PERS Select

Basic Plan

Preferred Provider Organization

Evidence of Coverage

Effective January 1, 2016 – December 31, 2016

A Self-Funded Plan Administered Under the
Public Employees' Medical & Hospital Care Act (PEMHCA)

CalPERS

HOW TO REACH US

Important: For all members outside of the United States, contact the operator in the country you are in to assist you in making a toll-free number call.

CUSTOMER SERVICE

For medical claims status, claim forms, identification cards, benefit information, or the latest booklets, call or visit on-line:

Customer Service Department
Anthem Blue Cross
1-877-737-7776
1-818-234-5141 (outside the continental U.S.)
1-818-234-3547 (TDD)
Web site: www.anthem.com/ca/calpers

Please mail your correspondence and medical claims for services by Non-Preferred Providers to:

PERS Select Health Plan
Anthem Blue Cross
P.O. Box 60007
Los Angeles, CA 90060-0007

If you travel outside California, please see pages 19-20 for more information about the BlueCard Program Preferred Provider network.

UTILIZATION REVIEW SERVICES

To obtain Precertification for hospitalizations and specified services, call:

The Review Center
Anthem Blue Cross
1-800-451-6780
1-818-234-5141 (outside the continental U.S.)

Case Management Triage Line
1-888-613-1130

24/7 NurseLine

You can reach a specially trained registered nurse who can address your health care questions by calling 24/7 NurseLine at 1-800-700-9185. Registered nurses are available to answer your medical questions 24 hours a day, seven days a week. Be prepared to provide your name, the patient's name (if you're not calling for yourself), the Subscriber's identification number, and the patient's phone number.

PRESCRIPTION DRUG PROGRAM

For information regarding the Retail Pharmacy For information regarding the Retail Pharmacy Program or Mail Service Program, call or visit on-line:

CVS/caremark
1-877-542-0284 (worldwide)
1-800-863-5488 (TDD)
Web site: www.caremark.com/calpers

For information regarding Protected Health Information:

CVS/caremark
P.O. Box 6590
Lee's Summit, MO 64064-6590

ELIGIBILITY AND ENROLLMENT

For information concerning eligibility and enrollment, contact the Health Benefits Officer at your agency (active) or the California Public Employees' Retirement System (CalPERS) Member Account Management Division (retirees). You also may write:

Member Account Management Division
CalPERS
P.O. Box 942715
Sacramento, CA 94229-2715

Or call:

888 CalPERS (or **888**-225-7377)
(916) 795-3240 (TDD)

ADDRESS CHANGE

Active Employees: To report an address change, active Employees should complete and submit the proper form to their employing agency's personnel office.

Retirees: To report an address change, retirees may contact CalPERS by phone at **888 CalPERS** (or **888**-225-7377), or on-line at www.calpers.ca.gov, select **Forms & Publications Centers** (http://www.calpers.ca.gov/index.jsp?bc=/about/forms-pubs/home.xml) and print and submit Change of Address Form to:

Member Account Management Division
CalPERS
P.O. Box 942715
Sacramento, CA 94229-2715

PERS Select MEMBERSHIP DEPARTMENT

For direct payment of premiums, contact:

PERS Select Membership Department
Anthem Blue Cross
P.O. Box 629
Woodland Hills, CA 91365-0629
1-877-737-7776
1-818-234-5141 (outside the continental U.S.)

HOW TO REACH US

Important: For all members outside of the United States, contact the operator in the country you are in to assist you in making a toll-free number call.

PERS Select WEB SITE

Visit our Web site at:

www.calpers.ca.gov

FINDING A PROVIDER ON-LINE

To find a Preferred Provider on-line, log on to the website, www.anthem.com/ca/calpers. Click on "Find a Doctor". Select the Plan you have enrolled in or if you are looking for a provider outside of California, click on "BlueCard PPO". In the Provider Finder window, please select a "Provider Type" using the drop down menu. Depending on the type of provider you choose, the site may ask you to select a specialty. Please pick a specialty or a specialty closest to what you need or you may leave the selection as "No Preference" for a broader search range, then click "Next". In this window, you may either find a provider closest to your address or find a provider within the selected county. Once you've filled out the address or county, if you want, you may fine-tune your search by clicking on "Refine Search". Once you've made your choices, click on "View Results" and a list of Preferred Providers will be provided. In the Search Results window you have the option to either sort results by different fields or jump to pages sorted alphabetically by the physician's last name in the drop down menus. If you click on a provider name, it will show you the provider's information in detail as well as a map of the driving directions for that provider.

IMPORTANT INFORMATION

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

No person has the right to receive any benefits of this Plan following termination of coverage, except as specifically provided under the Benefits After Termination or Continuation of Group Coverage provisions in this Evidence of Coverage booklet.

Benefits of this Plan are available only for services and supplies furnished during the term the Plan is in effect, and while the benefits you are claiming are actually covered by this Plan. Benefits of this Plan are subject to change and an Addendum or a new Booklet will be issued for viewing and/or distributed to each Member affected by the change. The latest updated Addendum and/or Booklet can be obtained through the website at www.anthem.com/ca/calpers, or you can call Customer Service at 1-877-737-7776.

Reimbursement may be limited during the term of this Plan as specifically provided under the terms in this booklet. Benefits may be modified or eliminated upon subsequent years' renewals of this Plan. If benefits are modified, the revised benefits (including any reduction in benefits or the elimination of benefits) apply for services or supplies furnished on or after the effective date of modification. There is no vested right to receive the benefits of this Plan.

Claim information can be used by Anthem Blue Cross and CVS/caremark to administer the program.

24/7 NurseLine

Your Plan includes a 24-hour nurse assessment service to help you make decisions about your medical care. You can reach a specially trained registered nurse to address your health care questions by calling the 24/7 NurseLine toll free at **1-800-700-9185**. If you are outside of the United States, you should contact the operator in the country you are in to assist you in making the call. Registered nurses are available to answer your medical questions 24 hours a day, seven days a week. Be prepared to provide your name, the patient's name (if you're not calling for yourself), the Subscriber's identification number, and the patient's phone number.

The nurse will ask you some questions to help determine your health care needs.* Based on the information you provide, the advice may be to:

- Take care of yourself at home. A follow-up phone call may be made to determine how well home self-care is working.
- Schedule a routine appointment within the next two weeks, or an appointment at the earliest time available (within 24 hours), with your Physician. If you do not have a Physician, the nurse will help you select one by providing a list of Physicians who are Preferred Providers in your geographical area.
- Call your Physician for further discussion and assessment.
- Go to the emergency room in a Preferred Provider Hospital.
- Immediately call 911.

In addition to providing a nurse to help you make decisions about your health care, 24/7 NurseLine gives you free unlimited access to its AudioHealth Library, featuring recorded information on more than 100 health care topics. To access the AudioHealth Library, call toll-free 1-800-700-9185 and follow the instructions given.

* Nurses cannot diagnose problems or recommend specific treatment. They are not a substitute for your Physician's care.

ConditionCare and Pharmacy Advisor

Your Plan includes ConditionCare to help you better understand and manage specific chronic health conditions and improve your overall quality of life. ConditionCare provides you with current and accurate data about asthma, diabetes, heart disease, and vascular-at-risk conditions plus education to help you better manage and monitor your condition. ConditionCare also provides depression screening.

You may be identified for participation through paid claims history, hospital discharge reports, physician referral, or Case Management, or you may request to participate by calling ConditionCare toll free at **1-800-522-5560**. Participation is voluntary and confidential. These programs are available at no cost to you. Once identified as a potential participant, a ConditionCare representative will contact you. If you choose to participate, a program to meet your specific needs will be designed. A team of health professionals will work with you to assess your individual needs, identify lifestyle issues, and support behavioral changes that can help resolve these issues. Your program may include:

- Mailing of educational materials outlining positive steps you can take to improve your health; and/or
- Phone calls from a nurse or other health professional to coach you through self-management of your condition and to answer questions.

ConditionCare offers you assistance and support in improving your overall health. It is not a substitute for your Physician's care.

Pharmacy Advisor Condition Alerts

CVS/caremark's' Pharmacy Advisor Condition Alerts uses medical and pharmacy data to improve care on more than 100 conditions. Ongoing review identifies opportunities to help improve condition management through laboratory tests, medical exams and prescription claims. We provide prescriber communications and coordinated member letters to support the patient-physician relationship.

LANGUAGE ASSISTANCE PROGRAM

Anthem introduced its Language Assistance Program to provide certain written translation and oral interpretation services to 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. 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 Anthem Blue Cross Customer Service Department at 1-877-737-7776 to update your language preference to receive future translated documents or to request interpretation assistance.

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

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BENEFIT AND ADMINISTRATIVE CHANGES

The following is a brief summary of benefit and administrative changes that will take effect January 1, 2016. Be sure to refer to the PERS Summary of Benefits section beginning on page 3, Maximum Calendar Year Financial Responsibility section beginning on page 23, Medical and Hospital Benefits section beginning on page 33, Utilization Review section beginning on page 64, General Provisions section beginning on page 89, Outpatient Prescription Drug Program section beginning on page 94, and Outpatient Prescription Drug Exclusions beginning on page 103, for more information.

- **Maximum Calendar Year Medical Financial Responsibility** – Your Maximum Calendar Year Medical Financial Responsibility for Preferred Provider services is changed to $4,850 per Member and $9,700 per family.

INTRODUCTION

Welcome to PERS Select!

As a Preferred Provider Organization (PPO) plan, PERS Select allows you to manage your health care through the selection of physicians, hospitals, and other specialists who you determine will best meet your needs. By becoming familiar with your coverage and using it carefully, you will become a wise health care consumer.

Anthem Blue Cross establishes medical policy for PERS Select, processes medical claims, and provides the Preferred Provider network of physicians, hospitals, and other health care professionals and facilities. In California, providers participating in the Preferred Provider network are referred to as "Select PPO Preferred Providers." Anthem Blue Cross also has a relationship with the Blue Cross and Blue Shield Association, which allows you to access the nationwide BlueCard Preferred Provider network under this Plan when you are traveling or otherwise temporarily outside of California and require medical care.

Anthem Blue Cross' Review Center provides utilization review of hospitalizations, specified services, and outpatient surgeries to ensure that services are Medically Necessary and efficiently delivered.

24/7 NurseLine provides a toll-free phone line, where registered nurses are available to answer your medical questions 24 hours a day, seven days a week.

CVS/caremark provides prescription drug benefit management services for PERS Select. These services include administration of the Retail Pharmacy Program and the Mail Service Program; delivery of specialty pharmacy products such as biotechs and injectables; clinical pharmacist consultation; and clinical collaboration with your Physician to ensure you receive optimal total healthcare.

Please take the time to familiarize yourself with this booklet. As a PERS Select Member, you are responsible for meeting the requirements of the Plan. **Lack of knowledge of, or lack of familiarity with, the information contained in this booklet does not serve as an excuse for noncompliance.**

Thank you for joining PERS Select!

PERS Select SUMMARY OF BENEFITS

The following chart is only a summary of benefits under your PERS Select Plan. It does not include all the benefits covered under the Plan. Please refer to the Deductibles section beginning on page 22, and the Maximum Calendar Year Financial Responsibility section beginning on page 23 for an explanation of your financial responsibilities. Also please refer to the Medical and Hospital Benefits section beginning on page 33 and the Outpatient Prescription Drug Program section beginning on page 94 for specific information regarding all benefits covered under the Plan. Services and supplies that are not covered under the Plan are listed under Benefit Limitations, Exceptions and Exclusions beginning on page 69 and Outpatient Prescription Drug Exclusions beginning on page 103. It will be to your benefit to familiarize yourself with the rest of this booklet before you need services so that you will understand your responsibilities for meeting Plan requirements. Deductibles, Copayments and Coinsurance applied to any other CalPERS-sponsored health plan will not apply to PERS Select and vice versa. **Lack of knowledge of, or lack of familiarity with, this information does not serve as an excuse for noncompliance.**

Calendar Year Deductible

For each Plan Member **$500**

For each family **$1,000**

(See page 22 for services not subject to the Deductible.)

Emergency Room Deductible ..... **$50 per visit**

Emergency Room Deductible does not count toward and is independent of your Calendar Year Deductible. However, it does count toward your Maximum Calendar Year Medical Financial Responsibility. (Emergency Room Deductible does not apply if you are admitted to a Hospital for Outpatient medical observation or on an Inpatient basis immediately following emergency room treatment.)

Maximum Calendar Year Coinsurance Responsibility for Preferred Provider (PPO) Services

For each Plan Member **$3,000**

For each family **$6,000**

Maximum Calendar Year Medical Financial Responsibility for Preferred Provider (PPO) Services*

Includes Maximum Calendar Year Coinsurance Responsibility for Preferred Provider (PPO) Services

For each Plan Member..... **$4,850**

For each family **$9,700**

Important Note: In addition to the amounts shown below, you are required to pay any charges for services provided by a Non-Preferred Provider or an Other Provider which are in excess of the Allowable Amount, plus all charges for non-covered services.

Benefits	Covered Services	Portion of the Allowable Amount that Member Pays			Contact Review Center
		Preferred Provider Tier 1	Preferred Provider Tier 2	Non-Preferred Provider	
Ambulance p. 33-34	Air or ground ambulance services when Medically Necessary.	20%	Not applicable	20%	No
Ambulatory Surgery Center p. 34-35	Services in connection with Outpatient surgery. (Separately Billed Charges for Physician services in connection with Outpatient surgery at an Ambulatory Surgery Center, such as surgeon and surgical assistant, are covered as stated under the Physician Services benefit below and on page 55.)	20%	Not applicable	40% (maximum Plan payment $350 applies to facility charges)	No (unless listed on page 65)

PERS Select SUMMARY OF BENEFITS

Important Note: In addition to the amounts shown below, you are required to pay any charges for services provided by a Non-Preferred Provider or an Other Provider which are in excess of the Allowable Amount, plus all charges for non-covered services.

Benefits	Covered Services	Portion of the Allowable Amount that Member Pays			Contact Review Center
		Preferred Provider Tier 1	Preferred Provider Tier 2	Non-Preferred Provider	
Arthroscopy Services p. 35	Routine arthroscopy services will be limited to $6,000 per procedure if performed in an Outpatient Hospital Setting (see Hospital benefits – Outpatient services on page 50). No benefit limitation when performed at an Ambulatory Surgery Center. Please contact Customer Service and/or visit www.anthem.com/ca/calpers to locate an Ambulatory Surgery Center.	20% (maximum Plan payment of $6,000 applies to Outpatient Hospital Setting)	30% (maximum Plan payment of $6,000 applies to Outpatient Hospital Setting)	40% (maximum Plan payment of $6,000 applies to Outpatient Hospital Setting)	No
Autism Spectrum Disorder p. 36	Outpatient care	$20	Not applicable	40%	No
Bariatric Surgery p. 37-38	Bariatric Surgery only at Centers of Medical Excellence.	20%	Not applicable	20%	Yes
Cardiac Care p. 38	Hospital and professional services provided in connection with cardiac care.	20%	Not applicable	40%	Yes
Cataract Surgery* p. 39	Routine cataract surgery will be limited to $2,000 per procedure if performed in an Outpatient Hospital Setting (see Hospital benefits – Outpatient services on page 50). No benefit limitation when performed at an Ambulatory Surgery Center. Please contact Customer Service and/or visit www.anthem.com/ca/calpers to locate an Ambulatory Surgery Center.	20% (maximum Plan payment $2,000 applies to Outpatient Hospital Setting)	30% (maximum Plan payment $2,000 applies to Outpatient Hospital Setting)	40% (maximum Plan payment $2,000 applies to Outpatient Hospital Setting)	No
Chiropractic and Acupuncture p. 39	Services provided by a licensed chiropractor, certified acupuncturist or any other qualified Health Professional. Benefits are limited to 20 visits per Calendar Year for any combination of chiropractic and acupuncture services.	$15	Not applicable	40%	No
Christian Science Treatment p. 39	Outpatient treatment for a covered illness or injury when services are provided by a Christian Science Nurse, Christian Science Nursing Facility or Christian Science Practitioner.	20%	Not applicable	20%	No
Cleft Palate p. 40	Medically Necessary dental or orthodontic services that are an integral part of Reconstructive Surgery for cleft palate	20%	Not applicable	40%	No
Clinical Trails p. 40-41	Routine patient costs for an approved clinical trial.	20%	Not applicable	40%	Yes (Hospital Admissions only)

PERS Select SUMMARY OF BENEFITS

Important Note: In addition to the amounts shown below, you are required to pay any charges for services provided by a Non-Preferred Provider or an Other Provider which are in excess of the Allowable Amount, plus all charges for non-covered services.

