Lifetime Maximum
Fertility Treatments	$7,000 combined for all PG&E self-insured medical plans administered by Anthem Blue Cross or prior claims administrators.
Organ Transplant Travel Services Transportation and lodging expenses for the transplant recipient and companion(s)	$10,000 combined for all travel expenses (IRS limit).

Benefit Percentages

The plan's coinsurance (percentage coverage) does not begin until after the annual deductible has been met (except when you receive in-network preventive services, which are not subject to the deductible). The percentages of reimbursement are listed under the Summary of In-Area HSA Medical Plan Benefits.

Eligible Expenses will be reimbursed based on negotiated rates for network providers and Customary and Reasonable Charges for non-network providers, after meeting the annual deductible, if applicable. If your non-network provider bills an amount above the Customary and Reasonable Charges (Eligible Expenses), you will be responsible for paying this difference along with your coinsurance. Network providers have agreed not to charge you more than the negotiated rate, so you will not be responsible for any amount in excess of the negotiated rate for Covered Health Services when you use a network provider.

Preventive Health Guidelines

Anthem Blue Cross provides guidelines that will help improve your health as well as help you determine whether the services you seek are considered preventive. These guidelines, which were developed based in part from suggestions from independent health care groups, such as the American Academy of Family Physicians, the Center for Disease Control, and the American Cancer Society, may change from time to time as new standards are developed.

The guidelines show suggested timelines for various screening and vaccinations at various ages for babies, children, and adult men and women. Preventive guidelines for pregnant women are based on prenatal schedules. It's important to note that these are guidelines that are suggested for people with average risk. Some people may be a higher risk for health issues due to their family history, their race or ethnicity, or other reasons, such as height or weight, use of tobacco or alcohol, or other health status factors.

You should use these guidelines to discuss routine or preventive care with your doctor not only to determine what would normally be considered preventive but also to help you know when to set up visits with your doctor for you and your children. Ask your doctor which exams, tests and vaccines are right for you, when you should get them and how often. This will help ensure that you and your covered dependents receive the appropriate level of preventive care.

If you need a copy of these Preventive Health Guidelines or if you have questions about coverage, please contact Anthem Blue Cross Member Services at 800-964-0530. You may also find a copy of the guidelines on the Anthem Blue Cross website at http://www.anthem.com/ca/health-insurance/health-and-wellness/preventive-care#tab3.

How Benefits Are Determined

Customary and Reasonable (C&R) Charges

Customary and Reasonable Charges are those covered charges for services rendered by or on behalf of a non-network physician, for an amount not to exceed the amount determined by Anthem Blue Cross in accordance with the applicable fee schedule.

A Customary and Reasonable Charge is a charge which 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 or severity of treatment for a specific case.

Covered Health Services

Covered Health Services are those health services, supplies or equipment provided for the purpose of preventing, diagnosing or treating a sickness, injury, covered medical condition, or its symptoms.

A Covered Health Service is a Medically Necessary health care service or supply described under In-Area HSA Medical Plan Covered Services as a Covered Health Service and which is not excluded under What the In-Area HSA Medical Plan Does Not Cover, including experimental or investigational services or unproven services.

Covered Health Services must be provided:

- When the Plan is in effect;
- Prior to the effective date of any of the individual termination conditions set forth in this Summary Plan Description; and
- Only when the person who receives services is a covered person and meets all eligibility requirements specified in the Plan.

Decisions about whether to cover new technologies, procedures and treatments will be determined by Anthem Blue Cross.

Medically Necessary Services

Medically Necessary Services are those procedures, supplies, equipment or services which the Claims Administrator, Anthem Blue Cross on behalf of Anthem Blue Cross Life & Health, determines to be:

- Appropriate and necessary for the diagnosis or treatment of the medical condition;
- Provided for the diagnosis or direct care and treatment of the medical condition;
- Within standards of good medical practice within the organized medical community;
- Not primarily for your convenience, or for the convenience of your physician or another provider; and
- The most appropriate procedure, supply, equipment or service which can safely be provided. The most appropriate procedure, supply, equipment or service must satisfy the following requirements:
  - There must be valid scientific evidence demonstrating that the expected health benefits from the procedure, supply, equipment or service are clinically significant and produce a greater likelihood of benefit, without a disproportionately greater risk of harm or complications, for you with the particular medical condition being treated than other possible alternatives; and
  - Generally accepted forms of treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable; and
  - For hospital stays, acute care as an inpatient is necessary due to the kind of services you are receiving or the severity of your condition, and safe and adequate care cannot be received by you as an outpatient or in a less intensified medical setting.

The fact that a physician, licensed professional or other provider may prescribe, order, recommend, or approve a service or supply does not, in itself, make it Medically Necessary, even though it is not specifically listed as an exclusion or limitation. The services or supplies must be ordered by the attending physician or licensed professional for the direct care and treatment of a covered illness, injury or condition. Services must be standard medical practice where received for the illness, injury or condition being treated and must be legal in the United States.

Special Situations — Emergency Care and Treatment Away From Home

Emergency Care

If you or a covered family member experiences a medical emergency, seeking prompt care should be the first priority. Under the Plan, emergency care is provided 24 hours a day, seven days a week, anywhere in the world.

A medical emergency is defined as a sudden and unforeseeable illness or injury of such a nature that failure to get immediate medical care could be life-threatening or cause serious harm to bodily function.

Examples of medical emergencies include:

- Apparent heart attack
- Severe shortness of breath
- Severe bleeding
- Apparent poisoning
- Obvious fractures
- Sudden vision loss
- Severe or multiple injuries
- Allergic reactions accompanied by swelling of the face and lips or wheezing in the chest
- Sudden loss of consciousness
- Convulsions

What to Do in Case of Emergency

In case of a medical emergency, go immediately to the nearest *hospital* emergency room. Call BlueCard at 800-810-BLUE (2583) or call collect at 804-673-1177 if you are admitted to the hospital.

It is important to understand that symptoms such as colds, earaches, sprains and rashes, although potentially serious, are not immediately life-threatening and, thus, may not require a visit to the emergency room. In these cases, you should always call your regular physician first.

Emergency room visits for non-emergencies (as determined by Anthem Blue Cross) at non-network *hospitals* will be covered at the non-network benefit level.

Treatment Away From Home

While Working Away From Home

If you have a work assignment outside of your home area — where there are no PPO network providers — you will be covered at the higher level of benefits for non-routine medical care provided by any licensed physician, surgeon or general hospital. To receive network benefits, you should submit a letter with your first claim explaining the location and length of your assignment. Anthem Blue Cross will verify the assignment with the HR Service Center. You will then be eligible to receive the higher level of network benefits for Covered Health Services.

While Traveling Away From Home

If you are traveling away from home — where there are no PPO network providers — and you need non-emergency medical services, you may be eligible to receive the higher level of network benefits by sending a written appeal to Anthem Blue Cross.

If you are traveling out of the country, you may seek care from any licensed provider. However, before leaving the U.S., you can call 800-810-BLUE (2583) and a BlueCard coordinator can provide you with a list of Blue Cross Association participating hospitals in several international cities. You may also find this information on the Web at www.anthem.com/ca/pge. For inpatient care at a network BlueCard hospital, you pay only the applicable deductible and coinsurance. The provider files the claim for you.

For inpatient care at a non-network hospital, you will need to pay the hospital at the time you receive services and then submit a claim for reimbursement. To locate a claim form, go to www.anthem.com/ca/pge, then under "Tools & Information," select "Forms." To receive higher level network benefits, submit your claim form to Anthem Blue Cross with a letter explaining that the claim was incurred while traveling outside the country, along with a receipt for services, translated in English, if possible, which includes the following:

- dates of service;
- procedure codes or description of services; and
- provider's name.

Dependent Children Living Away From Home

Dependent children covered under the In-Area HSA Medical Plan who are residing away from home (for example, while attending school) will receive benefits in accordance with the provisions of the In-Area HSA Medical Plan. If your dependent children reside in an area where there are no PPO network providers or BlueCard providers — and they need non-emergency medical services — they may be eligible to receive the higher level of network benefits by sending a written appeal to Anthem Blue Cross.

If out-of-state, your Enrolled Dependents may access benefits with the BlueCard program, which enables members traveling or living outside their home state to access a broader network of doctors and hospitals at discounted rates through other Blue Cross/Blue Shield plans. To locate BlueCard providers, call toll-free 800-810-BLUE (2583). This number is also printed on the back of your ID card for handy reference.

Medical Management Programs

Not Applicable for Secondary Coverage

Medical management requirements described in this section do not apply when coverage under this Plan is secondary to another plan providing benefits for you or your dependents.

Benefits are provided only for medically necessary and appropriate services. Medical management programs are designed to work together with you and your provider to ensure you receive appropriate medical care and avoid unexpected out-of-pocket expenses. The Medical Management Programs at Anthem Blue Cross include the Utilization Review Program, Authorization Program and Personal Case Management. The Utilization Review Program applies to inpatient hospital admissions. The Authorization Program applies to certain specialized services or treatments (e.g., organ and tissue transplants, home health care, or admissions to a skilled nursing facility.) The Personal Case Management Program helps you coordinate and manage long-term intensive medical care.

No benefits are payable, however, unless your coverage is in force at the time services are rendered, and payment of benefits is subject to all the terms and requirements of the Plan. If benefits are denied or reduced as a result of these programs, you may apply for consideration under the claims and appeals process.

Utilization Review Program

The Utilization Review Program evaluates the medical necessity and appropriateness of care and the setting in which care is provided. You and your physician are advised if it has been determined that services can be safely provided in an outpatient setting or if an inpatient stay is recommended. Services that are medically necessary and appropriate are certified by Anthem Blue Cross and monitored so that you know when it is no longer medically necessary and appropriate to continue those services.

When services are performed by network PPO providers, it is your provider's responsibility to start the utilization review process. For non-network providers, it is your responsibility to see that your physician starts the utilization review process before scheduling you for any service subject to the Utilization Review Program. If you receive any such service and do not follow the procedures set forth in this section, your benefits may be reduced.

Utilization Review Requirements

Services which require pre-authorization by Utilization Management include:

- Inpatient hospital stays.

  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.
- For mental health or substance abuse treatment, any inpatient, partial inpatient, or treatment at a residential treatment center.
- Alternate levels of care, such as intensive outpatient treatment, for either mental health or substance abuse.
- Ambulatory Surgical Center and outpatient surgeries.
- Home infusion.

Review Stages

There are three stages of utilization review:

- Pre-Service review determines the medical necessity and appropriateness of scheduled, non-emergency inpatient hospital admissions.
- Concurrent review determines whether services are medically necessary and appropriate when pre-service review is not required or when Anthem Blue Cross is notified while service is ongoing, for example, after an emergency admission to the hospital.
- Retrospective review is performed to review services that have already been provided.
  - This applies in cases when pre-authorization, 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.

Effect on Benefits

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

- The appropriate utilization reviews must be performed in accordance with the Plan.
- The services must be medically necessary and appropriate.

  Inpatient hospital benefits will be provided only when an inpatient stay is medically necessary and appropriate. If you proceed to receive any services that have been determined to be not medically necessary or not appropriate at any stage of the utilization review process, benefits will not be provided for those services.
- 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 or not 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.

How to Obtain Utilization Reviews

Remember, when your physician is a network provider, it is your physician's responsibility to confirm that the review has been performed. When your physician is a non-network provider, it is your responsibility to confirm that the review has been performed.