Benefits	Covered Services	Portion of the Allowable Amount that Member Pays			Contact Review Center
		Preferred Provider Tier 1	Preferred Provider Tier 2	Non-Preferred Provider	
Colonoscopy Services p. 41-42	See colonoscopy services section on pages 41-42	No copay-preventive 20% diagnostic (maximum Plan payment of $1,500 applies to Outpatient Hospital Setting)	No copay-preventive 30% diagnostic (maximum Plan payment of $1,500 applies to Outpatient Hospital Setting)	40% (maximum Plan payment of $1,500 applies to Outpatient Hospital Setting)	No
Diagnostic X-ray/Laboratory p. 43	Outpatient diagnostic X-ray and laboratory services, including Pap tests and mammograms for treatment of illness.	20%	Not applicable	40%	No (unless listed on page 65)
Durable Medical Equipment p. 43-44	Rental or purchase of Durable Medical Equipment, including one pair of custom molded and cast shoe inserts per Calendar Year, and Outpatient Prosthetic Appliances, including one scalp hair prosthetic up to $350 per Calendar Year.	20%	Not applicable	40%	Yes (specific DME)
Emergency Care Services p. 44-45	Services required to relieve the sudden onset of severe pain or the immediate diagnosis and treatment of an unforeseen illness or injury which could lead to further significant Disability or death, or which would so appear to a prudent layperson. Note: Emergency room facility charges for non-Emergency Care Services are the Plan Member's responsibility. A $50 Emergency Room Deductible applies for covered emergency room charges unless admitted to the Hospital for Outpatient medical observation or on an Inpatient basis. If admitted to the Hospital for Outpatient medical observation or on an Inpatient basis, the $50 Emergency Room Deductible is waived.	20%	Not applicable	20%	Yes (Hospital Admissions only)
Family Planning p. 45	Services for voluntary sterilization and abortions.	20%	Not applicable	40%	No

PERS Select SUMMARY OF BENEFITS

Important Note: In addition to the amounts shown below, you are required to pay any charges for services provided by a Non-Preferred Provider or an Other Provider which are in excess of the Allowable Amount, plus all charges for non-covered services.

Benefits	Covered Services	Portion of the Allowable Amount that Member Pays			Contact Review Center
		Preferred Provider Tier 1	Preferred Provider Tier 2	Non-Preferred Provider	
Gender Reassignment Surgery* p. 46-47	Medically Necessary services for gender reassignment surgery				Yes
	Inpatient or Outpatient facility-based care	20%	30%	40%	
	Physician office visits	$20	Not applicable	40%	
Hearing Aid Services p. 47	Hearing evaluation and hearing aid supplies; visits for fitting, counseling, adjustment, and repair. Up to $1,000 every 36 months for a hearing aid(s).	20%	Not applicable	40%	No
Hip and Knee Joint Replacement Surgery p. 47-48	Hip and knee joint replacement surgery will be limited to $30,000 per procedure. Please contact Customer Service and/or visit www.anthem.com/ca/calpers to verify that the Hospital qualifies under the Hip and Knee Joint Replacement for Value Based Purchasing Design and will provide services within this limitation.	20%	30%	40%	Yes
Home Health Care p. 48	Medically Necessary Skilled Care, not Custodial Care, furnished by a Home Health Agency, up to 45 visits per Calendar Year.	20%	Not applicable	40%	Yes
Home Infusion Therapy p. 48-49	Pharmaceuticals and medical supplies.	20%	Not applicable	40%	Yes
	Skilled nursing visits in association with Home Infusion Therapy services (provided under the Home Health Care benefit).	20%		40%	No
Hospice Care p. 49-50	Hospice Care for the palliative treatment of pain and other symptoms associated with a terminal disease.	20%	Not applicable	20%	No
Hospital Inpatient p. 50	Room and board, general nursing care services, operating and special care room fees, diagnostic X-ray and laboratory services.	20%	30%	40%	Yes

PERS Select SUMMARY OF BENEFITS

Important Note: In addition to the amounts shown below, you are required to pay any charges for services provided by a Non-Preferred Provider or an Other Provider which are in excess of the Allowable Amount, plus all charges for non-covered services.

Benefits	Covered Services	Portion of the Allowable Amount that Member Pays			Contact Review Center
		Preferred Provider Tier 1	Preferred Provider Tier 2	Non-Preferred Provider	
Hospital Outpatient p. 50-51	Diagnostic, therapeutic and surgical services, including radiation therapy, chemotherapy treatments and kidney dialysis. Services and supplies for the following Outpatient surgeries are limited: - Services for colonoscopy will be limited to $1,500 per procedure. - Services for cataract surgery will be limited to $2,000 per procedure. – Services for arthroscopy will be limited to $6,000 per procedure.	20%	30%	40%	No (unless listed on page 65)
Maternity Care p. 51	Prenatal and postnatal care; deliveries, hospitalization and newborn nursery care.	20%	30%	40%	No
Mental Health Inpatient p. 52	Hospital/Physician services to stabilize an acute psychiatric condition.	20%	30%	40%	Yes
Outpatient p. 52-53	Medically Necessary treatment to stabilize an acute psychiatric condition.				Yes (Outpatient facility-based care only)
	Facility-based care.	20%	30%	40%	
	Physician office visits.	$20	Not applicable	40%	
Natural Childbirth Classes p. 53	Lamaze classes given by licensed instructors certified by ASPO/Lamaze Childbirth Educators.	Plan pays 50% of registration fee up to $50, whichever is less.			No
Occupational Therapy p. 53-54	Services provided by a licensed occupational therapist for an Acute Condition. Benefits are limited to a combined total of 24 visits per Calendar Year for physical and Occupational Therapy.	20%	Not applicable	20%	Yes (additional visits only)
Outpatient Cardiac Rehabilitation p. 53	Up to 40 visits per Calendar Year.	20%	Not applicable	40%	No
Outpatient Pulmonary Rehabilitation p. 54	Up to 30 visits per Calendar Year.	20%	Not applicable	40%	No

PERS Select SUMMARY OF BENEFITS

Important Note: In addition to the amounts shown below, you are required to pay any charges for services provided by a Non-Preferred Provider or an Other Provider which are in excess of the Allowable Amount, plus all charges for non-covered services.

Benefits	Covered Services	Portion of the Allowable Amount that Member Pays			Contact Review Center
		Preferred Provider Tier 1	Preferred Provider Tier 2	Non-Preferred Provider	
Physical Therapy p. 53-54	Services provided by a licensed physical therapist for an Acute Condition. Benefits are limited to a combined total of 24 visits per Calendar Year for physical and Occupational Therapy.	20%	Not applicable	40%	Yes (additional visits only)
Physician Services p. 55	Office visits, Outpatient Hospital visits and Outpatient Urgent Care visits. Note: The $20 Copayment applies to the charge for the Physician visit only.	$20 copay (office visit only)	Not applicable	40%	No
	Other services, including affiliated facility charges.	20%	Not applicable	40%	No
Preventive Care p. 56-57	Immunizations, periodic routine health exams, including well baby and well child care, and tests performed in connection with routine physicals and billed with a preventive care diagnosis.	No copay	Not applicable	40%	No
Reconstructive Surgery p. 57	Hospital and Physician services provided in connection with Reconstructive Surgery.	20%	30%	40%	Yes
Retail Health Clinic p. 57-58	Basic medical services and supplies provided by Physician assistants and/or nurse practitioners during an office visit in a Retail Health Clinic.	$20 copay (office visit only)	Not applicable	40%	No
	Other services, including affiliated facility charges	20%		40%	
Skilled Nursing and Rehabilitation Care p. 58	Medically Necessary Skilled Care, not Custodial Care, in a Skilled Nursing Facility, up to 100 days per Calendar Year.	20% for 1st 10 days 30% next 90 days	Not applicable	40% 40%	Yes Yes
Smoking Cessation Program p. 58	Behavior modifying smoking cessation counseling or classes or alternative treatments, such as acupuncture or biofeedback, for the treatment of nicotine dependency or tobacco use when not covered under benefits stated elsewhere in this Evidence of Coverage.	Plan pays 100% of program fee up to $100 per Calendar Year.			No

PERS Select SUMMARY OF BENEFITS

Important Note: In addition to the amounts shown below, you are required to pay any charges for services provided by a Non-Preferred Provider or an Other Provider which are in excess of the Allowable Amount, plus all charges for non-covered services.

Benefits	Covered Services	Portion of the Allowable Amount that Member Pays			Contact Review Center
		Preferred Provider Tier 1	Preferred Provider Tier 2	Non-Preferred Provider	
Speech Therapy p. 54-55	Services provided by a qualified speech therapist for a Medically Necessary condition up to 24 visits per Calendar Year.	20%	Not applicable	40%	Yes (additional visits only)
Substance Abuse Inpatient p. 58-59	Hospital/Physician services for short-term medical management of detoxification or withdrawal symptoms.	20%	30%	40%	Yes
Outpatient p. 59	Facility-based care of Medically Necessary treatment to stabilize an acute substance abuse condition.	20%	30%	40%	Yes (Outpatient facility-based care only)
	Physician office visits.	$20	Not applicable	40%	No
Telemedicine Program p. 60	Services provided by a Telemedicine Network Presentation Site or Specialty Center	$20 + 20% of all other charges			No
Transplant Benefits p. 60-63	Cornea and Skin — see page 60.	20%	30%	40%	Yes (skin only)
	Special Transplants only at Centers of Medical Excellence — see pages 60-63.	20%	Not applicable	20%	Yes
Unreplaced Blood	Unreplaced blood	20%	Not applicable	20%	No
Urgent Care p. 63	Outpatient Urgent Care visits to a Physician.	$20 copay (office visit only)	Not applicable	40%	No
	Note: The $20 Copayment applies to the charge for the Physician visit only. Other Physician services provided during the visit, such as lab work or sutures.	20%	Not applicable	40%	No

PERS Select SUMMARY OF BENEFITS

Prescription Drug Benefit	Participating Retail Pharmacy Copay (Short-term use Medications) CVS/caremark Specialty Pharmacy	Mail Service/Maintenance Choice® Copay CVS/caremark Mail Service/CVS pharmacy (long term use – Maintenance Medications See pages 98-100 for details.)
	For short-term use up to a 30-day supply	For Maintenance Medications up to a 90-day supply
Generic	$5	$10
Preferred Brand-Name Medications (on CVS/caremark's Preferred Drug List)	$20	$40
Non-Preferred Brand Name Medications (Not on CVS/caremark's Preferred Drug List)	$50	$100
Partial Copay Waiver of Non-Preferred Brand-Name Copayment (Partial Copay Waiver, see CVS/caremark's appeal process pages 105-107)	$40	$70
Erectile or Sexual Dysfunction Drugs (does not apply to the Maximum Calendar Year Pharmacy Financial Responsibility)	50%	50%
Member-Pays the Difference (MPD) (does not apply to the Maximum Calendar Year Pharmacy Financial Responsibility)	Member Pays the Difference (page 96)	Member Pays the Difference (page 96)

Please see page 24 for details on Maximum Calendar Year Pharmacy Financial Responsibility.

ELIGIBILITY AND ENROLLMENT

Eligibility and Enrollment

Information pertaining to eligibility, enrollment, and termination of coverage, can be obtained through the CalPERS website at www.calpers.ca.gov, or by calling CalPERS. Also, please refer to the CalPERS Health Program Guide for additional information about eligibility. Your coverage begins on the date established by CalPERS.

It is your responsibility to stay informed about your coverage. For an explanation of specific enrollment and eligibility criteria, for active Members please consult your Health Benefits Officer, for retired Members, the CalPERS Member Account Management Division at:

CalPERS
Member Account Management Division
P.O. Box 942715
Sacramento, CA 94229-2715
or call:
888 CalPERS (or 888-225-7377)
(916) 795-3240 9TDD)

Live/Work

If you are an active Employee or a working CalPERS Annuitant, you may enroll in the Plan using either your residential or work ZIP Code. When you become an Annuitant and are no longer working for any Employer, you must select a health plan using your residential ZIP Code.

If you use your residential ZIP Code, all enrolled dependents must reside in the Plan's service area. When you use your work ZIP Code, all enrolled dependents must receive all covered services (except emergency and Urgent Care) within the Plan's service area, even if they do not reside in that area.

MONTHLY RATES

State Employees and Annuitants

Type of Enrollment	Enrollment Code	Cost
Insured Only	0451	$649.76
Insured and One Dependent	0452	$1,299.52
Insured and Two or More Dependents	0453	$1,689.38

The rates shown above are effective January 1, 2016, and will be reduced by the amount the State of California contributes toward the cost of your health benefits plan. These contribution amounts are subject to change. Any such change will be accomplished by the State Controller or affected retirement system without action on your part. For current contract information, contact your employing agency's or retirement system's Health Benefits Officer.

Rate Change. The CalPERS Board of Administration reserves the right to change the rates set forth above, in its sole discretion, upon 60 days' written notice to Plan Subscribers.

Public Agency Employees and Annuitants

Bay Area Region. Counties of Alameda, Amador, Contra Costa, Marin, Napa, Nevada, San Francisco, San Joaquin, San Mateo, Santa Clara, Santa Cruz, Solano, Sonoma, Sutter, and Yuba.

Type of Enrollment	Enrollment Code	Cost
Insured Only	0721	$730.07
Insured and One Dependent	0722	$1,460.14
Insured and Two or More Dependents	0723	$1,898.18

Los Angeles Region. Counties of Los Angeles, San Bernardino, and Ventura.

Type of Enrollment	Enrollment Code	Cost
Insured Only	0801	$547.55
Insured and One Dependent	0802	$1,095.10
Insured and Two or More Dependents	0803	$1,423.63

MONTHLY RATES

Other Southern California Counties. Counties of Fresno, Imperial, Inyo, Kern, Kings, Madera, Orange, Riverside, San Diego, San Luis Obispo, Santa Barbara, and Tulare.

Type of Enrollment	Enrollment Code	Cost
Insured Only	0821	$625.20
Insured and One Dependent	0822	$1,250.40
Insured and Two or More Dependents	0823	$1,625.52

Other Northern California Counties. Counties of Alpine, Butte, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Lake, Lassen, Mariposa, Mendocino, Merced, Modoc, Mono, Monterey, Plumas, San Benito, Shasta, Sierra, Siskiyou, Stanislaus, Tehama, Trinity, and Tuolumne.

Type of Enrollment	Enrollment Code	Cost
Insured Only	0531	$727.47
Insured and One Dependent	0532	$1,454.94
Insured and Two or More Dependents	0533	$1,891.42

Sacramento Region. Counties of El Dorado, Placer, Sacramento, and Yolo.

Type of Enrollment	Enrollment Code	Cost
Insured Only	0531	$665.35
Insured and One Dependent	0532	$1,330.70
Insured and Two or More Dependents	0533	$1,729.91

Out-of-California. PERS Select is not available to out-of-state Employees and Annuitants.

The rates shown above are effective January 1, 2016, and will be reduced by the amount your public agency contributes toward the cost of your health benefits plan. This amount varies among public agencies. For assistance in calculating your net cost, contact your employing agency's or your retirement system's Health Benefits Officer.

Rate Change. The CalPERS Board of Administration reserves the right to change the rates set forth above, in its sole discretion, upon 60 days' written notice to Plan Subscribers.

PERS SELECT IDENTIFICATION CARD

Following enrollment in PERS Select, you will receive a PERS Select ID card. To receive medical services and prescription drug benefits as described in the Plan, please present your ID Card to each provider of service. If you need a replacement card or a card for a family member, call the Anthem Blue Cross Customer Service Department at 1-877-737-7776.

Possession of a PERS Select ID card confers no right to services or other benefits of this Plan. To be entitled to services or benefits, the holder of the card must be a Plan Member on whose behalf premiums have actually been paid, and the services and benefits must actually be covered and/or preauthorized as appropriate.

If you allow the use of your ID card (whether intentionally or negligently) by an unauthorized individual, you will be responsible for all charges incurred for services received. Any other person receiving services or other benefits to which he or she is not entitled, without your consent or knowledge, is responsible for all charges incurred for such services or benefits.

CHOOSING A PHYSICIAN/HOSPITAL

Your Copayment or Coinsurance responsibility will be lower and claims submission easier if you choose Preferred Providers for your health care. (For more information, see Maximum Calendar Year Medical and Pharmacy Financial Responsibility on pages 23-24, and Payment and Member Copayment And Coinsurance Responsibility beginning on page 25.) To receive the highest level of benefits available under this Plan, make sure the providers you are using are Preferred Providers.

The Preferred Provider network available to PERS Select Members in California is called Select PPO. Anthem Blue Cross has designated certain doctors in California as participating in the Select PPO Preferred Provider network. This statewide network includes over 27,000 physicians and 372 hospitals, in addition to many other types of health care providers.

To make sure you are using a Select PPO Preferred Provider, do the following:

1. Ask your Physician or provider if he or she is a Select PPO Preferred Provider and request their tax identification number (TIN).
2. Call Customer Services at 1-877-737-7776 to verify that the provider you want to use is a Select PPO Preferred Provider at the location where services are rendered along with the TIN used for billing purposes.
3. Access the Web site at **www.anthem.com/ca/calpers**.
4. Request a Select PPO Preferred Plan Directory by calling 1-877-737-7776.

For information about Preferred Providers outside of California, see Out-Of-State/Out-Of-Country BlueCard Program on pages 19-20.

For Inpatient and Outpatient Hospital services, there are two types of Select PPO Hospitals in the Preferred Provider network to choose from, Tier 1 and Tier 2 Hospitals. The type of Preferred Provider Hospital you choose will determine the benefit level payable under the Plan. By choosing a Tier 1 Preferred Provider, you will receive the highest level of benefits available under this Plan. For more information on whether the Preferred Provider Hospital that you or your provider are considering is a Tier 1 or Tier 2 Hospital in the Select PPO Preferred Provider network, please call Customer Service at 1-877-737-7776.

Changes frequently occur after the directories are published; therefore, it is your responsibility to verify that the provider you choose is still a Preferred Provider and that any providers you are referred to are also Preferred Providers. Check the Anthem Blue Cross Web site, www.anthem.com/ca/calpers, and call Customer Service at 1-877-737-7776 one week prior to your visit or procedure to confirm that the provider is a Preferred Provider.