Pre-Service Reviews

- For all scheduled services that are subject to utilization review, you or your physician must initiate the pre-service review at least five working days prior to when you are scheduled to receive services.
- Physicians who are network providers will initiate the review on your behalf. A non-network provider may initiate the review for you, or you may call Anthem Blue Cross directly. The toll-free number for pre-authorization and pre-service review is 800-274-7767. This number is printed on your ID card.
- If you obtain certification for a service but the certified service is not rendered within 60 days of obtaining the certification, or if the nature of the service changes, a new pre-service review must be obtained.
- Anthem Blue Cross will certify services that are medically necessary and appropriate. For inpatient hospital stays, Anthem Blue Cross will, if appropriate, certify a specific length of stay for approved services. You, your physician and the provider of the service will receive a written confirmation showing this information.

Concurrent Reviews

- If pre-service review was not performed, Anthem Blue Cross must be contacted for concurrent review. For an emergency admission or procedure, Anthem Blue Cross must be notified within one working day of the admission or procedure, unless extraordinary circumstances prevent such notification within that time period.
  - In determining "extraordinary circumstances," Anthem Blue Cross may take into account whether or not your condition was severe enough to prevent you from notifying Anthem Blue Cross, or whether or not a member of your family was available to notify Anthem Blue Cross for you. You may have to prove that such "extraordinary circumstances" were present at the time of the emergency.
- When network providers have been informed of your need for utilization review, they will initiate the review on your behalf. You may ask a non-network provider to call the toll-free number printed on your identification card or you may call directly. The toll-free number for pre-authorization and pre-service review is 800-274-7767.

When it is determined that the service is medically necessary and appropriate, Anthem Blue Cross will, depending upon the type of treatment or procedure, certify the service for a period of time that is medically appropriate. Anthem Blue Cross will also determine the medically appropriate setting.

If it is determined that the service is not medically necessary or not appropriate, your physician will be notified by telephone no later than 24 hours following Anthem Blue Cross' decision. Anthem Blue Cross will send written notice to you and your physician within two business days following the decision. However, care will not be discontinued until your physician has been notified and a plan of care that is appropriate for your needs has been agreed upon.

Retrospective Reviews

- Retrospective review is performed when Anthem Blue Cross is not notified of the service you received, and is therefore unable to perform the appropriate review prior to your 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 be not medically necessary or not appropriate will be retroactively denied certification.

Authorization Program

The Authorization Program provides prior authorization for medical care or service from a non-network provider and for certain "special services." It is your responsibility to obtain authorization before you receive any service subject to the Authorization Program. Call Anthem Blue Cross' pre-authorization and pre-service review toll-free number at 800-274-7767, which is printed on your ID card.

If you receive any such service and do not follow the procedures outlined in this section, your benefits will be reduced as shown under "Effect on Benefits" under "Utilization Review Program" on page 190.

Services Requiring Authorization

Authorized Referrals

In order for the maximum benefits of the Plan to be payable, advance authorization is required for services received from non-network providers. When the appropriate authorization is obtained, these services are called "authorized referral services."

Note: Authorized referrals are not required for the services of physicians of a type not available within the Prudent Buyer Plan PPO network (for example, an audiologist). A physician's written referral is required, however, in order for the services of some physicians to be covered under the Plan.

Special Services

Pre-authorization is also required to obtain benefits for:

- Organ and tissue transplants; see "Organ and Tissue Transplants" on page 200.
- Transplant travel expense benefits; see "Transportation and Lodging" under "Organ and Tissue Transplants" on page 200.
- Home health care; hospice, or home hospice care; see "Home Health Care and Hospice Care" on page 198.
- Admissions to a skilled nursing facility; see "Skilled Nursing Facility" on page 206.
- Purchase or rental of durable medical equipment that is equal to or greater than $1,000.

Effect on Benefits

Authorized Referrals

- For services requiring an Authorized Referral, the coinsurance for network providers will apply for medically necessary and appropriate authorized referral services received from a non-network provider.
- The coinsurance for non-network providers will apply for referral services received from non-network providers that have not been authorized in advance.

Special Services

- No benefits will be paid if (1) pre-authorization is not obtained for the following special services received from either network or non-network providers and (2) the services are determined by Anthem Blue Cross to be not Medically Necessary: organ and tissue transplants; transplant travel expenses; skilled nursing facility admissions; home health care; hospice or home hospice care; or the purchase or cumulative rental of durable medical equipment equal to or over $1,000.

When Authorization Will Be Provided

Authorized Referrals

Referrals to non-network providers will be authorized only when all of the following criteria are met:

- There is not a network provider within a 30-mile radius of your residence who:
  - Practices the appropriate specialty, or
  - Provides the required services, or
  - Has the necessary facilities;
- You are referred to the non-network provider by a physician who is a network provider; and
- The services are authorized as medically necessary before services are received.

Special Services

Organ and Tissue Transplants

- Authorizations for organ and tissue transplants will be provided as follows:
  - For kidney or cornea transplants, both of the following criteria must be met:
    - The services are medically necessary and appropriate*;* and
    - The physicians on the surgical team and the facility in which the transplant is to take place are approved 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, both of the following criteria must be met:
    - The services are medically necessary and appropriate*;* and
    - The providers of related pre-operative and post-operative services are approved.

Note: Organ and Tissue Transplants are only covered if performed at a Center of Medical Excellence (CME). There is no coverage for transplants done at a network facility that is not a CME. See "Organ and Tissue Transplants" under "What the In-Area HSA Medical Plan Covers" on page 200 for more details.

Transplant Travel Expense Benefits

- Authorizations for transplant travel expense benefits will be provided for the recipient and one companion (up to two companions if the transplant recipient is a child) only if all of the following criteria are met:
  - The procedure is for transplantation of liver, heart, heart-lung, lung, kidney-pancreas, kidney, cornea, or bone marrow, including autologous bone marrow transplant, peripheral stem cell replacement and similar procedures, and authorized by Anthem Blue Cross;
  - The organ transplant is performed at a specific Center of Medical Excellence (CME); and
  - The specific CME is 75 miles or more from the recipient's home.

Home Health Care

See "What the In-Area HSA Medical Plan Covers" on page 197.

- Authorizations for home health care services will be provided only if all of the following criteria are met:
  - The services are medically necessary and appropriate and can be safely provided in the beneficiary's home, as certified by the attending physician;
  - The attending physician manages and directs the beneficiary's medical care at home; and
  - The attending physician must establish a definitive treatment plan which must be consistent with the beneficiary's medical needs and must list the services to be provided by the home health agency.

Skilled Nursing Facility

See "What the In-Area HSA Medical Plan Covers" on page 197.

- Anthem Blue Cross will authorize inpatient services provided in a skilled nursing facility only if all of the following criteria are met:
  - You require daily skilled nursing or rehabilitation, as certified by the attending physician;
  - You were an inpatient in a hospital for at least three consecutive days, and are to be admitted to the skilled nursing facility within 30 days of your discharge from the hospital;
  - You will be treated for the same condition for which you were treated in the hospital; and
  - The care that you will receive is medically necessary and is not custodial, as determined by Anthem Blue Cross.

Durable Medical Equipment

- Pre-authorization is required for the purchase or rental of durable medical equipment for which the total price is $1,000 or more.

How to Obtain an Authorization

For Authorized Referrals

You or your physician must call the toll-free telephone number printed on your identification card prior to scheduling an admission to a non-network facility or receiving the services of, a *non-network provider*.

For Special Services

To obtain authorization, you or your physician must call the Anthem Blue Cross pre-authorization and pre-service review toll-free number at 800-274-7767 prior to receiving services.

Medical Necessity Review Process

Anthem Blue Cross will work with you and your health care providers to determine what is or is not medically necessary and appropriate care and services. While the types of services requiring review and the timing of the reviews may vary, Anthem Blue Cross is committed to ensuring that reviews are performed in a timely and professional manner.

The review process follows the same procedures and timing as the benefit claim process. See "Claims and Appeals Process for Medical Benefits" on page 212. In addition:

- All pre-authorization, pre-service, concurrent and retrospective reviews for medical necessity are screened by clinically experienced, licensed personnel (called "Review Coordinators") using pre-established criteria and Anthem Blue Cross Medical Policy. These criteria and policies are developed and approved by practicing providers not employed by Anthem Blue Cross, and are evaluated at least annually and updated as standards of practice or technology change. Requests satisfying these criteria are certified as medically necessary. Review Coordinators are able to approve most requests.
- If the request fails to satisfy these criteria or medical policies, the request is referred to a Peer Clinical Reviewer. Peer Clinical Reviewers are health professionals who are 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, your provider will be given the option of having the request reviewed by a different Peer Clinical Reviewer.
- Only the Peer Clinical Reviewer may determine that the proposed services are not medically necessary or not appropriate.
- Reviewers may be Anthem Blue Cross employees or an independent third party chosen at the sole and absolute discretion of Anthem Blue Cross.
- You or your physician may request copies of specific criteria and/or medical policies by writing to the address shown on your Anthem Blue Cross identification card. Medical necessity review procedures may be disclosed 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 your 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
- You are not eligible for coverage when the service is actually provided.

Personal Case Management

The Personal Case Management Program enables you to obtain medically appropriate care in a more economical, cost-effective and coordinated manner during prolonged periods of intensive medical care. Anthem Blue Cross, through a case manager, may recommend an alternative plan of treatment which may include services not typically covered under the Plan. Anthem Blue Cross does not have an obligation to provide personal case management. These services are provided at the sole and absolute discretion of Anthem Blue Cross. Examples of conditions that may fall under Personal Case Management include:

- Burns
- CVA
- Migraine
- Sickle Cell Disease
- Trauma

These Are Examples

These conditions or diagnoses are not a guarantee of acceptance into the Personal Case Management Program. Cases are reviewed and criteria applied to determine possible enrollment, and enrollment is contingent upon member consent.

How Personal Case Management Works

You may be identified for possible personal case management through the Plan's utilization review procedures, by the attending physician or hospital staff, or through Anthem Blue Cross' claims reports. You or your family may also call Anthem Blue Cross and request personal case management.

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

- You require extensive long-term treatment;
- Anthem Blue Cross anticipates that such treatment utilizing services or supplies covered under the Plan will result in considerable cost;
- A cost-benefit analysis determines that the benefits payable under the Plan for the alternative plan of treatment can be provided at a lower overall cost than the benefits you would otherwise receive under the Plan while maintaining the same standards of care; and
- You (or your legal guardian) and your physician agree, in a letter of agreement, with Anthem Blue Cross' recommended substitution of benefits and with the specific terms and conditions under which alternative benefits are to be provided.

Alternative Treatment Plan

If Anthem Blue Cross determines that your needs could be met more efficiently, an alternative treatment plan may be recommended. This may include providing benefits typically not covered under the Plan. A case manager will review the medical records and discuss your treatment with the attending physician, you, and your family.

Anthem Blue Cross makes treatment recommendations only; you and your physician make the decisions regarding treatment. The Plan will not compromise your freedom to make such decisions.

The Effect Personal Case Management Has on Benefits

- Any alternative benefits are accumulated toward the corresponding benefit maximums.
- Benefits are provided for an alternative treatment plan on a case-by-case basis only. Anthem Blue Cross has absolute discretion in deciding whether or not to authorize services in lieu of benefits for any covered person, which alternatives may be offered and the terms of the offer.
- The authorization of services in lieu of benefits in a particular case in no way commits the Plan to do so in another case or for any other covered person.
- The Personal Case Management Program does not prevent Anthem Blue Cross from strictly applying the expressed benefits, exclusions and limitations of the Plan at any other time or for any other covered person.

Third Parties

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

What the In-Area HSA Medical Plan Covers

This topic lists covered services and supplies that are frequently used. If you have any questions on whether or not a specific service or supply is covered by the Plan, contact Anthem Blue Cross Member Services at 800-964-0530.

For ease of reviewing, the In-Area HSA Medical Plan Covered Services are listed in alphabetical order, with the exception of "Other Covered Services and Supplies," which is listed last.

Acupuncture

Under the In-Area HSA Medical Plan, acupuncture services received from an M.D. or licensed acupuncturist who participates in the Anthem Blue Cross PPO network will be covered at 90% of the negotiated rate, after deductible, for up to 20 visits per year. Acupuncture services received from a non-network acupuncturist will be covered at 70% of Customary and Reasonable Charges (Eligible Expenses), after deductible, for up to 15 visits per year.

Ambulance Services

The following ambulance services are covered at 90% of the negotiated rate for network providers or 90% of Customary and Reasonable charges for non-network providers.

Emergency Only

- Emergency ambulance transportation, provided by a licensed ambulance service, to the nearest hospital where emergency health services can be performed.

Non-Emergency

- Transportation by professional ambulance, other than air ambulance, to and from a medical facility when Medically Necessary.
- Transportation by regularly-scheduled airline, railroad or air ambulance, to the nearest medical facility qualified to give the required treatment when Medically Necessary.

Bariatric Surgery

The Plan covers bariatric surgery at 90%, after the deductible, for medically necessary surgery performed at a Center of Medical Expertise (CME) or other in-network facility. Medically necessary bariatric surgery performed at a non-network facility is covered at 70%. This surgery is only covered in cases of morbid obesity, and it is subject to utilization review. Inpatient services provided in connection with this medically necessary surgery for morbid obesity are also covered at 90% (in-network) or 70% (non-network), as applicable, after the deductible has been satisfied.

Travel expense benefits will be provided in connection with a covered bariatric surgical procedure only when the surgery is performed at a bariatric Center of Medical Excellence (CME) and the member's home is 50 miles or more from the CME. The 50-mile radius around the Bariatric CME will be determined by the Bariatric CME coverage area. Bariatric travel expense is covered at 100% and is limited to $130 a day and three trips per surgery (one pre-surgical visit, the initial surgery, and one follow-up visit). Hotel expenses are limited to $100 per day and two days per trip — limited to one room double occupancy. Companion travel is limited to $130 a day and two trips per surgery (the initial surgery and one follow-up visit). Hotel expenses for companions are limited to $100 per day and four days per trip — limited to one room double occupancy.

Chiropractic Care

The In-Area HSA Medical Plan covers in-network Medically Necessary chiropractic services at 90% after you meet the annual deductible. The in-network limit is 20 visits a calendar year. The Plan does not pay for more than 20 visits a calendar year. The Plan pays 70% of Customary and Reasonable Charges (after deductible) for out-of-network care. The annual limit for out-of-network chiropractic care is 15 visits a calendar year.

You can locate chiropractic providers who participate in the Anthem Blue Cross PPO network by calling Anthem Blue Cross Member Services at 800-964-0530 or you may visit the Anthem Blue Cross website at www.anthem.com/ca/pge or www.anthem.com/ca. If there is not a network chiropractor within 30 road miles of your residence, you may seek care from a non-network provider and receive network benefits. If this is the case, call Anthem Blue Cross Member Services to verify there are no network chiropractors within 30 miles and request the network level of benefit reimbursement.

Home Health Care and Hospice Care

Home health care and hospice care under the In-Area HSA Medical Plan are covered at 90% of the negotiated rate, after deductible, if you use an Anthem Blue Cross PPO network provider. Pre-authorization is required.

Non-network home health care and hospice care is covered at 70% of Customary and Reasonable Charges (Eligible Expenses) after deductible. The In-Area HSA Medical Plan will cover the services of an approved home health care agency or hospice agency, provided the services are Medically Necessary Covered Health Services, not custodial in nature, ordered by your attending physician (whether network or non-network), and rendered under a written treatment plan approved by Anthem Blue Cross. Custodial care, which is not covered, is defined as care provided primarily to assist an individual in meeting the activities of daily living including, but not limited to, walking, bathing, dressing, eating, preparation of special diets, changing catheters, and supervision over self-administration of medications not requiring constant attention of trained medical personnel. It is care that can be taught to a lay person who does not have any professional qualifications, skills or training.

When your doctor recommends either home health or hospice care, he or she must contact Anthem Blue Cross at 800-274-7767 for pre-authorization.

Services in Your Home

The Plan covers the following services when rendered in the patient's home, provided that the services are Medically Necessary Covered Health Services and are not considered custodial care, as determined by Anthem Blue Cross:

- Nursing services provided by a registered nurse (R.N.), or a licensed vocational nurse (L.V.N.) or licensed practical nurse (L.P.N.) when under the supervision of an R.N.
- Services of a home health aide.
- Physical, occupational, speech or respiratory therapy; medical social services; and nutritional counseling.
- For a patient formally admitted to a hospice program: homemaking services; counseling for the patient and covered family members; up to three days of respite care during a six-month period; and bereavement counseling by a certified social worker who is an employee of the hospice, for up to 12 months after the patient's death. Bereavement counseling benefits are limited to $25 per visit, four visits per family.

Hospice Facility

Medically Necessary Covered Health Services in a hospice facility are covered when a patient in the latter stages of a terminal illness is formally admitted to an inpatient hospice program and Medical Management has approved the admission.

The following inpatient hospice services are covered:

- Bed, board and general nursing care.
- Medical care provided by other professional providers employed by the facility.

- Hospice facility services and supplies.
- Family counseling related to the patient's illness.
- Bereavement counseling for the family after the patient's death.

Eligibility for hospice benefits begins on the date on which the patient's physician certifies that the patient has a life expectancy of six months or less.

The Plan does not cover homemaking services, except as specifically provided above. Food or home-delivered meals and services by volunteers who do not regularly charge for their services are not covered.

Coverage of physician, hospital, ambulance and hemodialysis services, purchase or rental of durable medical equipment, medical supplies, drugs and medicines is provided as described elsewhere in this Handbook.

Hospital Care — Inpatient

Inpatient hospital care is covered at 90% after meeting the annual deductible, when you use a participating PPO network provider. Non-network inpatient hospital care is covered at 70% of Eligible Expenses after meeting the deductible. For non-emergency inpatient hospital care, pre-authorization is required. When services are performed by a network provider, your provider will contact Anthem Blue Cross Medical Management for pre-authorization. When services are performed by a non-network provider, it is your responsibility to contact Anthem Blue Cross Medical Management for pre-authorization or make sure your provider has obtained the necessary pre-authorization.

Covered inpatient hospital services include:

- Room and board in semi-private accommodations; private room if Medically Necessary (as determined by standards set by Anthem Blue Cross — see "Medically Necessary Services" under "How the In-Area HSA Medical Plan Works" on page 185).
- Special care units.
- Medical and surgical supplies.
- General nursing care.
- Use of operating and special treatment rooms.
- Anesthesia and its administration by a salaried hospital employee.
- Administration of blood and blood plasma, including the cost of unreplaced blood, blood products and blood processing.
- Hospital ancillary services, including laboratory, cardiology, pathology, radiology and any professional components for such services.
- Routine nursery care for a newborn if the child is enrolled in the In-Area HSA Medical Plan.
- Drugs, medicines and oxygen supplied by and used in the hospital.
- Pre-admission testing performed within seven days before hospital admission or outpatient surgery.
- Radiation therapy, chemotherapy, physical therapy, respiratory therapy, and hemodialysis treatment.
- Short-term speech therapy for correction of speech impairments resulting from illness, injury, surgery, or previous therapeutic processes.
- Physical therapy when furnished by the hospital as a regular service
- Occupational therapy when furnished by the hospital in conjunction with physical therapy treatments.
- Dental care when a hospital admission is required for dental surgery or extraction of teeth, general anesthesia is required, and a physician certifies that the hospitalization is Medically Necessary.

Childbirth

Under federal law, the duration of benefits provided for any hospital stay in connection with childbirth for a mother or newborn child may not be restricted to less than 48 hours following a normal delivery, or less than 96 hours following a cesarean section. However, this federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her baby earlier than 48 hours (or 96 hours, as applicable).

Hospital Care — Outpatient

Covered outpatient hospital services include:

- Outpatient surgical services. This includes Medically Necessary Covered Health Services rendered in a freestanding ambulatory surgical center, a short-stay surgical unit or an outpatient department of a hospital.
- Emergency hospital outpatient services for the first visit for emergency care and treatment of a sudden and unforeseeable illness or injury which, if not immediately diagnosed and treated, could be life-threatening or cause serious harm to bodily function.
- Outpatient Medically Necessary Covered Health Services for radiation therapy, chemotherapy and hemodialysis treatment.

Organ and Tissue Transplants

Organ and tissue transplants are covered at 90% of the negotiated rate, after deductible, when pre-authorized by Anthem Blue Cross and performed at an Anthem Blue Cross Center of Medical Excellence (CME) facility. There is no coverage for transplants performed at non-network facilities or facilities which participate in the Anthem Blue Cross PPO network but are not CMEs. Pre-authorization is required for all transplant services.

Benefits are available for the following organ and tissue transplants when the transplant is ordered by a physician, meets the definition of a Covered Health Service and is not an unproven, experimental, or investigational service, as described under "What the In-Area HSA Medical Plan Does Not Cover" on page 208.

- Bone marrow transplants (either from you or from a compatible donor) and peripheral stem cell transplants, with or without high dose chemotherapy. Not all bone marrow transplants meet the definition of a Covered Health Service.
- Heart transplants
- Heart/lung transplants
- Lung transplants
- Liver transplants
- Kidney transplants
- Kidney/pancreas transplants
- Liver/small bowel transplants
- Pancreas transplants
- Small bowel transplants
- Cornea transplants

Organ or tissue transplants or multiple organ transplants, other than those listed in this section, are currently excluded from coverage.

Centers of Medical Excellence (CME) Transplant Facilities

In California, Anthem Blue Cross has established a Centers of Medical Excellence (CME) network of transplant facilities to provide services for specified organ transplants (heart, liver, lung, heart-lung, kidney-pancreas, or bone marrow, including autologous bone marrow transplant, peripheral stem cell replacement and similar procedures). Equivalent approved transplant facilities are located outside of California.

CMEs are health care providers designated by Anthem Blue Cross as a selected facility for specified medical services. A provider participating in a CME network has an agreement in effect with Anthem Blue Cross at the time services are rendered or is available through their affiliate companies or their relationship with the Blue Cross and Blue Shield Association. CMEs agree to accept the CME negotiated rate as payment in full for covered services. A participating provider in the Anthem Blue Cross PPO network is not necessarily a CME. A provider's participation in the Anthem Blue Cross PPO network or other agreement with Anthem Blue Cross is not a substitute for a CME Agreement.