ACCESSING SERVICES

Emergency Services

If you need emergency care, call your Physician or go to the nearest facility that can provide emergency care. Each time you visit a Hospital's emergency room for Emergency Care Services you will be responsible for paying a separate **$50** Emergency Room Deductible that will be subtracted from your covered charges. However, this Deductible will not apply if you are admitted to a Hospital either for Outpatient medical observation or on an Inpatient basis immediately following emergency room treatment. This Deductible does not apply to the Calendar Year Deductible. However, it does apply to the Maximum Calendar Year Medical Financial Responsibility.

If you are admitted to a Hospital following emergency room treatment, make sure that you, a Family Member, or a friend contact the Review Center at 1-800-451-6780 within 24 hours or by the end of the first business day following an Inpatient admission, whichever is later. Failure to notify the Review Center within the specified time frame may result in increased Coinsurance responsibility.

Non-Emergency Services

Before receiving non-emergency services, be sure to discuss the services and treatment thoroughly with your Physician and Other Provider(s) to ensure that you understand the services you are going to receive. Then refer to the Medical and Hospital Benefits section beginning on page 33 and the Benefit Limitations, Exceptions and Exclusions section beginning on page 69 to make sure the proposed services are covered benefits of this Plan. If you are still not sure whether the recommended services are benefits of this Plan, please refer to the inside front cover of this booklet for the appropriate number to call for assistance.

If Precertification by the Review Center is required, please refer to page 67 and remember to call the Review Center before services are provided to avoid increased Coinsurance responsibility on your part. **Do not assume the Review Center has been contacted — confirm with the Review Center yourself.**

Urgent Care Services

If you need Urgent Care (defined on page 117), call your Physician. If treatment cannot reasonably be postponed until the earliest appointment time available with your Physician, but your illness, injury or condition is not severe enough to require emergency care, Urgent Care can be obtained from any Physician. However, your financial expenses will be lower when covered services are provided by a Physician who is a Select PPO Preferred Provider in the urgent care network. Services received from a Select PPO Preferred Provider Physician participating in the urgent care network will, in most cases, save you money as compared to receiving the same services at a Hospital emergency room. Visit the Anthem Blue Cross Web site at www.anthem.com/ca/calpers or call 1-877-737-7776 to obtain a listing of Select PPO Preferred Providers in the urgent care network. Refer to page 63 for information on benefits for Physician services related to Urgent Care.

Medical Services

When you need health care, simply present your PERS Select ID card to your Physician, Hospital, or other licensed health care provider. Remember, your Copayment or Coinsurance responsibility will be lower if you choose a Preferred Provider.

Refer to page 17 for information on filing a medical claim.

Care After Hours

If you need care after your Physician's normal office hours and you do not have an emergency medical condition or need Urgent Care, please call your Physician's office for instructions.

ANTHEM BLUE CROSS

The benefits available through PERS Select depend on whether you and your family use Preferred Providers, except for emergencies.

Anthem Blue Cross has established and maintains a network of "Preferred Providers" throughout California. These providers participate in our preferred provider organization program (PPO), called the PERS Select Plan. They have agreed to accept payment amounts set by Anthem Blue Cross for their services. These "Allowable Amounts" are usually lower than what other Physicians and Hospitals charge for their services, so your portion of the charges, or your Copayment or Coinsurance, will also be lower.

The PERS Select Plan's Preferred Provider network also includes BlueCard Program participating providers for Members who are traveling or temporarily living outside California. The Blue Cross and Blue Shield Association, of which Anthem Blue Cross is a member/Independent Licensee, administers a program (called the "BlueCard Program") which allows our Members to have the reciprocal use of participating providers contracted under other states' Blue Cross and/or Blue Shield Plans. BlueCard Program participating providers are located throughout the United States. Preferred Providers (BlueCard Program participating providers) have agreed to accept Allowable Amounts set by their local Blue Cross and/or Blue Shield Plan as payment for covered services. See pages 19-20 for a further description of how the BlueCard Program works.

When you need health care, simply present your PERS Select ID card to your Physician, Hospital, or other licensed health care provider. Choosing Preferred Providers for your health care allows you to take advantage of the highest level of reimbursement. Prior to receiving services you should verify that the provider is a Preferred Provider, in case there have been any changes since your Preferred Provider directory was published.

Preferred Providers have agreed to accept the Plan's payment, plus applicable Member Deductibles and Copayments/Coinsurance, as payment in full for covered services. When you receive covered services from a Preferred Provider, the provider has agreed to submit a claim for payment directly, and the benefits of this Plan will be paid directly to the provider. This means you have no further financial responsibility, except for any Member Deductibles or Copayments that may apply, and therefore no claim forms to file.

If you go to a Non-Preferred Provider, payment for services may be substantially less than the amount billed. In addition to your Deductible and Coinsurance, you are responsible for any difference between the Allowable Amount and the amount billed by the Non-Preferred Provider. You will need to submit a claim if you received care from a Non-Preferred Provider.

Claims Submission

You will be reimbursed directly by PERS Select for covered services rendered by a Non-Preferred Provider. However, Non-Preferred Providers and Other Providers of service may be paid directly when you assign benefits in writing. Hospital charges are generally paid directly to the Hospital.

Claims for payment must be submitted to Anthem Blue Cross within 90 days after the date of the medical service, if reasonably possible, but in no event, except for the absence of legal capacity, may claims be submitted later than 15 months from the date of service or payment will be denied.

Each claim submission must contain the following:

- Subscriber's name
- Subscriber ID / Member number
- Group number
- Patient's name
- Patient's date of birth
- Patient's date of injury/illness or onset of illness or pregnancy
- Date(s) of service
- Diagnosis
- Type(s) of service
- Provider's name & tax ID number
- Amount charged for each service
- Patient's other insurance information
- For Members with Medicare — the Medicare ID number & the Medicare effective date

In addition, a copy of the provider's billing (showing the services rendered, dates of treatment, patient's name, relationship to the Plan Member, and provider's signature or ID number) must be included. Your PERS Select ID card has your Member ID and group numbers on it.

See the first page of this booklet, under How To Reach Us, for information on obtaining and submitting claim forms.

SERVICE AREAS

This section applies ONLY to Members who live or work in one of the qualifying Out-of-Area Zip Codes listed below.

PERS Select has established geographic service areas to determine the percentage of reimbursement for covered medical and Hospital services. The benefits available through PERS Select depend on whether you and your Family Members use Preferred Providers, and whether you are in-area or Out-of-Area. To determine if your provider is in-area or Out-of-Area, contact Customer Services at 1-877-737-7776. Reimbursement for covered services also depends on whether you are in-area or Out-of-Area.

If you must travel more than 50 miles from your home or work to the nearest Anthem Blue Cross Select PPO Preferred Provider, you are considered to be outside the PERS Select service area (Out-of-Area). Out-of-Area medical and Hospital services are reimbursed at the Preferred Provider level, based on Anthem Blue Cross' Allowable Amounts.

When a Preferred Provider is not available within a 50-mile radius of your residence or workplace, you must obtain an Authorized Referral prior to receiving services by a Non-Preferred Provider in order for that service to be paid at the Preferred Provider percentage of the Allowed Amount. To obtain an Authorized Referral, you or your Physician must call Customer Service at 1-877-737-7776 at least 3 business days prior to scheduling an admission to, or receiving the services of, a Non-Preferred Provider. If you have received an Authorized Referral, your claim will automatically be paid at the Preferred Provider percentage of the Allowed Amount. You are responsible to pay the remaining percentage and any charges in excess of the Allowable Amount, plus all charges for non-covered services. If the service you will receive from a Non-Preferred Provider requires Precertification, you will need to obtain Precertification from the Review Center in addition to the Authorized Referral. See page 65 for a list of services requiring Precertification. For Precertification contact the Review Center at 1-800-451-6780.

If an Authorized Referral is **NOT** obtained prior to services being provided, your claim will automatically be paid at the Non-Preferred Provider level. Upon receipt of your Explanation of Benefits (EOB), contact Customer Service at 1-877-737-7776 to request that your claim be reprocessed at the Preferred Provider level. You are responsible to pay the remaining percentage and any charges in excess of the Allowable Amount, plus all charges for non-covered services.

If your address of record indicates that you live or work within a PERS Select service area (in-area) but you choose to receive services Out-of-Area (outside a 50-mile radius from your home or workplace) by a Non-Preferred Provider, benefits will be reimbursed at the Non-Preferred Provider level.

Using the criteria explained above, the following California ZIP Codes will be considered qualifying "Out-of-Area" zip codes for reimbursement of covered medical and Hospital services.

COUNTIES	ZIP CODES
Humboldt	95556
Inyo	92328, 92384, 92389, 93513, 93514, 93515, 93522, 93526, 93530, 93545, 93549
Modoc	96108
Mono	93512, 93517, 93529, 93541 93546, 96107, 96133
Riverside	92239
San Bernardino	92242, 92267, 92280, 92309, 92319, 92323, 92332, 92364, 92366, 93562
Siskiyou	95568, 96023, 96039, 96058 96086, 96134

If you are traveling or otherwise temporarily outside California and require medical care or treatment, you may access Preferred Providers through the BlueCard Program. For additional information about the BlueCard Program, see pages 19-20.

To find out if you are considered Out-of-Area, please call Customer Service at 1-877-737-7776.

OUT-OF-STATE/OUT-OF-COUNTRY BLUECARD PROGRAM

What Is BlueCard?

BlueCard is a national program that allows PERS Select Basic Plan Members access to Blue Cross and/or Blue Shield Preferred Providers currently in 41 Blue Cross and/or Blue Shield Plans across the country. The BlueCard Program is administered by the national Blue Cross and Blue Shield Association, of which Anthem Blue Cross is a member/Independent Licensee.

Understanding BlueCard

Anthem Blue Cross has a relationship with the Blue Cross and Blue Shield Association which administers the BlueCard Program. The BlueCard Program allows PERS Select Members who are traveling or otherwise temporarily outside California and require medical care or treatment to use local Blue Cross and/or Blue Shield Plan participating providers throughout the United States.

Through the BlueCard Program, you have access to more than 550,000 physicians and over 61,000 hospitals nationwide participating in the Blue Cross and/or Blue Shield network of Preferred Providers.

To locate a Blue Cross and/or Blue Shield Plan participating provider, you may:

- Call the toll-free BlueCard Provider Access number at 1-800-810-BLUE (1-800-810-2583).
- Ask your Physician or provider if he or she participates in the local Blue Cross and/or Blue Shield Plan.
- Access the Blue National Doctor and Hospital Finder using the Find a Doctor or Hospital link on the Blue Cross and Blue Shield Association Web site at www.bcbs.com.
- Request a Preferred Provider directory by calling 1-877-PERS-PPO (1-877-737-7776).

Who Has BlueCard Program Preferred Provider Access?

All Members with PERS Select Basic Plan coverage have BlueCard Program Preferred Provider access. BlueCard Program Preferred Providers will identify you as a BlueCard Member by the small black suitcase logo containing the letters "PPO" on the front of your ID card.

When May I Access BlueCard Program Preferred Providers?

PERS Select Members may use local Blue Cross and/or Blue Shield Plan participating providers when needing medical care or treatment outside of California at any time.

How Do I Use BlueCard?

You can locate the names and phone numbers of Preferred Providers in the area that can provide you care or, if you need to inquire whether the Physician or facility you are planning to use is a Preferred Provider, use the resources as explained above under Understanding BlueCard. When you present your PERS Select ID card to a BlueCard Preferred Provider, the provider verifies your membership and coverage by calling the Customer Service number printed on the front of your ID card.

When you get covered health care services through the BlueCard Program, the amount you pay for covered services is calculated on the lower of the:

- The Billed Charges for your covered services; or
- The negotiated price that the local Blue Cross and/or Blue Shield Plan passes on.

This “negotiated price” is calculated in one of three ways: 1) a simple discount that reflects the actual price the local Blue Cross and/or Blue Shield Plan pays; 2) an estimated price that takes into account special arrangements with the provider or a provider group that include settlements, withholds, non-claims transactions and other types of variable payments; and 3) an average price, based on a discount that results in expected average savings after taking into account the same special arrangements used to obtain an estimated price. Average prices tend to vary more from actual prices than estimated prices.

Negotiated prices may be adjusted going forward to correct for over- or underestimation of past prices. However, the amount you pay is considered a final price.

Laws in a small number of states may require the local Blue Cross and/or Blue Shield Plan to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, your liability for any covered health care services would then be calculated according to the applicable state statute in effect when you received care.

How Does BlueCard Program Claim Filing Work?

The BlueCard Program Preferred Provider will file your claim with the local Blue Cross and/or Blue Shield Plan. The local Blue Cross and/or Blue Shield Plan transmits the claim electronically to Anthem Blue Cross. Anthem Blue Cross applies PERS Select benefits, electronically transmits the approved payment amount back to the provider's local Blue Cross and/or Blue Shield Plan, and then sends you an Explanation of Benefits (EOB). The local plan sends payment and an EOB to the provider. If Non-Preferred Providers are used, the Member or provider needs to submit the claim to Anthem Blue Cross. See page 17 for additional information on claims submission.

What If I Use Out-of-Network Providers?

Benefits are paid at the Non-Preferred Provider reimbursement level unless:

- You require Emergency Care Services.
- There are no Preferred Providers available. Call 1-800-810-BLUE (1-800-810-2583) to verify whether there are any Preferred Providers available to you BEFORE you receive services.

Members and/or out-of-network providers must submit claims for services delivered by out-of-network providers directly to the local Blue Cross and/or Blue Shield Plan, using a claim form.

For more information, please see the Payment and Member Copayment And Coinsurance Responsibility section beginning on page 25.

What Is BlueCard Worldwide And How Does It Work?

The BlueCard Worldwide Program assists you in finding Hospitals available to you in major international travel destinations. When you need Inpatient Hospital care outside the United States, simply present your PERS Select ID card at a participating Hospital. The Hospital will send a claim to Anthem Blue Cross and will charge you only the appropriate Copayment/Coinsurance or Deductible amounts. You may obtain a brochure containing further information, including how to locate participating Hospitals, by calling the Customer Service telephone number printed on the front of your ID card. You may also call the BlueCard Worldwide Service Center at 1-800-810-BLUE (1-800-810-2583) or access the Blue National Doctor and Hospital Finder using the Find a Doctor or Hospital link on the Web site at www.bcbs.com to locate a participating Hospital in the country you are visiting. Claims will be accepted for U.S. residents who are traveling in foreign countries for urgent or emergent care only. Claims for elective procedures will not be reimbursed. Members who temporarily reside in foreign countries may submit claims for routine, elective procedures, urgent and emergent care to Anthem Blue Cross. See Submitting Foreign Claims below for information on foreign claims submission.

Submitting Foreign Claims

Foreign Medical Claims: The benefits of this Plan are provided anywhere in the world. With the exception of services provided by a Hospital participating in the BlueCard Worldwide Network (see paragraph above), if you are traveling or otherwise temporarily in a foreign country and need medical care, you may have to pay the provider and then submit a claim to be reimbursed. Claims will be accepted for U.S. residents who are traveling in foreign countries for urgent or emergent care only. Claims for elective procedures will not be reimbursed. You should ask the provider for an itemized bill (written in English). The bill must then be submitted directly to **Anthem Blue Cross** at **P.O. Box 60007, Los Angeles, CA 90060-0007**. (See page 17 for additional information on claims submission.) Members traveling or temporarily outside the United States shall be considered “Out-of-Area.” Covered services such Members receive while outside the United States will be reimbursed at the higher Preferred Provider level of benefits, based on Anthem Blue Cross’ Allowable Amounts.

MEDICAL NECESSITY

The benefits of this Plan are provided only for those services that are determined to be Medically Necessary; however, even Medically Necessary services are subject to the Benefit Limitations, Exceptions And Exclusions section starting on page 69.

"Medically Necessary" services are procedures, treatments, supplies, devices, equipment, facilities or Drugs (all services) that a qualified Health Professional (as defined on page 111), exercising prudent clinical judgment, would provide to a covered individual for the purpose of preventing, evaluating, diagnosing or treating an illness, injury or disease or its symptoms, and that are:

1. in accordance with generally accepted standards of medical practice (i.e., standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, national physician specialty society recommendations and the views of medical practitioners practicing in relevant clinical areas and any other relevant factors); and
2. clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the covered individual's illness, injury or disease; and
3. not primarily for the convenience of the covered individual, Physician or other health care provider; and
4. not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that covered individual's illness, injury or disease.

The fact that a provider may prescribe, order, recommend or approve a service, supply, or hospitalization does not in itself make it Medically Necessary. The Plan reviews services to assure that they meet the medical necessity criteria above. The Plan's review processes are consistent with processes found in other managed care environments and are consistent with the Plan's medical and pharmacy policies. A service may be determined not to be Medically Necessary even though it may be considered beneficial to the patient.

Inpatient Hospital services or supplies which are generally not considered Medically Necessary include, but are not limited to, hospitalization:

1. for diagnostic studies or rehabilitative care that could have been provided on an Outpatient basis or in a nursing facility;
2. for medical observation or evaluation;
3. to remove the patient from his or her customary work and/or home for rest, relaxation, personal comfort, or environmental change (e.g., see definition of Custodial Care on page 110); or
4. for preoperative work-up the night before surgery.

Similarly, nursing facility services or Outpatient services may not always be considered Medically Necessary.

Claims Review

PERS Select reserves the right to review all claims and medical records to determine whether services, procedures, equipment and supplies are Medically Necessary and efficiently delivered, and whether any exclusions or limitations apply. In the event an error is discovered during claims review, payment may be retracted.

DEDUCTIBLES

Calendar Year Deductible

Charges incurred while covered by any other CalPERS-sponsored health benefits plan for services received prior to the effective date of enrollment in PERS Select are not transferable to PERS Select, and Deductibles under any other such plan will not apply toward the Calendar Year Deductible for PERS Select.