Obtain Authorization from Anthem Blue Cross' Authorization Program

Authorization is required for all transplant services. You must call the Pre-Authorization and Pre-Service toll-free number at 800-274-7767 as soon as the possibility of a transplant arises. The Authorization Program will arrange for a pre-transplantation evaluation to be performed at a CME transplant facility. The Authorization Program also can discuss your benefit options and any special transplant guidelines.

Transportation and Lodging

The Authorization Program will assist the patient and family with travel and lodging arrangements associated with transplant procedures. Expenses for travel and lodging for the transplant recipient and companion(s) are based on IRS guidelines and are as follows:

- Travel and lodging expenses are only available if the transplant recipient resides more than 75 miles from the Center of Medical Excellence facility.
- Transplant travel expense for an authorized, specified transplant: recipient and companion transportation limited to six trips/episode and $250/person/trip for round-trip coach airfare; hotel limited to one room double occupancy and $100/day for 6 trips/episode and 21 days/trip.
- If the patient is a covered dependent minor child, the transportation expenses of up to two companions will be covered.
- There is a combined overall lifetime maximum of $10,000 per covered person for all transportation and lodging expenses incurred by the transplant recipient and companion(s) and reimbursed under this Plan in connection with all transplant procedures, per IRS regulations.

Prescription Drugs

Inpatient Prescription Drugs

Prescription drugs you receive while you are hospitalized, or "inpatient" drugs, are covered by your Anthem Blue Cross medical plan. If you are hospitalized in a PPO network hospital, non-preventive prescription drugs are covered at 90%. If you are hospitalized in a non-network hospital, prescription drugs are covered at 70%.

Outpatient Prescription Drugs

The Outpatient Prescription Drug component of the In-Area HSA Medical Plan is administered by Medco Health. Medco and Anthem Blue Cross coordinate claims, however, so that all eligible medical and outpatient prescription drugs claims are combined in meeting both the annual deductible and the annual out-of-pocket maximum.

Benefit Level for Preventive Drugs

In general, the In-Area HSA Medical Plan pays 100% (before the deductible) for prescription drugs that are determined by Medco to be preventive. Preventive drugs filled at non-network pharmacies will be filled at 100% of the average negotiated network rate, before deductible. Preventive drugs are determined by Medco Health Solutions. Some prescription drugs are always considered preventive. Others may be preventive in some instances and not in others. Medco has a list of prescription drugs that are always considered preventive. See Generic Incentive Provision later in this subsection for limitations. There is also a penalty for the 4th fill of maintenance drugs at a retail pharmacy. See Retail Pharmacy Service

Benefit Level for Non-Preventive Drugs

In general, the Plan pays 90%, after the annual deductible has been satisfied, for outpatient prescription drugs that are not considered preventive. Non-preventive drugs filled at non-participating pharmacies will be filled at 90% of the average negotiated network rate, after deductible. Some prescription drugs are never considered preventive. Others may be preventive in some instances and not in others. Medco in its sole discretion as Claims Administrator will determine whether a prescription drug is considered preventive, based on diagnosis and other factors. See Generic Incentive Provision later in this subsection for limitations. There is also a penalty for the 4th fill of maintenance drugs at a retail pharmacy. See "Retail Pharmacy Service."

General Information

Medco has negotiated rates with many retail pharmacies. Benefits for prescription drugs purchased at these pharmacies are paid based on these negotiated rates. The pharmacies that Medco has negotiated with are called "participating" pharmacies. To receive the greatest benefit on retail prescriptions, participating pharmacies should be used. A directory of participating pharmacies can be obtained by calling Medco Member Services at 800-718-6590 or by visiting Medco's website at www.medcohealth.com. You also can use the easy "Medco by Mail" mail-order program for your maintenance drugs.

Manufacturer rebates are earned upon participant purchase of certain prescription drugs. The value of these rebates is based on the contract that Pacific Gas and Electric Company, as Plan sponsor, has with Medco Health. These rebates are received from Medco Health approximately six months after the purchase of a drug and are deposited back to the trust holding the plan assets for retirees or employees on long-term disability or back to Pacific Gas and Electric Company for active employees. The cost of the Plan is reduced by the value of the rebates.

Retail Pharmacy Service

The Retail Pharmacy Service, managed by Medco, helps you pay part of the cost of **retail** prescription drugs — that is, drugs that you purchase at local pharmacies.

When you enroll in one of the self-insured plans administered by Anthem Blue Cross, you are issued a member identification card by Medco. Go to any participating pharmacy (such as CVS, Rite Aid, Walgreens, Raley's or a number of independent pharmacies), present your card identifying you as a Medco member, and pay the appropriate coinsurance. You may also go to a non-participating pharmacy; however, you will be responsible for paying the entire cost of the prescription upfront and then filing a claim form for reimbursement. It is likely that a non-participating pharmacy will charge more than the pre-negotiated rates of a participating pharmacy. Reimbursement is based on the amount a participating pharmacy would have charged, minus the coinsurance amount. You may call 800-718-6590 or go to www.medco.com to verify pharmacy participation.

Prescription drugs purchased at a participating retail pharmacy will be reimbursed for up to three 30-day supplies at 100% for preventive drugs and 90% after the deductible for non-preventive drugs. There is a 15% penalty for maintenance drugs on the 4th fill at retail pharmacies — even if the drug is preventive and filled at a network pharmacy. Therefore, it is suggested that members use Medco By Mail for refills of maintenance drugs beyond a 90-day supply.

- Ask your physician for two separate prescriptions: one prescription for a 30-day supply (to be filled at your local retail pharmacy) and one prescription for a 90-day supply (to be filled through Medco By Mail).
- Have your 30-day prescription filled immediately at your retail pharmacy. About two weeks later (after you have used up half of your 30-day supply and have decided to continue taking this particular prescription drug), submit your 90-day prescription to Medco By Mail. This will allow a 14-day turn-around for your mail-order prescription to be delivered to your home. Medco will not issue your 90-day supply if you send your order in any sooner than this because it will still be too early to fill the prescription.

When Claim Forms Are Required

You will need to pay the full cost of your prescription and file a claim form for reimbursement if you:

- purchase drugs at a non-participating pharmacy;
- do not present your Medco identification card when purchasing drugs at a participating pharmacy; or
- have other prescription drug coverage which pays first before Medco and you want Medco to pay as secondary insurance on any claim remainder. This is called a Coordination of Benefits or "COB" claim; see "If You Have Other Coverage" under *Health Care Participation*.

A member may obtain prescription drugs from participating pharmacies without using their membership card and then seek reimbursement from Medco by submitting a claim form. However, the member's reimbursement in such cases will be limited to the cost for the drug negotiated by Medco and the pharmacy. Any additional amounts charged to the member by the pharmacy will be the member's responsibility.

To obtain a claim form, call Medco Member Services at 800-718-6590 or visit Medco's website at www.medcohealth.com. If you are a first-time visitor to www.medcohealth.com, take a minute to register. Please remember to have your member ID number and a recent prescription number handy.

Medco By Mail

This program enables you to purchase your maintenance medications, often at a savings, while having them delivered directly to your home via U.S. mail. "Maintenance" medications are those drugs that you take on a long-term or an on-going basis — in other words, those drugs that you know you'll need and can order in advance. Some examples of conditions for which maintenance medications are prescribed are high blood pressure, high cholesterol, heart disorders, diabetes, arthritis, and stomach ulcers.

How Medco By Mail Works

With Medco By Mail, you may obtain up to a 90-day supply of medication for each prescription. The Plan pays 100% for generic preventive drugs, and 90% for generic non-preventive drugs. If you elect to use a brand-name drug when a generic drug is available, you will be responsible for paying the difference between the price of the generic drug and the brand-name drug, plus coinsurance, as described under "Generic Incentive Provision" under "Paying Your Coinsurance" below in this section.

Patient Profile

When you order from Medco By Mail for the first time, you will need to complete the last portion of the initial order form, which is a Health Assessment Questionnaire. Complete this form and mail it, along with your original prescription, in an envelope addressed to:

Medco Health Solutions, Inc.
P.O. Box 747000
Cincinnati, Ohio 45274-7000

The Medco by Mail order form, which includes the Health Assessment Questionnaire, and mail-order envelopes are available by calling Medco Member Services at 800-718-6590. You may also download the form by accessing Medco's website at www.medcohealth.com.

The purpose of the Health Assessment Questionnaire is to alert the pharmacists who are filling your prescriptions of any allergies or medical conditions that might be affected by the prescriptions you are ordering, in an effort to prevent any potentially harmful drug reactions. All information in the Health Assessment Questionnaire is confidential.

Paying Your Coinsurance

You can request that Medco bill you for your coinsurance, up to $100, or you can instruct Medco to bill your credit card or debit card (e.g., VISA, MasterCard, etc.). Alternatively, you can submit payment in advance. To do so, you will need to call Medco to find out the amount of your coinsurance. Then send your personal check or money order, along with your original prescription, when you send in your order.

Obtaining Your Medications

Medco will mail your medications directly to your home. You will receive your medication within 14 days from the date on which Medco receives your order. If you need your prescription sooner, just let Medco know and, for an extra charge, your prescription will be sent via UPS or Federal Express.

Whenever possible, your prescription will be filled with a generic drug that meets the same standards as the brand name, unless your physician specifies otherwise.

Medco's specialty pharmacy, Accredo Health Group, handles complex conditions such as anemia, hepatitis C, multiple sclerosis, asthma, growth hormone deficiency, and rheumatoid arthritis, which are treated with specialty medications. Specialty medications are typically injectable medications administered either by yourself or by a health care professional, and often require special handling. In addition, Medco partners with Liberty Medical to fulfill prescription requests for certain drugs and supplies covered by Medicare Part B. For more information about Accredo or Liberty Medical, please call Medco Member Services at 800-718-6590.

Ordering Your Refills

You can order your refills by mail or by calling Medco directly at 800-718-6590, 24 hours a day, seven days a week, except Thanksgiving and Christmas. For refills by mail, send the refill slip provided with your last mail-order prescription, along with your copayment, to Medco Health Solutions, Inc., P.O. Box 747000, Cincinnati, Ohio 45274-7000. You may also order your refills online using Medco's website at www.medcohealth.com. You can also check on the status of your refill online.

When Your Current Prescription Expires

Prescriptions expire one year from the date of issue, regardless of whether you have any refills left. You may mail your new prescription to Medco Health Solutions, Inc., P.O. Box 747000, Cincinnati, Ohio 45274-7000. You may also have your physician fax your new prescription to Medco. Ask your doctor to call 888-327-9791 for instructions.

Generic Incentive Provision

For all prescription drug purchases, whether at a retail drug store or through mail-order, members will be responsible for paying the difference between the price of a generic prescription drug and a brand-name prescription drug, plus coinsurance, if purchasing a brand-name drug when a generic is available. (The difference in cost between the brand-name drug and the generic drug does not apply toward your annual deductible, if applicable, or annual out-of-pocket maximum.) Here's an example of how the "Generic Incentive Provision" works:

Al purchases a 30-day supply of Mevacor, a brand-name prescription drug, at the local pharmacy. He chooses not to use the generic alternative, Lovastatin. Although both drugs are considered preventive, Al must pay the difference between the brand name and the generic because he is opting not to use the generic that is available.

	Generic	Brand-Name
Drug Name and Price	Lovastatin ($24.04)	Mevacor ($79.10)
Price difference between brand-name and generic (What Al Pays)	Not applicable	$55.06

Note: Drugs listed on Medco Health's "Narrow Therapeutic List" are excluded from the Generic Incentive Provision.

What Prescription Drugs Are Covered

Covered expenses for prescription drugs under the In-Area HSA Medical Plan consist of drugs and medicines approved by the Food and Drug Administration for general use by the public that require a written prescription by a physician and that are dispensed by a licensed pharmacist, physician, or hospital for take-home purposes. Eligible drugs and medicines include:

- Drugs that require a prescription, except those specifically excluded under What The In-Area HSA Medical Plan Does Not Cover;

- Compound drugs that contain at least one prescription drug;
- Insulin, including hypodermic needles and syringes when insulin is also purchased;
- Over-the-counter diabetic supplies, including items used for daily blood and urine sample testing (except diabetic monitors);
- Retin-A for patients through age 25 (over age 25 when medically necessary);
- Vitamins that require a prescription;
- Attention Deficit Disorder drugs (e.g., Methylphenidate, Dextroamphetamine, Methamphetamine, Dextroamphetamine/Amphetamine);
- Smoking deterrents that require a prescription (e.g., Habitrol, Nicoderm, and Prostep anti-smoking patches);
- Anorexiants with prior authorization;
- Oral contraceptives; and
- Fertility, sexual dysfunction, and memory enhancement drugs, if medically necessary.

See "What the In-Area HSA Medical Plan Does Not Cover" on page 208 for prescription drug exclusions.

Medically Necessary

For prescription drugs, the In-Area HSA Medical Plan only covers services and supplies that are Medically Necessary. For the purpose of this Plan, Medically Necessary services and supplies are those provided by a hospital, physician or other provider that: (i) have been established as safe and effective; (ii) are furnished in accordance with generally accepted professional standards to treat illness or injury, and are in accordance with the accepted standards of medical practice in the geographic area where the services are provided; (iii) are consistent with the symptoms and diagnosis or treatment of the illness, injury or condition; (iv) are furnished at the most appropriate level that can be provided safely and effectively to the patient; and (v) are not furnished primarily for the convenience of the patient, the attending physician or other provider. Medically Necessary prescriptions will be paid at the standard level or rate of coverage.

How New Prescription Drugs Are Added

The In-Area HSA Medical Plan covers all prescription drugs approved by the Food and Drug Administration (FDA), as long as they are used in the FDA-approved manner and are used in accordance with manufacturers' usage guidelines. Coverage for new prescription drugs will begin upon FDA approval.

Professional Services

The following professional services are covered, if deemed to be Medically Necessary Covered Health Services as determined by Anthem Blue Cross:

- Services of a physician, surgeon or assistant surgeon
- Services of an anesthetist or anesthesiologist in connection with surgery
- Services of a consulting physician when requested by your doctor
- Constant care services rendered by a physician when you are in critical condition
- Physician visits to a hospital or skilled nursing facility during a covered inpatient confinement
- Visits to your doctor's office or physician house calls for treatment of illness, disease or injury
- Radiation therapy
- Outpatient diagnostic X-rays and lab exams
- Routine or diagnostic Pap smears and mammograms
- Routine physical exams
- Injections, inoculations and immunizations
- Physician services in the outpatient department of a hospital, ambulatory surgical facility or short-stay surgical unit
- Well-baby care (See "Preventive Health Guidelines" on page 187.)
- Services of a licensed physical therapist for a covered inpatient hospital or skilled nursing facility confinement

Psychiatric Care and Substance Abuse Treatment

Medically Necessary in-network mental health and substance abuse treatment is covered at 90%. Medically Necessary out-of-network mental health and substance abuse treatment is covered at 70%. For both mental health and substance abuse, pre-authorization is required for all inpatient treatment, treatment at a residential treatment center, or partial in-patient treatment. Medically necessary alternate levels of treatment, such as intensive outpatient treatment, for either mental health or substance abuse, also require pre-authorization from Anthem Blue Cross.

Skilled Nursing Facility

Skilled nursing facility services under the In-Area HSA Medical Plan are covered at 90% of the negotiated rate, after deductible, when you use an Anthem Blue Cross PPO network provider. Non-network skilled nursing facility services are covered at 70% of Customary and Reasonable Charges (Eligible Expenses) after the deductible. Pre-authorization is required. Remember, either you or your doctor must contact Anthem Blue Cross for pre-authorization (see "Medical Management Programs" on page 190) and meet all the stated criteria for coverage.

The services provided must be Medically Necessary Covered Health Services (and not considered custodial care) so as to require confinement in a skilled nursing facility, as determined by Anthem Blue Cross. (Custodial care is defined as care provided primarily to assist an individual in meeting the activities of daily living including, but not limited to, walking, bathing, dressing, eating, preparation of special diets, changing catheters, and supervision over self-administration of medications not requiring constant attention of trained medical personnel. It is care that can be taught to a lay person who does not have any professional qualifications, skills or training.)

Other Covered Services and Supplies

Other covered services and supplies include:

- Outpatient professional nursing services of a registered nurse (R.N.), licensed vocational nurse (L.V.N.) or licensed practical nurse (L.P.N.) that are certified as Medically Necessary Covered Health Services by your physician.
- Services of a licensed midwife working under the direction of a *physician*.
- Medically Necessary Covered Health Services of a licensed physical or occupational therapist, when provided by someone other than a close relative or someone who resides in your home, when ordered by a participating physician, and when judged by the physician to be subject to significant improvement through such therapy. The therapy must be expected to result in significant, objective, measurable physical improvement in the covered person's condition within two months of the start of the treatment. After 24 visits in a calendar year, all services will be reviewed by Anthem Blue Cross for Medical Necessity and must be deemed Medically Necessary to be covered. Both physical therapy and occupational therapy visits will be counted on a combined basis when calculating the first 24 visits each calendar year.
- Non-experimental inpatient drugs and medicines which are approved by the Food and Drug Administration (FDA).
- Artificial limbs or eyes, when determined to be a Medically Necessary Covered Health Service.
- Rental or purchase of durable medical equipment (including prosthetic and orthotic devices) that is ordered by a physician, approved by Anthem Blue Cross, determined by Anthem Blue Cross to be a Medically Necessary Covered Health Service, and is to be used solely by the patient. If an item is rented, the rental price for the entire rental period cannot be more than the purchase price. The rented item must be returned if the member switches plans. Necessary repairs and maintenance of purchased equipment are also covered if not provided under a manufacturer's warranty or purchase agreement.
- Eye chart vision screenings for adults and children (refraction exams not covered).
- Initial pair of eyeglasses or contact lenses prescribed by a doctor after eye surgery; eyeglasses or lenses when needed to replace loss of the natural lens.

- Treatment of an injury to sound and natural teeth, but only if treatment is completed within 12 months of the accident.
- Rental of dialysis equipment and all Medically Necessary Covered Health Services and supplies required for hemodialysis treatment.
- Oxygen, including its administration.
- Short-term speech therapy services rendered by a certified speech therapist when required due to surgery, illness, injury, or previous therapeutic processes, when ordered by a participating physician, and when judged by the physician to be subject to significant improvement through such therapy. Speech therapy due to functional nervous disorders is **not** covered. The therapy must be expected to result in significant, objective, measurable improvement in the covered person's condition within two months of the start of the treatment. After 24 visits in a calendar year, all services will be reviewed by Anthem Blue Cross for Medical Necessity and must be deemed Medically Necessary to be covered.
- Diabetes self-management education programs.
- Surgery to change an individual's appearance when the purpose is:
  - to correct the result of an accidental injury; or
  - to treat a condition, including a birth defect, that impairs the function of a body organ.
- Diagnostic procedures for the prenatal diagnosis of genetic disorders of the fetus when authorized by a participating physician in the case of high-risk pregnancy.
- Surgical treatment of morbid obesity when authorized by a participating physician and approved by Anthem Blue Cross, when surgical treatment of morbid obesity is necessary to treat another life-threatening condition involving morbid obesity, **and** when it has been documented that non-surgical treatments of the morbid obesity have failed.
- Fertility treatments, up to a lifetime maximum of $7,000 combined for all plans administered by Anthem Blue Cross or prior claims administrators. The benefit includes, but is not limited to, in vitro fertilization services, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), and microinjection techniques. Services provided must be considered safe and effective according to accepted clinical evidence reported by generally recognized medical professionals or publications.
- Coverage for routine mammographies (given as preventative measures to detect problems when a physician does not have a specific reason to suspect a medical problem), in accordance with Anthem Blue Cross' standard administrative policies. Diagnostic mammographies, which are given when there is a suspected problem, are covered as well.
- For a member receiving benefits in connection with a mastectomy and who elects breast reconstruction, the coverage will be provided in a manner determined in consultation with the attending physician and the patient for:
  - reconstruction of the breast on which the mastectomy was performed;
  - surgery and reconstruction of the other breast to produce a symmetrical appearance; and
  - prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

  Notify Anthem Blue Cross five business days before receiving non-network services. By notifying Anthem Blue Cross, it can be verified whether a service is a reconstructive or a cosmetic procedure.

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;

- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedemas.

Coverage of breast reconstruction will be provided subject to the deductibles and coinsurance benefit limits consistent with those established for other benefits under your plan. For more information, contact your medical plan directly.

Newborns' and Mothers' Health Protection

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a Cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, plans and insurers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

What the In-Area HSA Medical Plan Does Not Cover

Unless exceptions to the following are specifically noted elsewhere in this Handbook, no benefits are provided for the following:

- Services or supplies received from a provider or supplier who is not licensed, registered or certified under state law to the extent required to provide such service or supply, or if the service or supply provided is not within the scope of the provider's license, certificate or registration.
- Services or supplies that are not Covered Health Services, which includes all services that are not Medically Necessary (see the definition of "Covered Health Services" in the *Definitions* section) or that are educational in nature, as determined by Anthem Blue Cross.
- Charges in excess of the Customary and Reasonable Charges (Eligible Expenses), as determined by Anthem Blue Cross (see the definition of "Eligible Expenses" in the *Definitions* section and "How the In-Area HSA Medical Plan Works" on page 185), for services rendered by non-preferred providers.
- Services that are provided or a hospitalization that begins before coverage begins or after it ends, except as specifically noted elsewhere or unless the coverage began under another Company-sponsored medical plan.
- Hospitalization that continues after coverage has ended and after you have recovered sufficiently to be discharged, unless you are certified as totally disabled as explained in "**Extended Benefits When Coverage Ends**" in the **Health Care Participation** section.
- Hospitalization primarily for physical therapy or other rehabilitative care, unless approved by Anthem Blue Cross as a Medically Necessary Covered Health Service, except those benefits which would have been provided had the patient been treated on an outpatient basis. For example, charges for room and board during such a hospitalization are not covered.
- Services or supplies in connection with custodial care. Custodial care is defined as care provided primarily to assist an individual in meeting the activities of daily living including, but not limited to, walking, bathing, dressing, eating, preparation of special diets, changing catheters, and supervision over self-administration of medications not requiring constant attention of trained medical personnel. It is care that can be taught to a lay person who does not have any professional qualifications, skills or training.
- Services or supplies which would not have been rendered or furnished if the Plan did not exist or services or supplies for which you would not have been required to pay.
- Cosmetic procedures are excluded from coverage. Procedures that correct a congenital anomaly without improving or restoring physiologic function are considered cosmetic procedures. The fact that a covered person may suffer psychological consequences or socially avoidant behavior as a result of an injury, illness or congenital anomaly does not classify surgery or other procedures done to relieve such consequences or behavior as a reconstructive procedure.