After the Calendar Year Deductible and any other applicable Deductible are satisfied, payment will be provided for covered services. The Calendar Year Deductible, however, does not apply to some services (see the list below). The Deductible must be made up of charges for services covered by the Plan in the Calendar Year in which the services are provided. The Calendar Year Deductible applies separately to each Plan Member and is accumulated in the order in which claims processing has been completed.

The Calendar Year Deductible is **$500** for each Plan Member, and **$1,000** per family. It applies toward the Maximum Calendar Year Medical Financial Responsibility.

Charges will be applied to the Deductible beginning on January 1, 2016, and will extend through December 31, 2016. Some services, however, are not subject to the Deductible.

The Calendar Year Deductible does NOT apply to the following:

- Physician office, Outpatient Hospital and Urgent Care visits and consultations provided by Preferred Providers.
- Physician office visits provided by Preferred Providers in a Retail Health Clinic.
- Diabetes self-management education program services received from Preferred Providers.
- Immunizations received from Preferred Providers.
- Preventive care services received from Preferred Providers.
- Alternative Birthing Centers.
- Natural childbirth classes.
- Smoking cessation programs.
- Consultation or second opinion provided by Telemedicine Network Specialty Centers.
- Chiropractic care and acupuncture services provided by Preferred Providers.

NOTE: Other services received in conjunction with any of the services listed above ARE subject to the Deductible. Also, services listed above received from Non-Preferred Providers ARE subject to the Deductible.

Emergency Room Deductible

Each time you visit a Hospital's emergency room for Emergency Care Services you will be responsible for paying a separate **$50** emergency room Deductible that will be subtracted from your covered charges. However, this Deductible will not apply if you are admitted to a Hospital either for Outpatient medical observation or on an Inpatient basis immediately following emergency room treatment. This Deductible does not apply to the Calendar Year Deductible. However, it does apply to the Maximum Calendar Year Medical Financial Responsibility.

MAXIMUM CALENDAR YEAR FINANCIAL RESPONSIBILITY

Maximum Calendar Year Medical and Pharmacy Financial Responsibility

There is a Maximum Calendar Year Financial Responsibility of $6,850 per Member and $13,700 per family. This overarching maximum financial responsibility is broken down into a maximum medical responsibility ($4,850 per Member and $9,700 per family) and maximum pharmacy responsibility ($2,000 per Member and $4,000 per family).

Maximum Calendar Year Medical Financial Responsibility

When covered medical services are received from a Preferred Provider, in general, your Deductibles, Copayments and Coinsurance are applied toward the medical Maximum Calendar Year Financial Responsibility of $4,850 per Plan Member, and $9,700 per family. In most circumstances, once you incur expenses equal to those amounts, you will no longer be required to pay a Copayment or Coinsurance for the remainder of that year provided you receive covered medical services from a Preferred Provider, or if you live and received covered services outside a Preferred Provider area. You do, however, remain responsible for costs in excess of any specified Plan maximums and for services or supplies which are not covered under this Plan.

Your Maximum Calendar Year Financial Responsibility does not apply to covered services you receive from Non-Preferred Providers, whether referred by a Preferred Provider or not, if you live within a Preferred Provider area. * Remember, there is no maximum financial responsibility per Calendar Year if you use Non-Preferred Providers, and you will be responsible for any charges that exceed the Allowable Amount.

*Exceptions:

- Covered medical services received from Non-Preferred Providers will apply toward the Maximum Calendar Year Medical Financial Responsibility amount if (1) you cannot access a Preferred Provider who practices the appropriate specialty, provides the required services or has the necessary facilities within a 50-mile radius of your residence and you obtain an authorized referral, or (2) your claim is reprocessed to provide benefits at the higher Preferred Provider reimbursement level. Once the Maximum Calendar Year Medical Financial Responsibility is met, you will no longer be required to pay any applicable Deductible, Copayment or Coinsurance for such Non-Preferred Provider services, but you remain responsible for costs in excess of the Allowable Amount and for services or supplies which are not covered under this Plan.

- Emergency Care Services provided by Non-Preferred Providers will apply toward the Maximum Calendar Year Medical Financial Responsibility. Once the Maximum Calendar Year Medical Financial Responsibility is met, you will no longer be required to pay any applicable Deductible, Copayment or Coinsurance for such services, but remain responsible for costs in excess of the Allowable Amount and for services or supplies not covered under this Plan.

The following are not included in calculating your Maximum Calendar Year Medical Financial Responsibility. You will continue to be responsible for these charges even after you have reached the Maximum Calendar Year Medical Financial Responsibility:

- Coinsurance to Non-Preferred Providers if you live within a Preferred Provider area.
- Coinsurance for natural childbirth classes.
- Smoking cessation programs.
- Sanctions for non-compliance with utilization review.
- Charges for services which are not covered.
- Charges in excess of stated benefit maximums.
- Charges by Non-Preferred Providers in excess of the Allowable Amount.

MAXIMUM CALENDAR YEAR FINANCIAL RESPONSIBILITY

Maximum Calendar Year Pharmacy Financial Responsibility

When you receive covered Prescription services, your Copayments are applied toward the Maximum Calendar Year Pharmacy Financial Responsibility of $2,000 per Plan Member, and $4,000 per family. Once you incur expenses equal to those amounts, you will no longer be required to pay an additional Copayment for the remainder of that Calendar Year. Within and as a subset of this maximum, there is a mail-order pharmacy limit of $1,000. For covered Prescription services received through the Mail Services/Maintenance Choice, once you incur expenses equal to $1,000 per Plan Member, you will no longer be required to pay any additional Copayment for covered Prescription services received through the Mail Services/Maintenance Choice for the remainder of that Calendar Year. You do, however, remain responsible for costs in excess of any specified Plan maximums and for services or supplies which are not covered under this Plan.

The following are not included in calculating your mail-order pharmacy limit:

- Non-Preferred Brand Name Medication Copayments.

Partial Copay Waiver of Non-Preferred Brand-Name Copayments.

PAYMENT AND MEMBER COPAYMENT AND COINSURANCE RESPONSIBILITY

Disclosure of Allowable Amount

You may call Anthem Blue Cross Customer Service Department at 1-877-737-7776 and ask to be provided with information on how much the Plan will pay for certain planned procedures to be performed by a Non-Preferred Provider. In order for you to obtain this information, you must request that Anthem Blue Cross send a Disclosure of Allowable Amount form to your Non-Preferred Provider. Your Non-Preferred Provider will need to fill out the required information on the form (e.g., letter requesting the dates, specific procedure code numbers, and projected dollar amounts for the proposed). After receiving the completed form from your Non-Preferred Provider, the Allowable Amounts will be determined, and a copy of this information will be sent to you and your Non-Preferred Provider.

Disclosure of Allowable Amount estimates are only valid for 30 days. If your request is received more than 30 days prior to commencement of services, it cannot be processed. Any charges your Non-Preferred Provider may require for the completion of this form are not a covered benefit of this Plan. **Disclosure of Allowable Amount estimates are provided for informational purposes and are not a guarantee of payment.**

The following example shows the financial consequences of not choosing care through a Preferred Provider. The amount a Member pays is significantly more if care is received through a Non-Preferred Provider. The example below is illustrative only and is not actual claimant information. Also, though this example does not include Copayments, many actual covered services under the Plan have Copayments.

PAYMENT AND MEMBER COPAYMENT AND COINSURANCE RESPONSIBILITY

Payment Example for Single Member

Important Note: You are required to pay any charges for services provided by a Non-Preferred Provider or an Other Provider which are in excess of the Allowable Amount, plus all charges for non-covered services.

	Preferred Provider	Non-Preferred Provider
Billed Charge – the amount the provider actually charges for a covered service provided to a Member	$300,000	$300,000
Allowable Amount – the allowance or Negotiated Amount under the Plan for service provided (see definition on page 108). Note: This is only an example. Allowable Amount varies according to procedure and geographic area.	$130,000	$130,000
Calendar Year Deductible – the amount of the Allowable Amount the Member is responsible to pay each Calendar Year before Plan benefits are payable.	$500	$500
Coinsurance – the percentage of the remaining Allowable Amount the Member pays once any applicable Deductible and Copayment are met.	$3,000 20% of $129,500 the remaining Allowable Amount after the Deductible is met. **However,** there is a maximum Calendar Year Coinsurance responsibility of $3,000 for Preferred Providers, so your Coinsurance in this instance would be capped at $3,000	$51,800 40% of $129,500, the remaining Allowable Amount after the Deductible is met (since this is a non-Preferred Provider, the maximum Calendar Year Coinsurance responsibility is not applicable)
Plan Payment – the percentage of the remaining Allowable Amount the Plan pays once any applicable Deductible and Copayment are met.	$126,500 Plan pays 80% of the remaining Allowable Amount after the Deductible is met, and then any remaining Allowable Amount once the maximum Calendar Year Coinsurance responsibility is met	$77,700 60% of $129,500, the remaining Allowable Amount after the Deductible is met
Remaining Balance – Billed Charges exceeding Allowable Amount that the Member is responsible to pay	$0 Preferred Provider cannot bill the Member for the difference between Allowable Amount and Billed Charges	$170,000 Non-Preferred Provider can bill the Member for the difference between Allowable Amount and Billed Charges
For this Example: Total Amount the Member Is Responsible To Pay	**$3,500**	**$222,300**

PAYMENT AND MEMBER COPAYMENT AND COINSURANCE RESPONSIBILITY

(Not applicable to the Outpatient Prescription Drug Program)

Preferred Providers have agreed to accept the Plan's payment, plus applicable Member Deductibles and Copayments or Coinsurance, as payment in full for covered services. Plan Members are not responsible to pay Preferred Providers for any amounts above Anthem Blue Cross' or the local Blue Cross and/or Blue Shield Plan's Allowable Amount, whichever applies within a provider's geographic service area. After a Member meets their Calendar Year Deductible (see page 22 for more information on Deductibles) and the maximum Copayment or Coinsurance responsibility during a Calendar Year, the Plan will pay 100% of Allowable Amount, up to any applicable medical benefit maximums, for covered services and supplies provided by Preferred Providers for that Member for the remainder of that year. See page 23 for more information, including exceptions, on maximum Calendar Year Copayment or Coinsurance.

Non-Preferred Providers do **not** participate in Anthem Blue Cross' Select PPO Preferred Provider network (within California) or in a Blue Cross and/or Blue Shield plan network (outside of California). Non-Preferred Providers have **not** agreed to accept the Plan's payment, plus applicable Member Deductibles and Coinsurance as payment in full for covered services. The Allowable Amount for covered services provided by Non-Preferred Providers is usually lower than what they customarily charge. After a Member meets their Calendar Year Deductible, the Plan will pay 60% of Allowable Amount. Non-Preferred Providers may bill the Member for the difference between the Allowable Amount and the Non-Preferred Provider's Billed Charges in addition to applicable Member Deductibles, Coinsurance and amounts in excess of specified Plan maximums.

After the Calendar Year and any other applicable Deductible has been satisfied, reimbursement for covered services will be provided as described in this section.

Physician Services

1. Non-Emergency Services

a. Members Who Reside Within Area

i. When Accessing Preferred Providers:

Physician office visits, Physician office visits in Retail Health Clinic, Physician Outpatient Hospital visits and Physician Outpatient Urgent Care visits by a Preferred Provider are paid at Anthem Blue Cross' Allowable Amount or the local Blue Cross and/or Blue Shield Plan's Allowable Amount less the Member's $20 Copayment. The $20 Copayment will also apply to Physician or Health Professional visits for diabetes self-management education. Note: This Copayment applies to the charge for the Physician visit only.

Other covered services provided by a Preferred Provider are paid at 80% of the Allowable Amount, except for services with a $20 Copayment. This includes any separate facility charge by an affiliated Hospital for a covered office visit to a Physician. Plan Members are responsible for the remaining 20% and any charges for non-covered services if provided by a Preferred Provider. Preventive care services received from a Preferred Provider are paid at 100% of the Allowable Amount when billed with a routine or preventive care diagnosis.

NOTE: Members who reside within a Preferred Provider area and receive services from a Non-Preferred Provider will be reimbursed at the Non-Preferred Provider level as stated below in (ii).

ii. When Accessing Non-Preferred Providers:

Covered services provided by a Non-Preferred Provider are paid at 60% of the Allowable Amount. Plan Members are responsible for the remaining 40% and all charges in excess of the Allowable Amount, plus all charges for non-covered services.

NOTE: Regardless of the reason (medical or otherwise), referrals by Preferred Providers to Non-Preferred Providers will be reimbursed at the Non-Preferred Provider level.

iii. When Accessing a Non-Preferred Provider Because a Preferred Provider is not Available:

Covered services provided by a Non-Preferred Provider (other than for Emergency Care Services) are automatically paid at 60% of the Allowable Amount. However, if you receive covered services from a Non-Preferred Provider because a Preferred Provider is not available within a 50-mile radius of your residence, your claim will automatically be paid at 80% of the Allowable Amount if an Authorized Referral is obtained prior to services being provided. **You are responsible for the remaining percentage and any charges in excess of the Allowable Amount, plus all charges for non-covered services.**

If an Authorized Referral is NOT obtained prior to services being provided, your claim will automatically be paid at 60% of the Allowable Amount. Upon receipt of your Explanation of Benefits (EOB), contact your Customer Service Department to request that your claim be reprocessed at the 80% level. You are responsible for the remaining 20% and any charges in excess of the Allowable Amount, plus all charges for non-covered services.

To ensure that your claims will be paid at the 80% level, you should obtain an Authorized Referral BEFORE services are provided. To obtain an Authorized Referral, you or your Physician must call Customer Service at 1-877-737-7776 at least 3 business days prior to scheduling an admission to, or receiving the services of, a Non-Preferred Provider. If the service you will receive from a Non-Preferred Provider requires Precertification (for a list of services requiring Precertification, see page 65), you will need to obtain Precertification from the Review Center in addition to the Authorized Referral. For Precertification contact the Review Center at 1-800-451-6780.

b. Members Who Reside Out-of-Area
(Refer to the list of qualifying ZIP Codes information on page 18)

Physician office visits, Physician office visits in Retail Health Clinic, Physician Outpatient Hospital visits and Physician Outpatient Urgent Care visits are paid at the Allowable Amount less the Member's $20 Copayment. Members are responsible for the $20 Copayment, any charges in excess of the Allowable Amount, and all non-covered charges. The $20 Copayment will also apply to Physician or Health Professional visits for diabetes self-management education. Note: This Copayment applies to the charge for the Physician visit only.

Other covered services are paid at 80% of the Allowable Amount. This includes any separate facility charge by an affiliated Hospital for a covered office visit to a Physician. Members are responsible for the remaining 20%, any charges in excess of the Allowable Amount, and all non-covered charges.

Preventive care services are paid at 100% of the Allowable Amount when billed with a routine or preventive care diagnosis. Members are responsible for any charges in excess of the Allowable Amount and all non-covered charges.

c. Emergency Care

Physician services for emergency care provided by Preferred and Non-Preferred Providers are paid at 80% of the Allowable Amount. Members are responsible for the remaining 20%. In addition, when services are provided by a Non-Preferred Provider, Members are also responsible for all charges in excess of the Allowable Amount plus all charges for non-covered services. Some emergency room Physicians are Non-Preferred Providers at Preferred Hospitals.

PAYMENT AND MEMBER COPAYMENT AND COINSURANCE RESPONSIBILITY

Hospital Services

1. Non-Emergency Services

a. Members Who Reside Within Area

i. When Accessing Preferred Hospitals:

Covered services provided by a Tier 1 Preferred Hospital or Ambulatory Surgery Center are paid at 80% of the Negotiated Amount for covered services. Plan Members are responsible for the remaining 20% of the lesser of Billed Charges or the Negotiated Amount for covered services and all charges for non-covered services.

Covered services provided by a Tier 2 Preferred Hospital are paid at 70% of the Negotiated Amount for covered services. Plan Members are responsible for the remaining 30% of the lesser of Billed Charges or the Negotiated Amount for covered services and all charges for non-covered services.

NOTE: Members who reside within a Preferred Provider area and receive services from a Non-Preferred Provider will be reimbursed at the Non-Preferred Provider level as stated below in (ii). **Individual Providers at Preferred Hospitals may not be Preferred Providers.**

ii. When Accessing Non-Preferred Hospitals:

Covered services provided by a Non-Preferred Hospital are paid at 60% of Reasonable Charges. Plan Members are responsible for the remaining 40%, the amount billed over any Reasonable Charges, and all charges for non-covered services.

iii. Services Received from Non-Preferred Providers while receiving care at a Preferred Hospital:

Covered services provided by Non-Preferred Providers who are part of the Preferred Hospital or Outpatient Hospital Setting staff are paid at 80% of the Allowable Amount.* **Plan Members are responsible for the remaining 20% and all charges in excess of the Allowable Amount, plus all charges for non-covered services.** For example, you may be admitted to a Preferred Hospital or Outpatient Hospital Setting and some Physicians, such as anesthesiologists, radiologists and pathologists, on the hospital's staff are Non-Preferred Providers.

Providers, such as admitting Physician, surgeon and assistant surgeon, whose services are not included in and are not considered part of the Hospital or Outpatient Hospital Setting's facility charges, are paid at 60% of the Allowable Amount. Plan Members are responsible for the remaining 40% and all charges in excess of the Allowable Amount, plus all charges for non-covered services.

*Although benefits are provided at the higher reimbursement level, it is still in your best financial interest to verify that all health care providers treating you are Preferred Providers. Whenever possible, you should request that all of your care be provided by Preferred Providers upon entering a Preferred Hospital or Outpatient Hospital Setting.

b. Members Who Reside Out-of-Area
(Refer to the list of qualifying ZIP Codes information on page 18)

Covered services provided to Plan Members who reside Out-of-Area are paid at 80% of Reasonable Charges. Members are responsible for the remaining 20% and all charges for non-covered services.

c. Emergency Care

Covered services provided by a Preferred Hospital that are incident to emergency care are paid at 80% of Billed Charges or 80% of the Negotiated Amount, whichever is less. Covered services provided by a Non-Preferred Hospital that are incident to emergency care are paid at 80% of Reasonable Charges (defined on page 116). For both Preferred Hospitals and Non-Preferred Hospitals, Plan Members are responsible for the remaining 20% and all charges for non-covered services. In addition, at Non-Preferred Hospitals, Members are responsible for all charges in excess of the Reasonable Charges.

Emergency room facility charges for non-Emergency Care Services are the Plan Member's responsibility. If your emergency room charges are rejected under this Plan because it is determined that they were for non-emergency care and you feel that your condition required Emergency Care Services, you should contact Anthem Blue Cross and request a reconsideration. **Emergency Care Services** are those services required for the alleviation of the sudden onset of severe pain, or a Psychiatric Emergency Medical Condition, or the immediate diagnosis and treatment of an unforeseen illness or injury which could lead to further significant Disability or death, or which would so appear to a layperson. For more information, please see the Medical Claims Review And Appeals Process section on page 76-78.

NOTE: If a Member is a patient in a Non-Preferred Hospital, Emergency Care Services benefits shall be payable until the patient's medical condition permits transfer or travel to a Preferred Hospital. If the patient elects not to transfer or travel to a Preferred Hospital once his or her medical condition permits, reimbursement will be reduced to the 60% level and paid as stated in 1b. Payment to a Hospital will be reduced if utilization review requirements are not met.

Skilled Nursing Facility

For Preferred Providers, Inpatient services will be paid at:

- 80% of the Allowable Amount for the 10 days each Calendar Year. Members are responsible for the remaining 20% of the Allowable Amount for covered services and ALL charges for non-covered services.
- 70% of the Allowable Amount for the 90 days in the same Calendar Year. Members are responsible for the remaining 30% of the Allowable Amount for covered services and ALL charges for non-covered services.

For Non-Preferred Providers, Inpatient services will be paid at:

- 60% of the Allowable Amount for each day during a covered Stay. Members are responsible for the remaining 40% of the Allowable Amount for covered services and ALL charges for non-covered services.

These benefits require a precertified Treatment Plan.

Home Health Care Agencies, Home Infusion Therapy Providers, and Durable Medical Equipment Providers

Preferred Provider home health care agencies, Home Infusion Therapy Providers, and Durable Medical Equipment providers will be reimbursed at 80% of Anthem Blue Cross' Allowable Amount or 80% of the local Blue Cross and/or Blue Shield Plan's Allowable Amount. Members are responsible for the remaining 20%.

Non-Preferred Provider home health care agencies, Home Infusion Therapy Providers, and Durable Medical Equipment providers will be reimbursed at 60% of Anthem Blue Cross' Allowable Amount or 60% of the local Blue Cross and/or Blue Shield Plan's Allowable Amount. Members are responsible for the remaining 40%, any charges in excess of the Allowable Amount, and all charges for non-covered services and supplies.

Specific Durable Medical Equipment requires Precertification.

Site of Care Alignment

For select clinician-infused specialty Medications, a CVS/caremark CareTeam nurse will work with you and your Physician to assess your clinical history and to determine a clinically appropriate site of care (location for your infusion). Options may include homecare, an ambulatory infusion suite, physician office, etc. CVS/caremark CareTeam nurses will contact all eligible Members to provide assistance and guidance.

Clinical Trials

For Preferred Providers
Covered services related to clinical trials for Members who have been accepted into phase I, II, III, or IV clinical trials upon their Physician's referral will be paid at 80% of the Allowable Amount. Plan Members are responsible for the remaining 20% and any charges for non-covered services.

For Non-Preferred Providers
Covered services related to clinical trials for Members who have been accepted into phase I, II, III, or IV clinical trials upon their Physician's referral will be reimbursed at 60% of the lesser of the Billed Charges or the Allowable Amount that ordinarily applies when services are provided by Preferred Providers. Members are responsible for the remaining 40% and all charges in excess of the Allowable Amount, plus any charges for non-covered services.

Services by Other Providers

Hospice Care agencies and services by Other Providers (unless specifically provided otherwise) will be reimbursed at 80% of the lesser of Billed Charges or the amount that Anthem Blue Cross or the local Blue Cross and/or Blue Shield Plan determines was being charged by the majority of providers of like-covered services at the time and in the area where services were provided. Members are responsible for the remaining 20% and for any charges in excess of these amounts.

NOTE:

1. Payment for covered services is limited to the lesser of the benefit maximum or the applicable Anthem Blue Cross or local Blue Cross and/or Blue Shield Plan payment amount.
2. Payments will be reduced if utilization review requirements are not met.

Payment to Provider - Assignment of Benefits

The benefits of this Plan will be paid directly to Preferred Providers and medical transportation providers. Also, Non-Preferred Providers and Other Providers of service will be paid directly when you assign benefits in writing.

FINANCIAL SANCTIONS

You may incur unnecessary medical expenses if the Review Center is not notified and involved in the Precertification and management of your care. In order to promote compliance with utilization review notification requirements, financial sanctions (increased Copayment or Coinsurance responsibility) will be applied if you fail to notify the Review Center as required. In addition, if the Review Center determines that services are not Medically Necessary or are being provided at a level of care inconsistent with acceptable treatment patterns found in established managed care environments, financial sanctions will be applied and/or denial of all or some services may occur.

If you have questions about the application of a sanction based on the Review Center's decisions regarding compliance with late notification requirements, call the Review Center at 1-800-451-6780. If you do not agree with any portion of the Review Center's final determination, you or your Physician may appeal this decision by following the Medical Claims Review And Appeals Process described on pages 76-78.

For questions about how a sanction was applied to a specific claim, call Anthem Blue Cross at 1-877-737-7776.

Non-Compliance With Notification Requirements

A 10% Coinsurance (in addition to any other required Copayment or Coinsurance) will be applied to **all covered Hospital charges** associated with the Hospital Stay in question if Inpatient Hospital services are received and (a) notification is late, or (b) Precertification was not obtained even though services were approved after retrospective review.

A 10% Coinsurance (in addition to any other required Copayment or Coinsurance) will be applied to **Outpatient facility charges and professional charges*** if services listed under Utilization Review — Services Requiring Precertification on page 65 are received in an Outpatient facility or in a Physician's office and (a) notification is late, or (b) services were approved after retrospective review.

This additional Coinsurance amount will not accrue toward satisfying any other out-of-pocket Deductible or the Maximum Calendar Year Medical Financial Responsibility required under the payment design of the Plan.

*Note: This additional Coinsurance will not apply to emergency admissions and related emergency services, Medically Necessary transfers from one facility to another, or to advanced imaging procedures including, but not limited to, Magnetic Resonance Imaging (MRI), Computerized Axial Tomography (CAT scan), Positron Emission Tomography (PET scan), Magnetic Resonance Spectroscopy (MRS scan), Magnetic Resonance Angiogram (MRA scan), Echocardiography and Nuclear Cardiac Imaging if notification is late or services were approved after retrospective review.

Non-Compliance With Medical Necessity Recommendations for Temporomandibular Disorder Benefit or Maxillomadibular Musculoskeletal Disorders Services

A penalty of $500 will be assessed on Inpatient charges or $250 on Outpatient charges for (a) failure to obtain the required Precertification from the Review Center, or (b) failure to comply with the Review Center's recommendation. This additional Copayment amount will not accrue toward satisfying any other out-of-pocket Deductible or the Maximum Calendar Year Medical Financial Responsibility required under the payment design of the Plan.

Non-Certification of Medical Necessity

If the Review Center decides that services are not Medically Necessary or are being provided at a level of care not consistent with acceptable treatment patterns found in established managed care environments, the Review Center will advise the treating Physician and the patient, or a person designated by the patient, that coverage cannot be guaranteed. The actual amount of benefits paid will be determined retrospectively and will reflect appropriate sanctions, reductions, or denial of payment. For example, if you are hospitalized and the Review Center decides during the Stay that treatment can be provided in a less acute setting, charges associated with the treatment will be paid, but room and board charges for the number of days at the inappropriate level of care will not be paid. Therefore, if the Review Center declines to certify services as Medically Necessary but you nevertheless choose to receive those services, you are responsible for all charges not reimbursed by the Plan.

MEDICAL AND HOSPITAL BENEFITS

Description of Benefits

Except for Preventive Services or unless otherwise specified, reimbursement for covered services will be provided at the percentage of the Allowable Amount as described in this section less any applicable Deductible, Copayment or Coinsurance, for Medically Necessary services and supplies as provided by a qualified Health Professional (as defined on page 111). In addition, unless otherwise specified, any Deductibles, Coinsurance, and Copayments will count towards the Maximum Calendar Year Medical Financial Responsibility.

Services or a precertified Treatment Plan during a Contract Period must be commenced during that same Contract Period to qualify for continuing treatment in the event that the benefit becomes eliminated in a subsequent Contract Period. Otherwise, only benefits in effect during a Contract Period are available or covered.

Acupuncture

See Chiropractic and Acupuncture benefit description on page 39.

Allergy Testing and Treatment

80% Preferred Provider
60% Non-Preferred Provider

Allergy testing and treatment are subject to the Maximum Calendar Year Medical Financial Responsibility limits; however, services received from Non-Preferred Providers have no Coinsurance limits.

Qualified Health Professional services and supplies, except for Prescription Drugs, related to allergy testing and treatment are covered.

Alternative Birthing Center

80% All Providers

There is no Deductible, but there may be applicable Copayments and/or Coinsurance up to the Maximum Calendar Year Medical Financial Responsibility limits. An Alternative Birthing Center may be used instead of hospitalization. Alternative Birthing Center is defined as:

1. a birthing room located physically within a Hospital to provide homelike Outpatient maternity facilities, or
2. a separate birthing center that is certified or approved by a state department of health or other state authority and operated primarily for the purpose of childbirth.

Ambulance

80% of Billed Charges, All Providers

Ambulance services are subject to the Maximum Calendar Year Medical Financial Responsibility limits.

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

- For ground ambulance, you are transported:
  - From your home, or from the scene of an accident or medical emergency, to a Hospital,
  - Between Hospitals, including when you are required to move from a Hospital that does not contract with Anthem to one that does, or
  - Between a Hospital and a Skilled Nursing Facility or other approved facility.

- For air or water ambulance, you are transported:
  - From the scene of an accident or medical emergency to a Hospital,
  - Between Hospitals, including when you are required to move from a Hospital that does not contract with Anthem to one that does, or
  - Between a Hospital and another approved facility.

Ambulance services are subject to medical necessity reviews. When using an air ambulance in a non-emergency situation, Anthem reserves the right to select the air ambulance provider. If you do not use the air ambulance Anthem selects in a non-emergency situation, no coverage will be provided.

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

Coverage includes Medically Necessary treatment of an illness or injury by medical professionals from an ambulance service, even if you are not transported to a Hospital. If provided through the 911 emergency response system*, ambulance services are covered if you reasonably believed that a medical emergency existed even if you are not transported to a Hospital. Ambulance services are not covered when another type of transportation can be used without endangering your health. Ambulance services for your convenience or the convenience of your Family Members or Physician are not a covered service.

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

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

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

Air ambulance will not be covered if you are taken to a Hospital that is not an Acute Care Hospital (such a Skilled Nursing Facility), or if you are taken to a Physician's office or to your home.

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

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

Ambulatory Surgery Centers

100% Preventive care, PPO and Out-of-Area (see Colonoscopy Services on pages 41-42)
80% Preferred Provider, Diagnostic colonoscopy services
60% Non-Preferred Provider

Except for Preventive care, Ambulatory Surgery Center services are subject to the Maximum Calendar Year Medical Financial Responsibility limits; however, services received from Non-Preferred Providers have no Coinsurance limits.

All covered services and supplies provided and billed by an Ambulatory Surgery Center that is a Non-Preferred Provider are subject to **a maximum Plan payment of $350** per Outpatient surgery. This maximum payment does not apply to covered services provided by Preferred Providers and to Non-Preferred Provider Physician charges that are billed separate from the facility charges.

Providers, such as admitting Physician, surgeon and assistant surgeon, whose services are not included in and are not considered part of the facility charges for Ambulatory Surgery Center that is a Preferred Provider, are paid at 60% of the Allowable Amount. Plan Members are responsible for the remaining 40% of all charges in excess of the Allowable Amount, plus all charges for non-covered services.

Covered services provided by Non-Preferred Providers who are part of staff of an Ambulatory Surgery Center that is a Preferred Provider are paid at 80% of the Allowable Amount. **Plan Members are responsible for the remaining 20% and all charges in excess of the Allowable Amount, plus all charges for non-covered services.**

For example, you may be receiving services at an Ambulatory Surgery Center that is Preferred Provider, and some Physicians, such as anesthesiologists, radiologists and pathologists, on the Ambulatory Surgery Center's staff are Non-Preferred Providers. Although benefits are provided at the higher reimbursement level, it may be to your financial advantage to verify that all health care providers treating you are Preferred Providers. Whenever possible, you should request that all of your care be provided by Preferred Providers upon receiving services at an Ambulatory Surgery Center that is a Preferred Provider.

Please contact Customer Service and/or visit www.anthem.com/ca/calpers to verify that the Ambulatory Surgery Center is a Preferred Provider in Anthem Blue Cross' network.

Please see guidelines for Precertification of non-emergency procedures on page 67. Generally, various non-emergency procedures, services, and surgeries require Precertification by the Review Center. Precertification is required no later than 30 days, or 3 days, in specified instances, and at any time prior to the service of certain imaging procedures. Failure to obtain Precertification from the Review Center under the terms and conditions specified in this Evidence of Coverage and within the specified time frame may result in increasing your Coinsurance and liability responsibility by the application of financial sanctions (see page 32) and/or denial of benefits.

Arthroscopy Services

80% Preferred Provider (Tier 1 Hospital)
70% Preferred Provider (Tier 2 Hospital)
60% Non-Preferred Provider

Arthroscopy services are subject to the Maximum Calendar Year Medical Financial Responsibility limits; however, services received from Non-Preferred Providers have no Coinsurance limits.

Anthem Blue Cross has a network of Ambulatory Surgery Centers that routinely provide arthroscopy services generally within the maximum benefit of $6,000. No benefit limitation will apply when procedure is performed at an Ambulatory Surgery Center that is a Preferred Provider. Please contact Customer Service and/or visit www.anthem.com/ca/calpers to verify that the facility is listed as a preferred Ambulatory Surgery Center in Anthem Blue Cross' network.

If this routine service is provided in an Outpatient Hospital Setting, arthroscopy services are limited to **a maximum payment of $6,000** per procedure.

Examples for an exception to allow routine arthroscopy services to be performed in an Outpatient Hospital include the following reasons:

- Patient safety; or
- If there is no preferred Ambulatory Surgery Center provider within a 30 mile radius of the Member's home.

The Member should consult their Physician and contact Customer Service for instructions on how to receive an exception.

Autism Spectrum Disorder

Outpatient Care (Physician Office Visits, Physician Outpatient Hospital Visits, and Physician Urgent Care Visits)

$20 Copayment Preferred Provider
60% Non-Preferred Provider

Autism Spectrum Disorder Outpatient care services are subject to the Maximum Calendar Year Medical Financial Responsibility limits; however, services received from Non-Preferred Providers have no Coinsurance limits.

There is a $20 Copayment for each office visit which applies toward the Maximum Calendar Year Medical Financial Responsibility limits. Other Physician services rendered during an office visit, Outpatient Hospital visit, or Urgent Care visit are paid at 80% of the Allowable Amount and services received from Non-Preferred Providers have no Coinsurance limits.

This Plan provides coverage for behavioral health treatment for Autism Spectrum Disorder. Services provided by Qualified Autism Service Providers, Qualified Autism Service Professionals, and Qualified Autism Service Paraprofessionals will be covered under the Plan equivalent to office visits to Physicians, whether services are provided in the provider's office or in the patient's home. Services provided in a facility, such as the Outpatient department of a Hospital, will be covered under the Plan and paid according to the benefits that apply to a facility.

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

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

Bariatric Surgery

Hospital Services	80% at Centers of Medical Excellence
Professional	80% for Physicians on surgical team at designated Centers of Medical Excellence

Covered services are subject to the Maximum Calendar Year Medical Financial Responsibility limits.

Precertification for all bariatric surgical procedures must be obtained from the Review Center as soon as possible, but no later than 3 business days before services are provided. Failure to obtain Precertification from the Review Center under the terms and conditions specified in this Evidence of Coverage and within the specified time frame may result in increasing your Coinsurance and liability responsibility by the application of financial sanctions (see page 32) and/ or denial of benefits.

Services and supplies provided in connection with Medically Necessary bariatric surgery for treatment of morbid obesity are a benefit only when the procedure is in accordance with Anthem Blue Cross Medical Policy, prior authorization has been obtained from the Review Center, and services are performed at a designated Centers of Medical Excellence (CME) facility. Services provided for or in connection with a bariatric surgical procedure performed at a facility other than a designated CME will **not** be covered.