- Services or supplies furnished in connection with cosmetic surgery or surgery performed mainly to change appearance. This includes surgery performed to treat a mental, psychoneurotic, or personality disorder through a change in appearance. The following are not considered to be cosmetic surgery:
  - Surgery to correct the result of an accidental injury;
  - Surgery to treat a condition, including a birth defect, that impairs the function of a body organ; or
  - Surgery to reconstruct a breast after a mastectomy.
- Services and supplies furnished in connection with surgical procedures for gender reassignment surgery, unless Medically Necessary as determined by Anthem Blue Cross.
- Personal comfort and convenience items and services such as guest meals, television rental or barber services.
- Reimbursement for meal expenses incurred in connection with the transplant travel benefit.
- Medical or surgical treatment of excessive sweating (hyperhidrosis).
- Dental and orthodontia services, including braces, bridges, and guards, or X-ray exams involving one or more teeth, the tissue or structure around them, the alveolar process, or the gums. This applies even if a condition requiring any of these services involves a part of the body other than the mouth, such as the treatment of Temporomandibular Joint Disorders (TMJD) or malocclusion involving joints or muscles by methods including, but not limited to, crowning, wiring or repositioning teeth.

  This exclusion does not apply to services for treatment or removal of a malignancy; physicians' services or X-ray exams for treatment of accidental injury to natural teeth ("treatment" includes the replacement of those teeth), provided the participant is covered by the Plan, the accident occurred while covered, and the treatment is received within 12 months of the accident; or surgery on the maxilla or mandible that is Medically Necessary to correct TMJD or other medical disorders.
- Maintenance chiropractic care. However, non-maintenance chiropractic services are Covered Health Services when approved and received as described under "Chiropractic Care" in "What the In-Area HSA Medical Plan Covers" on page 197.
- Any services in connection with medical exams or tests not connected with the care and treatment of an actual illness, disease, or injury, except services that Anthem Blue Cross as Claims Administrator determines are standard preventive or well-care services (such as annual physical examinations, mammograms and colonoscopies) and that are provided in accordance with Anthem Blue Cross' guidelines. Diagnostic procedures are covered for the prenatal diagnosis of genetic disorders of the fetus when authorized by a preferred provider in the case of high-risk pregnancy.
- Services or supplies for or in connection with:
  - Exams to determine the need for (or changes of) eyeglasses or lenses of any type, except eye chart vision screening;
  - Eyeglasses or lenses of any type (except replacements for loss of the natural lens, or the initial pair of eyeglasses or contact lenses after eye surgery);
  - Eye surgery such as radial keratotomy or lasik surgery; or
  - Services for a surgical procedure to correct refraction errors of the eye, including any confinement, treatment, services or supplies given in connection with, or related to, the surgery.
- Services or supplies furnished by the employer or a member of the participant's immediate family.
- Services that do not meet the definition of Covered Health Services.
- Any services or supplies that are considered to be "experimental" or "investigational," as determined solely by Anthem Blue Cross. Experimental procedures are defined as procedures that are mainly limited to laboratory and/or animal research. Investigational services include any treatment, therapy, procedure, drug, facility, equipment, device or supply that is not recognized in accordance with generally accepted professional medical standards as being safe and effective for use in the treatment of an illness, injury or condition. Investigational services also include those which require approval by the federal government or any agency thereof, or by any state governmental agency, prior to use, and where such approval has not been granted at the time the services were rendered.

- Speech therapy that is not determined to be a Medically Necessary Covered Health Service, as determined solely by Anthem Blue Cross, including but not limited to treatment received after the first 24 visits in a calendar year that is deemed by Anthem Blue Cross to be not Medically Necessary.
- Physical and/or occupational therapy that is not determined to be a Medically Necessary Covered Health Service, as determined solely by Anthem Blue Cross, including but not limited to treatment received after the first 24 visits in a calendar year that is deemed by Anthem Blue Cross to be not Medically Necessary. For purposes of counting the first 24 visits each calendar year, both physical therapy and occupational therapy visits will apply on a combined basis.
- Massage therapy, if performed by a massage therapist, or any services performed by a massage therapist who is not also a physician or other approved health care provider (see the ***Definitions*** section). However, massage therapy performed by a physical therapist or chiropractor is covered, if deemed to be Medically Necessary by Anthem Blue Cross.
- Screenings to determine the need for hearing correction; routine hearing tests; and hearing aids and exams to determine the need for hearing aids or the need to adjust them. This exclusion does not apply to cochlear implants for adults and children (age 2 or older) for the following diagnoses: (1) severe to profound bilateral sensorineural hearing loss and severely deficient speech discrimination; or (2) post-lingual deafness in an adult.
- Any services or supplies for learning disabilities, behavioral problems, mental retardation, autistic disease of childhood, or hospitalization for environmental change; services and supplies in connection with mental, psychoneurotic, and personality disorders, or for abuse of or addiction to alcohol and drugs, unless such services and supplies are covered elsewhere by the Plan. This exclusion does not apply to services and supplies for medical detoxification.
- Any services or supplies furnished in connection with foot care, unless they are determined to be Medically Necessary Covered Health Services and ordered by your attending physician (whether preferred or non-preferred).
- Orthopedic shoes (except when joined to braces) or shoe inserts, such as orthotics, even if recommended by your physician.
- Charges in excess of Customary and Reasonable or Eligible Expenses, as determined by Anthem Blue Cross, or in excess of any specified limitation.
- Services or supplies that are not determined to be Covered Health Services, including any confinement or treatment given in connection with a service or supply that is not covered under the Plan.
- Exercise programs, exercise monitoring, exercise equipment, health spa programs and outpatient dietary consultations.
- Services or supplies primarily for weight reduction or treatment of obesity, unless they are determined to be Medically Necessary Covered Health Services and authorized by a preferred provider and Anthem Blue Cross. This exclusion will not apply to surgical treatment involving morbid obesity if:
  - surgical treatment of morbid obesity is necessary to treat another life-threatening condition involving morbid obesity, and
  - it has been documented that non-surgical treatments of the morbid obesity have failed, and
  - surgical treatment has been approved by Anthem Blue Cross.
- Heating pads and thermometers, and other over-the-counter products.
- Devices and computers to assist in communication and speech.
- Air purifiers, air conditioners and humidifiers.
- Supplies for comfort, hygiene or beautification.
- Services and supplies furnished in connection with injury or disease arising out of, or in the course of, any work for wage or profit (whether or not with the employer) if such injury or disease is covered by any Workers' Compensation law, occupational disease law or similar law. The Anthem Blue Cross In-Area HSA Medical Plan will provide services and supplies in connection with such injury or disease but will be entitled to reimbursement for them in accordance with rules set out in The Pacific Gas and Electric Company Health Care Plan for Active Employees Plan Document.

- Treatment for conditions caused by war or aggression, declared or undeclared, or international armed conflict.
- Services or supplies to the extent furnished by any law or government, unless required by law.
- Benefits provided under the "Medicare" section of the Social Security Act.
- Services and supplies for which coverage is available under any other Company-sponsored health plan or benefit program.
- Alternative treatments such as acupressure, aromatherapy, hypnotism, rolfing and other forms of alternative treatment, as defined by the Office of Alternative Medicine of the National Institutes of Health.
- Charges for failure to keep a scheduled appointment, transfer of medical records, and other similar charges for which no medical treatment or services have been provided.
- Services that are educational in nature, unless specifically authorized by Anthem Blue Cross.
- Except as otherwise provided herein for preventive and well-care exams and tests, any services in connection with medical exams not connected with the primary purpose of the discovery of a medical condition, disease or illness leading to treatment, such as a pre-employment medical exam or a team sports exam.
- Benefits provided under the extension of a benefits provision of other insurance policies, benefit plans, or health plan contracts.

See "Reductions/Exclusions for Duplicate Coverage" in the *Health Care Participation* section.

What Outpatient Prescription Drugs the Plan Does Not Cover

No benefit will be provided for any expense incurred for the following drugs, medicines, substances or supplies rendered, unless specifically listed as a benefit under What the Plan Covers. Ineligible drugs, medicines, substances and supplies include:

- Drugs, medicines, substances or supplies that are not Medically Necessary (see "Medically Necessary" in the *Definitions* section);
- Experimental and investigational drugs;
  - Experimental or investigational drugs are not covered under the In-Area HSA Medical Plan. These drugs are typically new products that are still being tested by the FDA and have not been approved for general distribution under the standard prescription process. Further, drugs that are limited by federal law to investigational use and that are labeled as such are not covered. A drug may also be considered experimental if prescribed for an indication or at a dosage that is not an accepted use based on published reports in standard drug publications such as the American Hospital Formulary Service Drug Information and the United States Pharmacopeia Dispensing Information.
- Drugs or supplies that may be dispensed without a prescription;
- Medications not used in accordance with the FDA's approval specifications;
- Inpatient medications (i.e., drugs dispensed or used while you are a patient in a licensed hospital, rest home, sanitarium, extended care facility, skilled nursing facility, convalescent home, nursing home, or similar institution);
- Retin-A (unless prescribed for medical treatment other than anti-aging or for individuals under age 26);
- Smoking deterrents other than those listed under "Prescription Drugs" on page 201;
- Allergy serums;
- Therapeutic devices or appliances;
- Drugs prescribed solely for cosmetic purposes (e.g., Renova) or to promote or stimulate hair growth (e.g., Rogaine);
- Immunization agents and vaccines;
- Biologicals, blood, or blood plasma;

- Charges for the administration or injection of a drug;
- Any prescription refill in excess of the number specified by the physician, or any refill after one year from the date of the physician's original order;
- Medications to which you are entitled under any Workers' Compensation or occupational disease law;
- Medication furnished by any other drug or medical service for which no charge is made to the participant; and
- Any drug for which benefits are paid under another Company-sponsored health plan or benefit program.

See "Reductions/Exclusions for Duplicate Coverage" in the *Health Care Participation*.

Third Party Exclusion

The Plan contains an exclusion for any injury, illness or other condition for which a third party may be liable or legally responsible by reason of negligence, intentional action or breach of legal obligation. These exclusions, limitations, and conditions are described under "If You Have Other Coverage" in the *Health Care Participation* section.

Claims and Appeals Process for Medical Benefits

This subsection describes the claims and appeals process for medical benefits, including mental health and substance abuse benefits, administered by Anthem Blue Cross in the In-Area HSA Plan. For outpatient prescription drug benefits, see "Claims and Appeals for Outpatient Prescription Drug Benefits" on page 218.

For information about claims and appeals regarding your eligibility to participate in The Pacific Gas and Electric Company Health Care Plan for Active Employees or to make election changes to your coverage under the Plans, see the *Health Care Participation* section.

Language Assistance

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

The Language Assistance Program makes it possible for you to access oral interpretation services and certain written materials vital to understanding your health coverage at no additional cost to you. Written materials available for translation include grievance and appeal letters, consent forms, claim denial letters, and explanations of benefits (EOBs). These materials are available in the following languages:

- Spanish
- Chinese
- Vietnamese
- Korean
- Tagalog

Oral interpretation services are available in additional languages.