CME agrees to accept the Negotiated Amount as payment for covered services. Plan Members are responsible for the remaining 20% of the lesser of Billed Charges or the Negotiated Amount for covered services and all charges for non-covered services. The Review Center can assist in facilitating your access to a CME. Please notify the Review Center at 1-800-451-6780 as soon as your provider recommends a bariatric surgical procedure for your medical care.

Centers of Medical Excellence (CME) facilities for bariatric surgery are not available outside California.

Travel Benefits for Bariatric Surgery

If the Member's place of residence is outside a 50 mile radius of the nearest designated CME, certain travel expenses incurred by the Member may be covered in connection with an authorized bariatric surgical procedure performed at a designated CME. No benefits are payable for travel expenses to other than a designated CME.

Travel expenses must be authorized in advance by the Review Center. Prior authorization can be obtained by calling Customer Service at 1-877-737-7776. Except for mileage, a legible copy of dated receipts for all expenses must be submitted along with a travel reimbursement form to Anthem Blue Cross to obtain reimbursement. No benefits are payable for unauthorized travel expenses. Details regarding reimbursement can be obtained by calling Customer Service at 1-877-737-7776.

The Calendar Year Deductible will not apply, and no Copayments or Coinsurance will be required for authorized bariatric travel expenses. Benefits for meal, lodging and ground transportation will be provided, up to the limits set forth in the Internal Revenue Code or the current State Travel Rate, as determined by the Plan, at the time expenses are incurred. Reimbursement is limited to the specified amounts below.

Covered travel expenses include:

- Transportation to and from the designated CME for the Member, up to 3 trips (one pre-surgical visit, the initial surgery and one follow-up visit) per authorized bariatric surgical procedure, not to exceed $130 per trip.
- Transportation to and from the designated CME for one companion, up to 2 trips (the initial surgery and one follow-up visit), not to exceed $130 per trip. (Only if the companion travels separately from the Member.)
- One room double occupancy hotel accommodations for the Member and one companion for the pre-surgical and follow-up visits, up to 2 days per trip, not to exceed $100 per day.
- One room double occupancy hotel accommodations for the companion during the Member's initial surgery Stay, up to 4 days, not to exceed $100 per day. (Only if the companion Stays in a separate room from the Member.)

- Other necessary expenses, such as meals, are limited to a combined total of $25 per day, up to 4 days per trip. Tobacco, alcohol and Drug expenses are not covered.

Cardiac Care

Hospital Services	80% at Centers of Medical Excellence 80% Preferred Provider, other than Centers of Medical Excellence 60% Non-Preferred Provider
Evaluations and Diagnostic Tests	80% at Centers of Medical Excellence 80% Preferred Provider, other than Centers of Medical Excellence 60% Non-Preferred Provider

Cardiac care services are subject to the Maximum Calendar Year Medical Financial Responsibility limits; however, services received from Non-Preferred Providers have no Coinsurance limits.

All non-emergency hospitalizations require Precertification by the Review Center as soon as possible, but no later than 3 business days before services are provided. Failure to obtain Precertification from the Review Center under the terms and conditions specified in this Evidence of Coverage and within the specified time frame may result in increasing your Coinsurance and liability responsibility by the application of financial sanctions (see page 32) and/or denial of benefits. For information on benefits for services related to Emergency Care Services, refer to the Emergency Care Services benefit description on pages 44-45.

The selection criteria used in designating Centers of Medical Excellence for Cardiac Care were developed in collaboration with expert Physicians and medical organizations, including the American College of Cardiology (ACC) and The Society of Thoracic Surgeons (STS). Potential Centers of Medical Excellence submit clinical data to establish that they meet certain selection criteria, which include:

- An established cardiac care program, performing required annual volumes for certain procedures (e.g. a minimum of 125 cardiac surgical procedures annually, including both CABG and/or valve surgery).
- Appropriate experience of its cardiac team, including sub-specialty board certification for interventional cardiologists and cardiac surgeons.
- An established Acute Care Inpatient facility, including intensive care, emergency and a full range of cardiac services.
- Full accreditation by a Centers for Medicare and Medicaid Services (CMS)-deemed national accreditation organization.
- Low overall complication and mortality rates.
- A comprehensive quality management program.

Hospital and professional services provided in connection with cardiac care are a benefit only to the extent that the services are Medically Necessary and medically appropriate for the patient. Cardiac care does not include heart transplants (see Transplant Benefits on pages 60-63) nor services for Outpatient cardiac Rehabilitation (see Outpatient or Out-of-Hospital Therapies on page 53).

As with Anthem Blue Cross Preferred Providers, CME agrees to accept the Negotiated Amount as payment for covered services. The Review Center can assist in facilitating your access to a CME. Please notify the Review Center at 1-800-451-6780 as soon as your provider recommends an Inpatient hospitalization for your medical care.

Cataract Surgery

80% Preferred Provider (Tier 1 Hospital)
70% Preferred Provider (Tier 2 Hospital)
60% Non-Preferred Provider

Cataract surgery services are subject to the Maximum Calendar Year Medical Financial Responsibility limits; however, services received from Non-Preferred Providers have no Coinsurance limits.

Anthem Blue Cross has a network of Ambulatory Surgery Centers that routinely provide cataract surgery services generally within the maximum benefit of $2,000. No benefit limitation will apply when procedure is performed at an Ambulatory Surgery Center that is a Preferred Provider. Please contact Customer Service and/or visit www.anthem.com/ca/calpers to verify that the facility is listed as a preferred Ambulatory Surgery Center in Anthem Blue Cross' network.

If this routine service is provided in an Outpatient Hospital Setting, cataract surgery services are limited to **a maximum payment of $2,000** per procedure.

Examples for an exception to allow cataract surgery services to be performed in an Outpatient Hospital include the following reasons:

- Patient safety; or
- If there is no preferred Ambulatory Surgery Center provider within a 30 mile radius of the Member's home.

The Member should consult their Physician and contact Customer Service for instructions on how to receive an exception.

Chiropractic and Acupuncture

$15 Copayment, Preferred Provider
60% Non-Preferred Provider

There is a $15 Copayment for Preferred Provider Chiropractic and acupuncture services which are subject to the Maximum Calendar Year Medical Financial Responsibility limits;

Services received from Non-Preferred Providers have no Coinsurance limits.

Coverage for acupuncture services provided by a Physician or Health Professional to treat a disease, illness or injury, includes a patient history visit, physical examination, treatment planning and evaluation, electroacupuncture, cupping and moxibustion.

Chiropractic care is covered for the treatment of illness or injury. Services include, but are not limited to, manipulation of the spine, joints and/or musculoskeletal soft tissue, re-evaluation, and/or other services.

Acupuncture and chiropractic care services are limited to **a combined maximum of 20 visits** per Calendar Year.

Christian Science Treatment

80% All Providers

Christian Science treatments are subject to the Maximum Calendar Year Medical Financial Responsibility limits.

Outpatient treatment for a covered illness or injury through prayer is payable when services are provided by a Christian Science Nurse, Christian Science Nursing Facility, or Christian Science Practitioner, as defined under "Definitions". This benefit includes treatment in absentia (Christian Science Practitioners or nurses providing services, such as consultation or prayer, via the telephone). Benefits are limited to 24 sessions per person per Calendar Year.

No payment will be made for overnight Stays in a Christian Science Nursing Facility.

Cleft Palate

80% Preferred Provider
60% Non-Preferred Provider

Cleft palate benefit is subject to the Maximum Calendar Year Medical Financial Responsibility limits; however, services received from Non-Preferred Providers have no Coinsurance limits.

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

Benefits are not payable for services provided in connection with complications arising from a non-authorized or Cosmetic Procedure.

Clinical Trials

80% Preferred Provider
60% Non-Preferred Provider

Clinical trials are subject to the Maximum Calendar Year Medical Financial Responsibility limits; however, services received from Non-Preferred Providers have no Coinsurance limits.

Routine patient costs, as described below, for an approved clinical trial.

Coverage is provided for services you receive as a participant in an approved clinical trial. The services must be those that are listed as covered by this Plan for Members who are not enrolled in a clinical trial.

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

1. Federally funded trials approved or funded by one or more of the following:
    a. The National Institutes of Health,
    b. The Centers for Disease Control and Prevention,
    c. The Agency for Health Care Research and Quality,
    d. The Centers for Medicare and Medicaid Services,
    e. A cooperative group or center of any of the four entities listed above or the Department of Defense or the Department of Veterans Affairs,
    f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants, or
    g. Any of the following departments if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of Health and Human Services determines (1) to be comparable to the system of peer review of investigations and studies used by the National Institutes of Health, and (2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review:
        i. The Department of Veterans Affairs,
        ii. The Department of Defense, or
        iii. The Department of Energy.
    h. Studies or investigations done as part of an investigational new drug application reviewed by the FDA.
    i. Studies or investigations done for drug trials that are exempt from the investigational new drug application.

When a service is part of an approved clinical trial, it is covered even though it may otherwise be an investigative service as defined by the Plan (see the definition on page 111).

Participation in such clinical trials must be recommended by your Health Professional after determining participation has a meaningful potential to benefit the Member.

Routine patient costs do not include costs associated with:

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

Note: You will pay for costs of services that are not covered.

Colonoscopy Services

Physician Office Visits

Preventive Care

100% PPO and Out-of-Area
60% Non-PPO

Preventive Services received from Preferred Providers are not subject to the Calendar Year Deductible. Preventive Services received from Non-Preferred Providers are subject to the Calendar Year Deductible but NOT the Maximum Calendar Year Medical Financial Responsibility limits.

For purposes of this benefit, “preventive care” means Physician visits and medical services related to a colonoscopy when billed with a preventive care diagnosis code. For example:

- A routine colonoscopy screening for colon cancer.

Diagnostic Care

80% PPO and Out-of-Area
60% Non-PPO

Diagnostic colonoscopy services are subject to the Maximum Calendar Year Medical Financial Responsibility limits; however, services received from Non-Preferred Providers have no Coinsurance limits.

Diagnostic care means Physician visits and medical services related to a colonoscopy when billed with a diagnostic care diagnosis code. For example:

- Follow-up colonoscopy after abnormal results or cancer treatment.

Anesthesia during colonoscopies: Intravenous conscious sedation provided by the gastroenterologist during a colonoscopy is a covered benefit. There is no Deductible, Copayment, or Coinsurance for anesthesia services performed in connection with a preventive colonoscopy if the attending Preferred Provider determines that anesthesia would be Medically Necessary for the Member

However, any anesthesia services by a Preferred Provider that is not Medically Necessary or is not performed in connective with a preventive colonoscopy is not a covered benefit unless you obtain prior authorization. Your Physician can obtain prior authorization by calling the Review Center at 1-800-451-6780; he or she should allow up to five days for the request to be processed. Members should verify prior authorization by calling Customer Service at 1-877-737-7776. If prior authorization has been obtained, general anesthesia will be covered subject to the Deductible and Copayment/Coinsurance of the Plan.

Facility Services

Ambulatory Surgery Centers

100% Preventive Care, PPO and Out-of-Area
80% Diagnostic Care, PPO and Out-of-Area
60% Non-PPO

Preventive Care services are not subject to the Calendar Year Deductible.

Diagnostic colonoscopy services are subject to the Maximum Calendar Year Medical Financial Responsibility limits; however, services received from Non-Preferred Providers have no Coinsurance limits.

Colonoscopy services are considered routine services and can be performed safely at an Ambulatory Surgery Center. If this routine procedure is performed in an Ambulatory Surgery Center (as defined on page 108), benefits will be paid according to the Plan (see Ambulatory Surgery Centers on pages 34-35.)

Anthem Blue Cross has a network of Ambulatory Surgery Centers that routinely provide this service generally within the maximum benefit of $1,500. No benefit limitation will apply when procedure is performed at an Ambulatory Surgery Center that is a Preferred Provider. Please contact Customer Service and/or visit www.anthem.com/ca/calpers to verify that the facility is listed as a preferred Ambulatory Surgery Center in Anthem Blue Cross' network.

Outpatient Hospital

80% Preferred Provider (Tier 1 Hospital)
70% Preferred Provider (Tier 2 Hospital)
60% Non-Preferred Provider

Preventive Care services are not subject to the Calendar Year Deductible; however, the $1,500 benefit maximum will apply to Preventive Care services received at an Outpatient Hospital Setting. The Member will be responsible for all charges in excess of the benefit maximum.

Diagnostic colonoscopy services are subject to the Maximum Calendar Year Medical Financial Responsibility limits; however, services received from Non-Preferred Providers have no Coinsurance limits.

If this routine service is provided in an Outpatient Hospital Setting (as defined on page 113), whether a preventive or diagnostic service, the Allowable Amount for colonoscopy services is limited **to a maximum of $1,500** per procedure.

Examples for an exception to allow routine colonoscopy services to be performed in an Outpatient Hospital include the following reasons:

- Patient safety; or
- If there is no preferred Ambulatory Surgery Center provider within a 30 mile radius of the Member's home.

The Member should consult their Physician and contact Customer Service for instructions on how to receive an exception.

Diabetes Self-Management Education Program

$20 Copayment, Preferred Provider
60% Non-Preferred Provider

There is a $20 Copayment for the Preferred Provider which applies toward the Maximum Calendar Year Medical Financial Responsibility limits, and services received from Non-Preferred Providers have not Coinsurance limits.

Benefits are provided for patients enrolled in a diabetes education program for:

- The charges of a day care center for diabetes self-management education;
- The services of a Physician or other Health Professional who is knowledgeable about the treatment of diabetes, such as a registered nurse, registered pharmacist and registered dietitian, provided that charges for such services do not duplicate those charged by a day care center.

A covered "diabetic education program" (1) is designed to educate a Member who is a patient and their Family Members about the disease process and the daily management of diabetic therapy; (2) includes self-management training, education, and medical nutrition therapy to enable the Member to properly use the equipment, supplies, and Medications necessary to manage the disease; and (3) is supervised by a Physician.

Members may also elect to participate in ConditionCare for diabetes. See the front of this Evidence of Coverage for additional information on ConditionCare.

Diagnostic X-Ray and Laboratory

80% Preferred Provider
60% Non-Preferred Provider

Diagnostic x-ray and laboratory services are subject to the Maximum Calendar Year Medical Financial Responsibility limits; however, services received from Non-Preferred Providers have no Coinsurance limits.

Outpatient services from all providers, including diagnostic X-rays, diagnostic examinations, clinical laboratory services, and Pap tests or mammograms for treatment of illness. If Outpatient services are received at a Hospital or Outpatient Hospital Setting, the Hospital benefits will apply (see Hospital Benefits – Outpatient Services on pages 50-51),

Advanced Imaging Procedures

Precertification is required for advanced imaging procedures including, but not limited to, MRI, CAT scan, PET scan, MRS scan, MRA scan, Echocardiography, and Nuclear Cardiac Imaging. You may call customer service at 1-877-737-7776 to find out if an imaging procedure requires Precertification of medical necessity. Failure to obtain Precertification from the Review Center under the terms and conditions specified in this Evidence of Coverage and within the specified time frame may result in increasing your Coinsurance and liability responsibility by the application of financial sanctions (see page 32) and/or denial of benefits. This Precertification requirement does not apply to services received outside of California; however, any service provided outside of California is still subject to review for medical necessity.

Durable Medical Equipment

Home Medical Equipment and Prosthetic Appliances

80% Preferred Provider
60% Non-Preferred Provider

Durable Medical Equipment is subject to the Maximum Calendar Year Medical Financial Responsibility limits; however, services received from Non-Preferred Providers have no Coinsurance limits.

Specific Durable Medical Equipment must be precertified by the Review Center no later than 3 business days **prior** to rental or purchase of the equipment. Failure to obtain Precertification from the Review Center under the terms and conditions specified in this Evidence of Coverage and within the specified time frame may result in increasing your Coinsurance and liability responsibility by the application of financial sanctions (see page 32) and/or denial of benefits.

Note: The list of specific Durable Medical Equipment subject to Precertification review is reviewed regularly by Anthem Blue Cross to keep pace with advances in medicine and technology, as well as updated for standards of care.

Purchase, including repair and maintenance, of standard Outpatient Prosthetic Appliances (defined on page 115).

Examples of Prosthetic Appliances include:

- Artificial limbs and eyes and their fitting.
- Surgically implantable hearing devices (e.g., cochlear implants and bone-anchored hearing aid), when Medically Necessary in accordance with Anthem Blue Cross Medical Policy, and related follow-up services.
- One Medically Necessary scalp hair prosthesis each Calendar Year, worn for hair loss caused by alopecia areata, alopecia totalis, or alopecia medicamentosa, resulting from the treatment of any form of cancer or leukemia. Benefits are limited to one prosthetic each year up to a maximum payment of $350 per Member.
- Custom molded and cast shoe inserts, limited to one pair per Calendar Year, and orthopedic braces, including shoes only when permanently attached to such braces.

Rental or purchase of dialysis equipment; dialysis supplies. Rental or purchase of other Durable Medical Equipment (defined on page 110) and supplies which are:

- Of no further use when medical needs end (but not disposable);
- For the exclusive use of the patient;
- Not primarily for comfort or hygiene;
- Not for environmental control or for exercise; and
- Manufactured specifically for medical use.

Examples of Durable Medical Equipment include crutches, Standard Wheelchairs and hospital beds. Lancets and lancing devices are covered for the purpose of self-administration of blood tests to monitor a covered condition (e.g., checking blood glucose level for self-management of diabetes). Augmentative and alternative communication and speech generating devices and systems are a benefit only when Medically Necessary in accordance with Anthem Blue Cross Medical Policy.

The Plan may cover either rental charges, up to the purchase price, or the actual purchase price. Anthem Blue Cross will determine whether the Member is to purchase or continue to rent the equipment. If purchase is required, the Member will be notified to initiate the purchase of Durable Medical Equipment by the Plan. After notification the Plan will discontinue rental authorization.

Prosthetic and Durable Medical Equipment replacement and repairs resulting from loss, misuse, abuse and/or accidental damage are not a covered benefit of the Plan.

Refer to page 71 for Benefit Limitations, Exceptions and Exclusions related to this benefit.

Emergency Care Services

80% All Providers

Emergency Care Services are subject to the Maximum Calendar Year Medical Financial Responsibility limits.

A $50 emergency room Deductible applies for covered emergency room charges unless admitted to the Hospital for Outpatient medical observation or on an Inpatient basis. If admitted to the Hospital for Outpatient medical observation or on an Inpatient basis, the emergency room Deductible is waived. Note: this additional Deductible apply toward the Maximum Calendar Year Medical Financial Responsibility limits.

For Inpatient Hospital services, the Review Center must be notified within 24 hours or by the end of the first business day following admission, whichever is later. Failure to obtain Precertification from the Review Center under the terms and conditions specified in this Evidence of Coverage and within the specified time frame may result in increasing your Coinsurance and liability responsibility by the application of financial sanctions (see page 32) and/or denial of benefits.

Services in a Physician's office, Outpatient facility or an emergency room of a Hospital are covered when required for a sudden, serious, and unexpected acute illness, injury, or condition (including without limitation sudden and unexpected severe pain), or a Psychiatric Emergency Medical Condition, which the Member reasonably perceives, could permanently endanger health if medical treatment is not received immediately. This benefit includes emergency room Physician visits. Emergency Care Services are determined as Medically Necessary in accordance with Anthem Blue Cross Medical Policy.

Benefits are also provided for emergency maternity admissions if due to unexpected "premature" delivery. A premature delivery is one that occurs prior to the 8th month of pregnancy.

Only Physician charges shall be payable for non-emergency services received in an emergency room of a Hospital. Emergency room facility charges for non-emergency services are not covered. The reimbursement level for Physician or other charges will be based on the Preferred or Non-Preferred status of the provider and benefits are payable as described under Physician Services on page 55.

If a patient is in a Non-Preferred Provider Hospital, Emergency Care Services benefits shall be payable until the patient's medical condition permits transfer or travel to a Preferred Provider Hospital. If the patient does not wish to transfer to a Preferred Provider Hospital, reimbursement shall be payable at the Non-Preferred Provider level for all subsequent charges.

Family Planning

80% Preferred Provider
60% Non-Preferred Provider

Family planning services are subject to the Maximum Calendar Year Medical Financial Responsibility limits; however, services received from Non-Preferred Providers have no Coinsurance limits.

Services for voluntary sterilization, including tubal ligation and vasectomy, and abortions are covered. Office visits for contraceptive management, including services of a Physician in connection with the prescribing and fitting of contraceptive diaphragms or injectable Drugs for birth control administered during the office visit and supplied by the Physician, are covered. Intra-uterine devices (IUDs) and time-released subdermal implants for birth control that are administered in a Physician's office are covered. Oral contraceptives are covered under the Outpatient Prescription Drug Program. Infertility services, including Drugs for treating infertility, are not covered.

Note: For services that meet the "Women's Preventive Services Guidelines" of the Health Resources and Services Administration (HRSA), benefits will be provided under the Preventive Care benefit. See Preventive Care on pages 56-57 for more information.

Refer to pages 71-74 for Benefit Limitations, Exceptions and Exclusions of this benefit.

Gender Reassignment Surgery

Inpatient Care or Outpatient Care (Facility-Based)

80% Preferred Provider (Tier 1 Hospital)
70% Preferred Provider (Tier 2 Hospital)
60% Non-Preferred Provider

Outpatient Care (Physician Office Visits, Physician Outpatient Hospital Visits, and Physician Urgent Care Visits)

$20 Copayment Preferred Provider
60% Non-Preferred Provider

Gender reassignment surgery benefits are subject to the Maximum Calendar Year Medical Financial Responsibility limits; however, services received from Non-Preferred Providers have no Coinsurance limits.

Precertification from the Review Center must be obtained 3 business days before the start of services. Failure to obtain Precertification from the Review Center under the terms and conditions specified in this Evidence of Coverage and within the specified time frame may result in increasing your Coinsurance and liability responsibility by the application of financial sanctions (see page 32) and/or denial of benefits.

There is a $20 Copayment for each office visit which applies to the Maximum Calendar Year Medical Financial Responsibility limits. Other Physician services rendered during an office visit, Outpatient Hospital visit, or Urgent Care visit are paid at 80% of the Allowable Amount (see Other Physician Services below) and services received from Non-Preferred Providers have no Coinsurance limits.

This Plan provides benefits for many of the services for sex reassignment surgery. Not all services are eligible for payment and some are only eligible to a limited extent. Sex reassignment surgery must be performed at a facility designated and approved by Anthem Blue Cross for the type of sex reassignment surgery requested and must be precertified prior to being performed. Medical Necessity for sex reassignment surgery will be determined according to the guidelines stated in the 2011 World Professional Association for Transgender Health Standards of Care documents at http://www.wpath.org/.

Charges for services that are not precertified, or which are provided in a facility other than which Anthem Blue Cross has designated and approved for the sex reassignment surgery requested, will not be considered covered expense.

Travel Benefits for Gender Reassignment Surgery

If the Member's place of residence is outside a 50 mile radius of the nearest facility, certain travel expenses incurred by the Member may be covered in connection with an authorized sex reassignment surgery. No benefits are payable for travel expenses to other an approved facility by Anthem Blue Cross.

Precertification from the Review Center must be obtained as soon as possible, but no later than 3 business days before the start of services. Failure to obtain Precertification from the Review Center under the terms and conditions specified in this Evidence of Coverage and within the specified time frame may result in increasing your Coinsurance and liability responsibility by the application of financial sanctions (see page 32) and/or denial of benefits.

Except for mileage, a legible copy of dated receipts for all expenses must be submitted along with a travel reimbursement form to Anthem Blue Cross to obtain reimbursement. No benefits are payable for unauthorized travel expenses. Details regarding reimbursement can be obtained by calling Customer Service at 1-877-737-7776.

The Calendar Year Deductible will not apply, and no Copayments or Coinsurance will be required for authorized travel expenses. Benefits for meal, lodging and ground transportation will be provided, up to the limits set forth in the Internal Revenue Code or the current State Travel Rate, as determined by the Plan, at the time expenses are incurred. Reimbursement is limited to the specified amounts below.

The Plan will pay for the following travel expenses, for up to six trips, in connection with an authorized, sex reassignment surgery performed at a facility which is designated by Anthem Blue Cross:

- Round trip coach airfare to the facility which is designated by Anthem Blue Cross and approved for the sex reassignment surgery requested, not to exceed **$250** per person per trip.
- Hotel accommodations, not to exceed **$100** per day for up to 21 days per trip, limited to one room, double occupancy.
- Other necessary expenses, such as meals, not to exceed $25 per day for each person, for up to 21 days per trip.

Hearing Aid Services

80% Preferred Provider
60% Non-Preferred Provider

Hearing aid services are subject to the Maximum Calendar Year Medical Financial Responsibility limits; however, services received from Non-Preferred Providers have no Coinsurance limits.

The following hearing aid services are covered when provided by or purchased as a result of a written recommendation from an otolaryngologist or a state-certified audiologist.

1. Audiological evaluations to measure the extent of hearing loss and determine the most appropriate make and model of hearing aid.
2. Hearing aids (monaural or binaural), including ear mold(s), the hearing aid instrument, batteries, cords and other ancillary equipment.
3. Visits for fitting, counseling, adjustments and repairs for a one year period after receiving the covered hearing aid(s).

Benefits are limited to a maximum payment of $1,000 per Member once every 36 months. The Plan provides payment of up to $1,000 regardless of the number of hearing aids purchased. Refer to page 71 for Benefit Limitations, Exceptions and Exclusions of this benefit.

Surgically implanted hearing devices (e.g., cochlear implants and bone-anchored hearing aid) are not covered under this Hearing Aid Services benefit but may be covered under the Plan benefits for Prosthetic Appliances described under the Durable Medical Equipment benefit on pages 43-44.

Hip and Knee Joint Replacement Surgery

80% Value Based Purchasing Design for Hip and Knee Joint Replacement and Tier 1 and Out-of-Area
70% outside Value Based Purchasing Design for Hip and Knee Joint Replacement/Tier 2
60% Non-Preferred Provider

Hip and knee joint replacement surgery benefits are subject to the Maximum Calendar Year Medical Financial Responsibility limits; however, services received from Non-Preferred Providers have no Coinsurance limits.

The benefit maximum for Inpatient services provided for hip and knee joint replacement is $30,000 per procedure. Anthem Blue Cross has developed a list of Value Based Purchasing Design (see the definition on page 117) Hospitals that routinely provide this service below this threshold. Please contact Customer Service and/or visit www.anthem.com/ca/calpers to verify that the Hospital qualifies under the Hip and Knee Joint Replacement for Value Based Purchasing Design and will provide services within this limitation.

Benefits are provided for Inpatient services for Medically Necessary routine hip and knee joint replacement surgery.

Precertification from the Review Center must be obtained as soon as possible, but no later than 3 business days prior to the commencement of services. Failure to obtain Precertification from the Review Center under the terms and conditions specified in this Evidence of Coverage and within the specified time frame may result in increasing your Coinsurance and liability responsibility by the application of financial sanctions (see page 32) and/or denial of benefits.

Travel Benefits for Hip and Knee Joint Replacement Surgery

If the Member's place of residence is outside a 50 mile radius of the nearest designated Value Based Purchasing Design (VBPD), certain travel expenses incurred by the Member may be covered in connection with an authorized routine hip and knee joint replacement surgical procedure performed at a designated VBPD. No benefits are payable for travel expenses to other than a designated VBPD.

For specific travel benefit information, see Travel Benefits for Bariatric Surgery on pages 37-38.

Home Health Care

80% Preferred Provider
60% Non-Preferred Provider

Home health care services are subject to the Maximum Calendar Year Medical Financial Responsibility limits; however, services received from Non-Preferred Providers have no Coinsurance limits.

Medically Necessary Skilled Care for continued treatment of an injury or illness furnished by a Home Health Agency is covered if the Member is Homebound, for up to **45 visits per Calendar Year**.

A treatment plan must be submitted in writing to the Review Center for precertification. Failure to obtain precertification from the Review Center under the terms and conditions specified in this Evidence of Coverage may result in increased Member costs and/or denial of benefits (see page 32).

A Physician must order the home health care and renew the order at least once every 30 days. Providers in California must be California licensed Home Health Agencies. Other out-of-state providers must be recognized as home health care providers under Medicare.

A visit is defined as 4 hours or less of covered services and Medically Necessary supplies provided by one of the following providers:

a. A registered nurse or licensed vocational nurse under the supervision of a registered nurse or a Physician;
b. A licensed therapist for physical, occupational, speech, or respiratory therapy;
c. A medical social service worker; or
d. A certified Home Health Aide employed by (or under arrangement with) a Home Health Agency. A certified Home Health Aide is covered only if you are also receiving the services of a registered nurse or licensed therapist employed by the same organization and the registered nurse is supervising the services. Custodial Care is not covered.

Notes:

- Speech, physical and occupational therapies provided in the home are covered under the Outpatient or Out-of-Hospital Therapies benefit and subject to the limitations specified in the benefit description on pages 53-55.
- Skilled nursing visits related to covered Home Infusion Therapy described below are included under these Home Health Care benefits and will be counted against the 45 visit per Calendar Year maximum.

Home Infusion Therapy

80% Preferred Provider
60% Non-Preferred Provider

Home Infusion Therapy services are subject to the Maximum Calendar Year Medical Financial Responsibility limits; however, services received from Non-Preferred Providers have no Coinsurance limits.

Services and medications must be precertified by the Review Center as soon as possible. Failure to obtain precertification from the Review Center under the terms and conditions specified in this Evidence of Coverage may result in increased Member costs and/or denial of benefits (see page 32).

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

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

Skilled nursing visits, including skilled nursing visits in association with Home Infusion Therapy services are included under the Home Health Care benefit. See the Home Health Care benefit description as shown above.

Hospice Care

80% All Providers

Hospice Care services are subject to the Maximum Calendar Year Medical Financial Responsibility limits.

To be eligible for Hospice Care benefits, charges must be incurred during a “benefit period” or period of bereavement which commences while the family unit is covered under PERS Select. Such charges must be made by, or under the direction of, a hospice program and incurred for a patient who is terminally ill as certified by his or her treating Physician.

A benefit period begins on the date that the treating Physician certifies that the patient is terminally ill and ends 90 days after it began or on the date of the patient’s death, whichever comes first. If the benefit period ends before the death of the patient, a new benefit period may begin if the treating Physician certifies that the patient is still terminally ill. A period of bereavement begins on the date of the patient’s death and ends 90 days after it began even though coverage under PERS Select may have ended on the date of death.

Covered services are provided, under the direction of the treating Physician, as follows:

- Interdisciplinary team care with the development and maintenance of an appropriate plan of care;
- Full-time, part-time or intermittent skilled nursing service provided by a registered nurse or licensed vocational nurse in the home or in a hospice facility;
- Part-time or intermittent home health services that provide supportive care in the home or in a hospice facility;
- Homemaking services for the patient at the place of residence;
- Social services and counseling services provided by a qualified social worker;
- Dietary and nutritional guidance. Nutritional support such as intravenous feeding or hyperalimentation;
- Physical Therapy, Occupational Therapy, Speech Therapy, and respiratory therapy provided by a licensed therapist;
- Volunteer services provided by trained hospice volunteers under the direction of a hospice staff member;
- Pharmaceuticals, medical equipment, and supplies necessary for the management of your condition. Oxygen and related respiratory therapy supplies;
- Counseling for the patient and family. Family counseling includes no more than 2 visits of bereavement counseling, up to 90 days following the patient’s death;
- Up to 5 days of Inpatient Hospital care for the patient (Respite Care);

- Palliative care which is appropriate for the illness. Palliative care is care that controls pain and relieves symptoms but is not intended to cure the illness.

Hospital Benefits

80% Preferred Provider (Tier 1 Hospital)
70% Preferred Provider (Tier 2 Hospital)
60% Non-Preferred Provider

Hospital benefits are subject to the Maximum Calendar Year Medical Financial Responsibility limits; however, services received from Non-Preferred providers have no Coinsurance limits.

All non-emergency hospitalizations and acute Inpatient Rehabilitation require Precertification by the Review Center as soon as possible, but no later than 3 business days before services are provided (except for maternity care and admissions for mastectomy or lymph node dissection). Certain Outpatient procedures, services and surgeries also require Precertification by the Review Center. Precertification is required no later than 3 business days or 30 business days prior to the start of services listed under Services Requiring Precertification on page 65. Failure to obtain Precertification from the Review Center under the terms and conditions specified in this Evidence of Coverage and within the specified time frame may result in increasing your Coinsurance and liability responsibility by the application of financial sanctions (see page 32) and/or denial of benefits. For information on benefits for Hospital services related to Emergency Care Services, refer to pages 44-45.

Note: Whenever possible, you should request that all of your care be provided by Preferred Providers upon entering a Preferred Hospital or Outpatient Hospital Setting. For example, you may be admitted to a Preferred Hospital or Outpatient Hospital Setting and some Physicians, such as anesthesiologists, radiologists and pathologists, on the Hospital's staff are Non-Preferred Providers.

Inpatient Services

Medically Necessary accommodations in a semi-private room and all Medically Necessary ancillary services, supplies, unreplaced blood and Take-Home Prescription Drugs, up to a 3 day supply. Covered benefits will not include charges in excess of the Hospital's prevailing semi-private room rate unless your Physician orders, and Anthem Blue Cross authorizes, a private room as Medically Necessary.

Outpatient Services

Outpatient services and supplies provided by a Hospital, including Outpatient surgery. Medically Necessary diagnostic, therapeutic and/or surgical services performed at a Hospital or Outpatient facility, including, but not necessarily limited to, kidney dialysis, chemotherapy, and radiation therapy.

Colonoscopy, cataract surgery, and arthroscopy services are considered routine services and these services can be performed safely at an Ambulatory Surgery Center. If these routine services are provided in an Ambulatory Surgery Center, benefits will be paid according to the Plan (see Ambulatory Surgery Centers on pages 34-35). If these routine services are provided in an Outpatient Hospital Setting, without an approved exception form, the following maximums will apply:

- Colonoscopy services are limited to **a maximum payment of $1,500** per procedure (see Colonoscopy Services on pages 41-42).
- Cataract surgery services are limited to **a maximum payment of $2,000** per procedure (see Cataract Surgery on page 39).
- Arthroscopy services are limited to **a maximum payment of $6,000** per procedure (see Arthroscopy Services on page 35).

Examples for an exception to allow routine colonoscopy, cataract surgery or arthroscopy services to be performed in an Outpatient Hospital include the following reasons:

- Patient safety; or
- If there is no preferred Ambulatory Surgery Center provider within a 30 mile radius of the Member's home.

The Member should consult their Physician and contact Customer Service for instructions on how to receive an exception.

Maternity Care

80% Preferred Provider
60% Non-Preferred Provider

For Inpatient or Outpatient services provided by a Hospital:

80% Preferred Provider (Tier 1 Hospital)
70% Preferred Provider (Tier 2 Hospital)
60% Non-Preferred Provider

Maternity care services are subject to the Maximum Calendar Year Medical Financial Responsibility limits; however, services received from Non-Preferred Providers have no Coinsurance limits.