To request a written or oral translation, please contact customer service by calling the phone number on your ID card to update your language preference to receive future translated documents or to request interpretation assistance.

Filing a Claim for Benefits

Anthem Blue Cross on behalf of Anthem Blue Cross Life & Health Insurance Company is the Claims Administrator for the In-Area Health Savings Account (HSA) Medical Plan sponsored by Pacific Gas and Electric Company. As the Claims Administrator, Anthem Blue Cross contracts with a network of providers and processes claims. Anthem Blue Cross pays the network providers directly for your Covered Health Services. You are responsible for paying coinsurance and/or deductibles to the network provider after Anthem Blue Cross processes your claim and you receive a bill from the provider. If a network provider bills you for a portion of any Covered Health Services that should have been covered by the Plan, contact Anthem Blue Cross at 800-964-0530.

When you receive Covered Health Services from a non-network provider, you are responsible for paying the provider up front and filing a claim with Anthem Blue Cross, even if your services were due to an emergency or because your network provider referred you to a non-network provider. You must file the claim in a format that contains all of the information required. Claim forms may be obtained by calling Anthem Blue Cross at 800-964-0530 or by accessing the Anthem Blue Cross Web site at www.anthem.com/ca/pge.

You must file a claim for payment of benefits within two years of the date of service. If a non-network provider submits a claim on your behalf, you will be responsible for the timeliness of the submission. If your claim relates to an inpatient hospital stay, the date of service is the date on which your inpatient stay ends. If you don't file a claim and provide all required information to Anthem Blue Cross of California within **two years** of the date of service, benefits for that health service will be denied. This time limit does not apply if you are legally incapacitated.

Required Information

When you request payment of benefits from Anthem Blue Cross, you must provide Anthem Blue Cross with all of the following information.

- The member's name and address.
- The patient's name, age, and relationship to the member.
- The member identification number and group number stated on your ID card.
- An itemized bill from your provider that includes the following:
  - Patient diagnosis;
  - Date(s) of service;
  - Procedure code(s) and description of service(s) rendered;
  - Charge for each service tendered; and
  - Provider name, address, and Tax Identification Number (TIN).
- The date on which the injury or sickness began.
- A statement indicating whether or not you are enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage, you must include the name(s) of the other carrier(s).

Send your claim to:

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

Payment of Benefits for Non-Network Benefits

Anthem Blue Cross will make a benefit determination on non-network services. Benefits will be paid directly to you, unless either of the following is true:

- The provider notifies the Claims Administrator that your signature is on file, assigning benefits directly to that provider; or
- You make a written request for the non-network provider to be paid directly at the time you submit your claim.

Anthem Blue Cross will not reimburse third parties who have purchased or who have been assigned benefits to physicians or other providers.

Benefit Determinations (Before an Appeal Is Filed)

There are various types of benefit claims. Each benefit claim can be categorized as a post-service, pre-service, urgent, or current claim. Depending on the type of the claim, Anthem Blue Cross must process your claim within different time-frames. The processing time frames for each type of claim are explained in this section.

Post-Service Claims

- Post-Service claims are those claims that are filed for payment of benefits after medical care has been received. If your post-service claim is denied, Anthem Blue Cross will send you a written response in the form of an Explanation of Benefits (EOB) within 30 days of receipt of the claim, provided that all required information was included with the claim. Anthem Blue Cross will notify you within this 30-day period if additional information is needed to process your claim, and may request a one-time extension of no longer than 15 days and pend your claim until all required information is received.
- If notified that an extension is necessary due to incomplete claim information, you will have 45 days to provide the required information to Anthem Blue Cross. If all of the required information is received within the 45-day time-frame and the claim is then denied, Anthem Blue Cross will notify you of the denial within 15 days of receipt of the additional information. If you do not provide the needed information within the 45-day period, your claim will be denied.
- If your claim is denied, the denial notice – typically an Explanation of Benefits statement – will explain the reason(s) for the denial, refer to the Plan provision(s) on which the denial is based, and provide procedures on how to appeal the claim.

Pre-Service Claims

Pre-Service claims are those claims for services that require notification or approval prior to receiving the services. Requests for pre-service claims that are not urgent may be requested by the *network provider* by calling 800-274-7767 or by submitting the request in writing to:

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

If your claim is a pre-service claim and was submitted properly with all the required information, Anthem Blue Cross will send you and your network provider written notice of its claim decision within 15 days of receipt of the claim. If you file a pre-service claim improperly, Anthem Blue Cross will notify you and the network provider that the claim was improperly filed within five days of receiving the pre-service claim and will give you information on how to correct it. If additional information is needed to process the pre-service claim, Anthem Blue Cross will notify you within 15 days of receipt of the claim that additional information is needed, and may request a one-time extension of no longer than 15 days and pend your claim until all required information is received.

If notification of an extension is necessary due to incomplete claim information, you will have 45 days to provide the required information to Anthem Blue Cross. If all of the required information is received within the 45-day time-frame, Anthem Blue Cross will notify you of its determination within 15 days of receipt of the additional information. If you don't provide the required information within the 45-day period, your claim will be denied.

If your claim is denied, the denial notice will explain the reason(s) for the denial, refer to the Plan provision(s) on which the denial is based, and provide procedures on how to appeal the claim.

Urgent Claims that Require Immediate Action

Urgent care claims are those claims (1) that require notification or approval prior to receiving medical care, and (2) where a delay in treatment could jeopardize your life, health, or the ability to regain maximum function or, in the opinion of a physician with knowledge of your medical condition, could cause severe pain. In these situations, you or your network provider may submit your request in writing to Anthem Blue Cross or call Anthem Blue Cross at 800-274-7767. After Anthem Blue Cross receives the request, you will receive a response as follows:

- You and your network provider will receive notice of the benefit determination in writing or by telephone within 72 hours of Anthem Blue Cross' receipt of all necessary information, taking into account the seriousness of your condition. Notice of denial may be oral with a written confirmation to follow within three days.
- If you file an urgent care claim improperly, Anthem Blue Cross will notify you or your network provider within 24 hours of receiving the urgent claim that the claim was improperly filed and will give you information on how to correct it. If additional information is needed to process the claim, Anthem Blue Cross will notify you or your network provider of the information needed within 24 hours of receiving the claim. You will have 48 hours to provide the requested information.

You and your network provider will be notified of Anthem Blue Cross' determination no later than 48 hours after:

- Anthem Blue Cross' receipt of the requested information; or
- The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that timeframe.

If your claim is denied, the notice of the denial will explain the reason(s) for the denial, refer to the Plan provision(s) on which the denial is based, and provide procedures on how to appeal the claim.

Concurrent Care Claims

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and you or your network provider requests to extend the treatment as an urgent care claim, Anthem Blue Cross will make a determination on your request within 24 hours of receiving your request, provided your request is made at least 24 hours prior to the end of the approved treatment. If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an urgent care claim and handled according to the described time-frames.

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and you or your network provider requests to extend treatment in a non-urgent circumstance, your request will be considered a new claim and decided according to post-service or pre-service time-frames, whichever applies.

Concurrent claims that are considered urgent may be submitted in writing or by calling Anthem Blue Cross at 800-274-7767. Non-urgent claims may also be submitted in writing to:

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

To Resolve a Problem

Anthem Blue Cross has established a complaint resolution and grievance process to resolve members' problems or complaints. If you or a covered dependent has a question, problem, or complaint, you should call 800-964-0530 or write to the following address:

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

If your question or concern is about a benefit determination, you should typically contact Member Services before filing a formal appeal. If the Member Services representative cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing or file an appeal. If you wish to file an appeal, you should contact Customer Service again and state that you would like to file an appeal. You may also send your written appeal to Anthem Blue Cross at the following address:

Anthem Blue Cross
P.O. Box 4310
Woodland Hills, CA 91365-4310

If you are appealing a pre-service urgent care claim denial, please refer to Urgent Claims that Require Immediate Action, earlier in this section, and contact Member Services at 800-964-0530 immediately. The Member Services telephone number is also shown on your ID card. Member Services representatives are available to take your call during posted business hours, Monday through Friday.

Appeals

How to Appeal a Claim Decision — Non-Urgent

If you still disagree with a claim determination after following the steps for filing a claim, you can contact Anthem Blue Cross in writing to formally appeal the claim. If the appeal relates to a claim for payment, your request should include:

- The patient's name and the identification number from your ID card;
- The date(s) of medical service(s);
- The provider's name;
- The reason you believe the claim should be paid; and
- Any document or other written information to support your request for claim payment.

Send your appeal to:

Anthem Blue Cross
P.O. Box 4310
Woodland Hills, CA 91365-4310

Your first request to appeal the claim must be submitted to Anthem Blue Cross within 180 days of your receipt of the claim denial.

Appeals Process

Two levels of appeals are provided for each claim. In each appeal step, a qualified individual who was not involved in an earlier denial of your claim will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be conducted by a health care professional who has appropriate expertise in the specific clinical area and who was not involved in any prior determination. Anthem Blue Cross may consult with, or seek the participation of medical experts as part of the appeal resolution process. If applicable, you must consent to this referral and the sharing of pertinent medical claim information to continue the appeal process. You may request, at no cost, to have access to and copies of all documents, records, and other information relevant to your claim for benefits.

To initiate a second appeal, you must repeat the same steps as your first claim appeal. Your second-level appeal must be submitted to Anthem Blue Cross within 60 days of your receipt of Anthem Blue Cross' first-level appeal denial.

Appeals Determinations

Pre-Service and Post-Service Claim Appeals

You and your network provider will be provided written notification of Anthem Blue Cross' decision on your appeal as follows:

- For appeals of **pre-service claims,** Anthem Blue Cross will conduct the first-level review and notify you of its decision within 15 days of receipt of your request to appeal the denied claim. If your first-level appeal is denied, you may request a second-level appeal review within 60 days of the date on which your first-level appeal was denied. If you request a second-level appeal review, Anthem Blue Cross will also conduct this review and notify you of its decision within 15 days of receipt of your request for a second-level appeal review.
- For appeals of **post-service claims,** Anthem Blue Cross will conduct the first-level review and notify you of its decision within 30 days of receipt of your request to appeal the denied claim. If your first-level appeal is denied, you may request a second-level appeal review within 60 days of the date on which your first-level appeal was denied. If you request a second-level appeal review, Anthem Blue Cross will also conduct this review and notify you of its decision within 30 days of receipt of your request for a second-level appeal review.

Please note that Anthem Blue Cross' decision is based only on whether or not benefits are Covered Health Services, as defined by the appropriate medical plan. The determination as to whether the health service is necessary or appropriate is between you and your physician.

Urgent Claim Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly jeopardize your life, health or the ability to regain maximum function, or cause severe pain. In these urgent situations:

- Your appeal does not need to be submitted in writing. You or your physician should call Anthem Blue Cross at 800-274-7767 as soon as possible. Anthem Blue Cross will provide you with a written or oral determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.
- To initiate a second appeal, you must follow the same steps as outlined above under "How to Appeal a Claim Decision — Non-Urgent" or as described under "Urgent Claim Appeals that Require Immediate Action." Your second-level appeal must be submitted to Anthem Blue Cross within 60 days of your receipt of Anthem Blue Cross's first-level appeal decision.

PG&E's Voluntary Review Process

If you are not satisfied with the claims and appeals process completed with Anthem Blue Cross, you may elect to either use PG&E's Voluntary Review Process or elect to bring a civil action. You have 90 days from the date of receipt of the final decision from Anthem Blue Cross to elect this voluntary review. Initiation of the Voluntary Review Process does not restrict your ability to bring a civil action against the Plan.

Step 1

The first step of the Voluntary Review Process is to write to the Benefits Department, requesting a review of your appeal. Your appeal should include all pertinent documentation. To expedite processing, you should also include a HIPAA AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION form. You can access a copy online from the **Human Resources Forms** section of the PG&E@Work intranet or by calling the HR Service Center at Company extension 8-223-4357, externally at 415-973-HELP (415-973-4357) or toll-free at 800-788-2363.

Send your appeal to:

Pacific Gas and Electric Company
Benefits Department
Appeals — Step One
1850 Gateway Blvd, 7th Floor
Concord, CA 94520

The PG&E Benefits Department will review your appeal and make a decision within 60 days of the date on which the appeal is received (non-receipt of the HIPAA Authorization form may delay your appeal). There may be special circumstances where an extension of up to 90 days may be required. You will be notified if such an issue occurs.

If your claim deals with specific medical issues, the Benefits Department may suggest that your claim be submitted to an External Review Program as part of the first step of the Voluntary Review Program. The External Review Program entails having an independent third party review the claim in question. This program only applies if the decision is based on either of the following:

- clinical reasons such as previous denials for medical necessity, custodial care or cosmetic services; or
- the exclusions for Experimental or Investigational Services.

The External Review Program is not available if the coverage determinations are based on explicit benefit exclusions or defined benefit limits. The External Review Program is optional, and its costs are paid by the Plan. If the External Review Program recommends that the claim be covered, the Benefits Department will instruct the Claims Administrator to abide by the recommendation of the External Review Program.

If the Benefits Department denies your claim, you will receive a written response that will include:

- the reason(s) for the denial;
- a reference to the Plan provision(s) that apply to the denial; and
- an explanation of additional appeals procedures.

Step 2

If the first step of the Voluntary Review Process results in a denial of your appeal, you may proceed to the second step of the process. The second step of the Voluntary Review Process is to submit your appeal to an independent neutral third party for review. The third-party reviewer will be selected from a predetermined panel of arbitrators familiar with benefits law. You have the option of submitting the same written appeal prepared for Step One or may choose to supplement the Step One write-up with additional written material. The neutral third party will issue a written decision within 45 days of receipt of the appeal documentation. The neutral third party's decision shall be final and binding on the Plan, but not on you.

You have 60 days from receipt of a denied appeal in Step One to exercise your right to initiate the second step of the Voluntary Review Process. Send your written appeal with any additional information to:

Pacific Gas and Electric Company
Benefits Department
Appeals — Step Two
1850 Gateway Blvd., 7th Floor
Concord, CA 94520

If you are not satisfied with the decision resulting from Step Two of the Voluntary Review Process, you may bring a civil action under Section 502(a) of ERISA.

If you would like more information regarding the Voluntary Review Process, call the HR Service Center at Company extension 8-223-4357, externally at 415-973-HELP (415-973-4357) or toll-free at 800-788-2363.

Requirement to File First- and Second-Level Appeals Before Filing a Lawsuit

You must exhaust all mandatory Anthem Blue Cross appeals before you may bring a civil action under Section 502(a) of ERISA. You do not have to pursue the PG&E Voluntary Review Process.

Claims and Appeals for Outpatient Prescription Drug Benefits

For information about claims and appeals regarding your eligibility to participate in The Pacific Gas and Electric Company Health Care Plan for Active Employees or to make election changes to your coverage under the Plan, see the *Health Care Participation* section.

Claims and Inquiries

Medco is the Claims Administrator for the prescription drug benefits provided by the HSA Medical Plans. Through Medco, a network of retail pharmacies is available as well as mail-order prescription drug coverage. When you go to a participating retail pharmacy, simply present your identification card and pay the appropriate coinsurance.

If you use a non-participating pharmacy, you will be responsible for paying the full cost of the prescription to the pharmacist, and then filing a claim for reimbursement. Claim forms are available by calling Medco at 800-718-6590 or at Medco's website at www.medcohealth.com.

In accordance with federal law, all claims for prescription drugs, except controlled substances, must be made within twelve months of the date on which the prescription was written by the physician. If you do not file a claim within this timeframe, your claim will be denied. Federal law also requires that all claims for controlled substances must be made within six months of the date on which the prescription was written by the physician.

If you have an issue or complaint regarding your prescription drug benefits, you should first address your concerns with Medco within 60 days after the issue or complaint arises. Many problems, complaints, and potential claim issues can be resolved informally. You can address these informal complaints by phoning Medco at 800-718-6590. Medco may ask you to provide additional information or ask your physician to do so, or may try to clarify any information already provided. Medco will research your issue and respond to you on its findings either in writing or by telephone within 15 days for prescriptions that have not been filled, and within 30 days for prescriptions that have already been filled and paid for.

Appeals

Pre-Service Denials — Non-Urgent

If a pharmacist will not fill your prescription and your situation is not urgent, it is recommended that you first try to resolve the situation informally as previously described. However, if you are not satisfied with the initial resolution or you believe that you have received some type of adverse benefit determination that is preventing you from filling a prescription, you or your authorized representative (such as your physician) can appeal the benefit denial/determination in writing within 180 days of receipt of the denial or adverse determination. Your appeal must be in writing and must include the following information: your name, member ID, phone number, the prescription drug for which benefit coverage has been denied, and any additional information that may be relevant to your appeal. The appeal should be sent to:

Medco Health Solutions, Inc.
Attention: Coverage Appeals
P.O. Box 631850
Irving, Texas 75063-0030

A decision notice will be mailed to you within 15 days of receipt of your appeal. The notice will include the specific reason(s) for the decision and the Plan provision(s) on which the decision was based. You have the right to receive, upon request only and at no charge, the information used to review your appeal.

If you are not satisfied with Medco's decision, you have 90 days from the date of your receipt of the decision notice to request a second-level of appeal. To initiate a second-level of appeal, you must submit the appeal in writing to Medco's address. A decision will be made regarding your request and will be sent to you within 15 days of Medco's receipt of the request. A qualified individual who was not involved in the review of your original appeal will review your appeal. If, at this point, your appeal is denied, you can initiate PG&E's Voluntary Review Process or you can bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974 ("ERISA").

Initiation of the Voluntary Review Process does not restrict your ability to bring a civil action against the Plan.

Pre-Service Appeal — Urgent

If a pharmacist will not fill your prescription as desired and your situation is urgent, you may request an expedited review by calling Medco at 800-753-2851. In cases of an appeal for coverage involving urgent care, you will be notified of the benefit determination within 72 hours of Medco's receipt of the appeal. An urgent appeal is any claim for treatment with respect to which the application of the time periods for a non-urgent care determination could seriously jeopardize the life or health of the claimant or the claimant's ability to regain maximum function or, in the opinion of a physician with knowledge of the claimant's medical condition, could subject the claimant to severe pain that cannot be adequately managed. You or your physician may submit an urgent appeal by phone or in writing. If the appeal does not contain sufficient information to determine whether benefits are covered, you will be notified of the missing information within 24 hours of Medco's receipt of your appeal. You will then have 48 hours to provide the missing information to Medco and will be notified by phone or in writing of Medco's decision within 48 hours of receipt of the information. All written appeals must be sent to:

Medco Health Solutions, Inc.
Attention: Coverage Appeals
P.O. Box 631850
Irving, Texas 75063-0030

If, at this point, your appeal is denied, you can initiate PG&E's Voluntary Review Process or you have the right to bring a civil action under Section 502(a) of ERISA.

Post-Service Appeals

If you paid for your prescription and believe that your level of coverage was incorrect, you can try to resolve this issue informally, as described previously under CLAIMS AND INQUIRIES. If this approach is unsatisfactory, you or an authorized representative, such as your physician, may appeal the decision in writing within 180 days of your receipt of the claim processing determination (e.g., pharmacy receipt). Your appeal must be in writing and must include the following information: your name, member ID, phone number, the prescription drug for which the level of coverage appears incorrect, and any additional information that may be relevant to your appeal. The appeal should be sent to:

Medco Health Solutions, Inc.
Attention: Coverage Appeals
P.O. Box 631850
Irving, Texas 75063-0030

A decision notice will be mailed to you within 30 days of Medco's receipt of your appeal. The notice will include the specific reason(s) for the decision and a reference to the Plan provision(s) on which the decision was based. You also have the right to receive, only upon request and at no charge, the information that Medco used to review your appeal.

If you are not satisfied with the decision, you have 90 days from the date of your receipt of the notice to request a second-level of appeal. To initiate a second-level of appeal, you must submit the appeal in writing to Medco's address. A qualified individual who was not involved in the review of your original appeal will review your second appeal. A decision will be made regarding your request and will be sent to you within 30 days of Medco's receipt of your appeal. Medco's decisions are based only on whether or not a benefit is covered by the Plan.

If at this point your appeal is denied, you can initiate PG&E's Voluntary Review Process or you can bring a civil action under Section 502(a) of ERISA.

Initiation of the Voluntary Review Process does not restrict your ability to bring a civil action against the Plan.

PG&E's Voluntary Review Process

If you are not satisfied with the claims and appeals process completed with Medco, you may elect to use either PG&E's Voluntary Review Process or elect to bring a civil action. You have 90 days from the date of receipt of the final decision from Medco to elect this voluntary review. Initiation of the Voluntary Review Process does not restrict your ability to bring a civil action against the Plan.

Step 1

The first step of the Voluntary Review Process is to write to the Benefits Department, requesting a review of your appeal. Your appeal should include all pertinent documentation. To expedite processing, you should also include a HIPAA AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION form. You can access a copy online from the **Human Resources Forms** section of the PG&E@Work intranet or by calling the HR Service Center at Company extension 8-223-4357, externally at 415-973-HELP (415-973-4357) or toll-free at 800-788-2363.

Send your appeal to:

Pacific Gas and Electric Company Benefits Department
Appeals — Step One
1850 Gateway Blvd., 7th Floor
Concord, CA 94520

The Benefits Department will review your appeal and make a decision within 60 days of the date on which the appeal is received (non-receipt of the HIPAA Authorization form may delay your appeal). There may be special circumstances where an extension of up to 90 days may be required. You will be notified if such an issue occurs. If the Benefits Department denies your claim, you will receive a written response that will include:

- the reason(s) for the denial;
- a reference to the Plan provision(s) that apply to the denial; and
- an explanation of additional appeals procedures.

Step 2

If your appeal is denied, you may then request a Second-Level review by the Employee Benefit Appeals Committee (EBAC). To do so, you must submit a new appeal in writing within 60 days of the date on which you received the Step One denial. Your appeal should state the reason(s) for your appeal and should include all relevant documentation and information that supports your appeal. Unless there are special circumstances where an extension of up to an additional 90 days may be required, you shall receive EBAC's decision within 90 days of EBAC's receipt of the appeal.

Send your appeal to:

Pacific Gas and Electric Company Benefits Department
EBAC Appeals
1850 Gateway Blvd., 7th Floor
Concord, CA 94520

If EBAC denies your appeal, you will receive a written response which will include:

- the specific reason(s) for the denial;
- a reference to the specific Plan provision(s) on which the denial is based;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits; and
- a statement of your right to bring a civil action under section 502(a) of ERISA.