Medically Necessary Physician, nurse midwife and Hospital services relating to prenatal and postnatal care and complications of pregnancy. Physician and Hospital services for routine care for the first 30 days, including nursery care, examination of the newborn and circumcision of the newborn, if the child's natural mother is an enrolled Employee, or an enrolled Annuitant or Family Member. Physician and Hospital services provided for a newborn beyond routine care will be under the newborn's Plan and subject to a separate Calendar Year Deductible and any other applicable Deductibles, Copayments and Coinsurance as provided under the newborn's Plan.

An Alternative Birthing Center may be used instead of hospitalization. Covered services provided by Alternative Birthing Centers, for both Preferred Providers and Non-Preferred Providers, are not subject to the Calendar Year Deductible, are payable at 80% of the Allowable Amount, and apply toward the Maximum Calendar Year Medical Financial Responsibility limits. An Alternative Birthing Center is defined as:

1. a birthing room located physically within a Hospital to provide homelike Outpatient maternity facilities, or
2. a separate birthing center that is certified or approved by a state department of health or other state authority and operated primarily for the purpose of childbirth.

Under the Newborns' and Mothers' Health Protection Act of 1996, the Plan may not limit length of Stay to less than 48 hours for normal vaginal delivery or 96 hours for Cesarean section delivery. Any earlier discharge of a mother and her newborn child from the Hospital must be made by the attending provider in consultation with the mother.

Refer to page 45 for emergency maternity admissions.

Mental Health Benefits

Inpatient Care

80% Preferred Provider (Tier 1 Hospital)
70% Preferred Provider (Tier 2 Hospital)
60% Non-Preferred Provider

Inpatient mental health benefits are subject to the Maximum Calendar Year Medical Financial Responsibility limits; however, services received from Non-Preferred Providers have no Coinsurance limits.

Precertification from the Review Center must be obtained 3 business days before admission, or within 24 hours or by the end of the first business day following an emergency admission, whichever is later. Failure to obtain Precertification from the Review Center under the terms and conditions specified in this Evidence of Coverage and within the specified time frame may result in increasing your Coinsurance and liability responsibility by the application of financial sanctions (see page 32) and/or denial of benefits.

Benefits are provided for Hospital, residential treatment center, and Physician services Medically Necessary to stabilize an acute psychiatric condition.

Note: Whenever possible, you should request that all of your care be provided by Preferred Providers upon entering a Preferred Hospital or Outpatient Hospital Setting. For example, you may be admitted to a Preferred Hospital or Outpatient Hospital Setting and some Physicians, such as anesthesiologists, radiologists and pathologists, on the Hospital's staff are Non-Preferred Providers.

Refer to pages 72-73 for Benefit Limitations, Exceptions and Exclusions of this benefit.

Outpatient Care (Facility-Based)

80% Preferred Provider (Tier 1 Hospital)
70% Preferred Provider (Tier 2 Hospital)
60% Non-Preferred Provider

Mental health Outpatient care (facility-based) services are subject to the Maximum Calendar Year Medical Financial Responsibility limits; however, services received from Non-Preferred Providers have no Coinsurance limits.

All covered Outpatient facility-based care provided by a Residential Treatment Facility must be precertified by the Review Center at least 3 business days before services are provided. Failure to obtain Precertification from the Review Center under the terms and conditions specified in this Evidence of Coverage and within the specified time frame may result in increasing your Coinsurance and liability responsibility by the application of financial sanctions (see page 32) and/or denial of benefits. For information on Precertification, refer to page 66.

For benefits to be payable, the provider must be a currently licensed Physician or mental health provider.

The intent of this benefit is to provide Medically Necessary treatment to stabilize an acute psychiatric condition. Mental health treatment is limited to evaluation, crisis intervention, and treatment for conditions which are subject to significant improvement through short-term therapy. Treatment for non-therapeutic treatment, Custodial Care and educational programs are not covered.

Refer to pages 72-73 for Benefit Limitations, Exceptions and Exclusions of this benefit.

Outpatient Care (Physician Office Visits, Physician Outpatient Hospital Visits, and Physician Urgent Care Visits)

$20 Copayment, Preferred Provider
60% Non-Preferred Provider

Includes:
- Individual and group sessions
- Physician/psychiatrist visits for mental health medication management
- Physician/psychiatrist Outpatient consultations

There is a $20 Copayment for each office visit which applies toward the Maximum Calendar Year Medical Financial Responsibility limits. Other Physician services rendered during an office visit, Outpatient Hospital visit, or Urgent Care visit are paid at 80% of the Allowable Amount and services received from Non-Preferred Providers have no Coinsurance limits.

The $20 Copayment applies to non-emergency Physician services received in the emergency room of a Hospital. This Copayment applies to the charge for the Physician visit only.

For benefits to be payable, the provider must be a currently licensed Physician or mental health provider.

The intent of this benefit is to provide Medically Necessary treatment to stabilize an acute psychiatric condition. Mental health treatment is limited to evaluation, crisis intervention, and treatment for conditions which are subject to significant improvement through short-term therapy. Treatment for non-therapeutic treatment, Custodial Care and educational programs are not covered.

Refer to pages 72-73 for Benefit Limitations, Exceptions and Exclusions of this benefit.

Natural Childbirth Classes

50% of class registration fee up to $50
(whichever is less)

Refresher classes — 50% of class registration
fee up to $25 (whichever is less)

Natural childbirth classes do not apply toward the Maximum Calendar Year Medical Financial Responsibility limits.

To prepare new and expectant parents for a natural birthing experience, the Plan will pay up to $50 or 50% of total fees (whichever is less) for natural childbirth classes. Classes will be reimbursed only when given by licensed instructors certified by ASPO (American Society for Psychoprophylaxis in Obstetrics)/Lamaze Childbirth Educators. Refresher classes are also provided by the Plan up to $25 or 50% of class fees (whichever is less).

Outpatient or Out-of-Hospital Therapies

Cardiac Rehabilitation

80% Preferred Provider
60% Non-Preferred Provider

Cardiac Rehabilitation services are subject to the Maximum Calendar Year Medical Financial Responsibility limits; however, services received from Non-Preferred Providers have no Coinsurance limits.

Outpatient cardiac Rehabilitation is primarily a monitored exercise treatment program design to strengthen the heart muscle, increase cardiac efficiency, or decrease the frequency of arrhythmia or angina. The cardiac Rehabilitation program is designed to help cardiac patients change their overall lifestyle so that health risks are decreased. Outpatient cardiac Rehabilitation is eligible for benefits only when prescribed by a Physician for the prevention or treatment of heart disease. Upon referral of a Physician, Medically Necessary services are covered **to a maximum of 40 visits per Calendar Year** when provided by licensed personnel in a formal cardiac Rehabilitation program. Outpatient cardiac Rehabilitation services do not include cardiac care services (see Cardiac Care on page 38) or any services in connection with a heart transplant (see Transplant Benefits on pages 61-63).

Physical Therapy and Occupational Therapy

80% Preferred Provider (Physical Therapy)
60% Non-Preferred Provider (Physical Therapy)
80% All Providers (Occupational Therapy)

Physical Therapy and occupation therapy services are subject to the Maximum Calendar Year Medical Financial Responsibility limits; however, services received from Non-Preferred Providers have no Coinsurance limits.

Upon referral by a Physician, Medically Necessary services are covered when rendered by a licensed physical therapist or a licensed occupational therapist for the treatment of an Acute Condition.

- Physical Therapy provided on an Outpatient basis for the treatment of illness or injury includes the therapeutic use of heat, cold, exercise, electricity, ultra violet radiation, manipulation of the spine, or massage for the purpose of improving circulation, strengthening muscles, or encouraging the return of motion. (This includes many types of care which are customarily provided by physical therapists and osteopaths.)

- Occupational Therapy provided on an Outpatient basis when the ability to perform daily life tasks has been lost or reduced, or has not been developed, due to, illness or injury. It includes programs which are designed to rehabilitate mentally, physically or emotionally disabled persons. Occupational Therapy programs are designed to maximize or improve a patient's upper extremity function, perceptual motor skills and ability to function in daily living activities.

Benefits are limited to a maximum of 24 visits per Calendar Year and no more than 1 visit per day. The Plan will pay for additional visits during a Calendar Year if you obtain Precertification from the Review Center.

If covered charges are applied to the Calendar Year Deductible those visits will **NOT** be included in the combined maximum of 24 visits per Calendar Year. When the Plan pays for covered charges toward a visit, then those visits will be included in the combined maximum of 24 visits per Calendar Year.

Benefits are not payable for care provided to relieve general soreness or for conditions that may be expected to improve without treatment. For the purposes of this benefit, the term "visit" shall include any visit by a Physician in that Physician's office, or in any other Outpatient setting, during which one or more of the services covered under this limited benefit are rendered, even if other services are provided during the same visit.

Precertification from the Review Center must be obtained for additional visits beyond those provided under this benefit. Precertification is required no later than 3 business days prior to the commencement of the additional services. Contact the Review Center at 1-800-451-6780 for Precertification of additional visits. Failure to obtain Precertification from the Review Center under the terms and conditions specified in this Evidence of Coverage and within the specified time frame may result in increasing your Coinsurance and liability responsibility by the application of financial sanctions (see page 32) and/or denial of benefits.

Pulmonary Rehabilitation

80% Preferred Provider
60% Non-Preferred Provider

Pulmonary Rehabilitation services are subject to the Maximum Calendar Year Medical Financial Responsibility limits; however, services received from Non-Preferred Providers have no Coinsurance limits.

Upon referral of a Physician, Medically Necessary services are covered **to a maximum of 30 visits per Calendar Year** when provided by licensed personnel in a formal pulmonary Rehabilitation program.

Speech Therapy

80% Preferred Provider
60% Non-Preferred Provider

Speech Therapy services are subject to the Maximum Calendar Year Medical Financial Responsibility limits; however, services received from Non-Preferred Providers have no Coinsurance limits.

Subject to a **maximum of 24 visits per Calendar Year. The Plan will pay for additional visits during a Calendar Year if you obtain Precertification from the Review Center**.

Precertification from the Review Center must be obtained for additional visits beyond those provided under this benefit. Precertification is required no later than 3 business days prior to the commencement of the additional services. Contact the Review Center at 1-800-451-6780 for Precertification of additional visits. Failure to obtain Precertification from the Review Center under the terms and conditions specified in this Evidence of Coverage and within the specified time frame may result in increasing your Coinsurance and liability responsibility by the application of financial sanctions (see page 32) and/or denial of benefits.

The Plan will pay for Medically Necessary services provided by a qualified speech therapist holding a certificate of competence in clinical speech pathology with the American Speech and Hearing Association.

Speech Therapy is considered **Medically Necessary** when your Physician prescribes the Speech Therapy based on a clinical assessment and is in accordance with Anthem Blue Cross Medical Policy for Speech Therapy. Under the direction of your Physician, the speech therapist will develop a specific Speech Therapy **plan of care**. The speech therapist will provide the services as specified in that plan of care.

Speech Therapy services must be documented in a **plan of care** which must be submitted with the claim. The plan of care must:

- Identify the types and frequency of treatment used;
- Be updated during ongoing therapy (indicates progress/plateau toward goal); and
- Be re-evaluated quarterly by your Physician.

Refer to page 73 for Benefit Limitations, Exceptions and Exclusions related to this benefit.

Physician Services

Physician Office Visits,
Physician Outpatient Hospital Visits, and
Physician Urgent Care Visits

$20 Copayment Preferred Provider (Office Visits)
60% Non-Preferred Provider

There is a $20 Copayment for the visit portion of the Physician's bill which applies toward the Maximum Calendar Year Medical Financial Responsibility limits. Other Physician services rendered during an office visit, Outpatient Hospital visit, or Urgent Care visit are paid at 80% of the Allowable Amount (see Other Physician Services below) and services received from Non-Preferred Providers have no Coinsurance limits.

The $20 Copayment applies to non-emergency Physician services received in the emergency room of a Hospital. This Copayment applies to the charge for the Physician visit only.

Other Physician Services

80% Preferred Provider
60% Non-Preferred Provider

Physician services received during an office visit (e.g., lab work or stitching a wound) are subject to the Maximum Calendar Year Medical Financial Responsibility limits. This includes any separate facility charge by an affiliated Hospital for a covered office visit to a Physician.

Services received from a Non-Preferred Provider have no Coinsurance limits.

NOTE: Visits and consultations by an ophthalmologist for an active illness are covered under the Physician Services benefit described above. Routine foot care, such as toenail trimming, is covered when provided during a covered Physician office visit in conjunction with treatment of diabetic or circulatory disorders of the lower limbs. Physician visits determined to be Emergency Care Services and received in an emergency room are covered under the Emergency Care Services benefit (as described on pages 44-45). Physician services related to mental health or substance abuse are covered under the Mental Health or Substance Abuse benefit, respectively. Physician services related to surgery are covered under Hospital Benefits. Services related to chiropractic care are covered under the Chiropractic and Acupuncture benefit. Health care services provided via Telemedicine (defined on page 117) may be covered under the Telemedicine Program benefit (as described on page 60).

Prior Authorization is required for certain Drugs that are dispensed and administered in a Physician's office.

Preventive Care

100% Preferred Providers
60% Non-Preferred Provider

Services received from Preferred Providers are not subject to the Calendar Year Deductible. However, the benefit maximum will apply to preventive care for arthroscopy, cataract and colonoscopy services received at an Outpatient Hospital Setting. The Member will be responsible for all charges in excess of the benefit maximum for these services.

Services received from Non-Preferred Providers have no Coinsurance limits.

Screening services and supplies provided in connection with preventive care services as shown below.

1. A Physician's services for routine physical examinations.
2. Immunizations prescribed by the examining Physician.
3. Radiology and laboratory services and tests ordered by the examining Physician in connection with a routine physical examination, excluding any such tests related to an illness or injury. Those radiology and laboratory services and tests related to an illness or injury will be covered as any other medical service available under the terms and conditions of the Plan.
4. Health screenings as ordered by the examining Physician for the following: breast cancer, including BRCA testing if appropriate (in conjunction with genetic counseling and evaluation), cervical cancer, including human papillomavirus, prostate cancer, colorectal cancer, and other medically accepted cancer screening tests, blood lead levels, high blood pressure, type 2 diabetes mellitus, cholesterol, obesity, and screening for iron deficiency anemia in pregnant women.
5. Human immunodeficiency virus (HIV) testing, regardless of whether the testing is related to a primary diagnosis.
6. Counseling and risk factor reduction intervention services for sexually transmitted infections, HIV, contraception, tobacco use, and tobacco use-related diseases.
7. Additional preventive care and screening for women provided for in the guidelines supported by the HRSA, including the following:
   a. All FDA-approved contraceptive methods for women, including over the counter items, if prescribed by a Physician. In order to be covered as preventive care, contraceptive Prescription Drugs must be either a generic or single-source brand name drug*. Also covered are sterilization procedures and counseling.

      * <u>If a Member's attending Provider recommends a particular service or FDA-approved item based on a determination of medical necessity with respect to that Member, the service or item is covered at 100% if using a Preferred Provider.</u>

   b. Breast feeding support, supplies, and counseling. One breast pump will be covered per pregnancy under this benefit.
   c. Gestational diabetes screening.
8. Preventive services for certain high-risk populations as determined by your Physician, based on clinical expertise.

This list of preventive care services is not exhaustive. Preventive tests and screenings with a rating of A or B in the current recommendations of the United States Preventive Services Task Force, or those supported by the HRSA will be covered with no Copayment and will not apply to the Calendar Year Deductible.

You may call Customer Service at 1-877-737-7776 for additional information about these services. You may also view the federal government's web sites:

https://www.healthcare.gov/what-are-my-preventive-care-benefits

http://www.ahrq.gov

http://www.cdc.gov/vaccines/acip/index.html

This benefit does apply to screenings. For example:

- A routine mammogram screening for breast cancer.

This benefit does not apply to treatment or follow-up testing. For example:

- Follow-up mammogram after abnormal results or cancer treatment.

Prior to receiving the indicated services, please discuss with your Physician regarding the nature of the tests and procedures.

For colonoscopy benefit, refer to the Colonoscopy Services on pages 41-42.

Reconstructive Surgery

80% Preferred Provider (Tier 1 Hospital)
70% Preferred Provider (Tier 2 Hospital)
60% Non-Preferred Provider

Reconstructive Surgery services are subject to the Maximum Calendar Year Medical Financial Responsibility limits; however, services received from Non-Preferred Providers have no Coinsurance limits.

Precertification from the Review Center must be obtained as soon as possible, but no later than 3 business days before services are provided. Failure to obtain Precertification from the Review Center under the terms and conditions specified in this Evidence of Coverage and within the specified time frame may result in increasing your Coinsurance and liability responsibility by the application of financial sanctions (see page 32) and/or denial of benefits.

Hospital and Physician services provided in connection with Reconstructive Surgery performed to correct deformities caused by congenital or developmental abnormalities, illness, or injury for the purpose of improving bodily function or symptomatology or creating a normal appearance. However, dental surgery, including dental implants (materials implanted into or on bone or soft tissue), is not covered even if related to Emergency Care Services or treatment of injury, except as specifically provided under the Cleft Palate benefit on page 40. Services must commence within 90 days from the date on which the injury was sustained or within 90 days of the date treatment was first medically appropriate.

Reconstructive Surgery performed to restore symmetry following a mastectomy for documented medical pathology, such as cancer, is covered. Prosthetic Devices and services provided in connection with a mastectomy are a benefit regardless of when the mastectomy was performed. Benefits are also payable for Medically Necessary services provided in connection with complications arising from Reconstructive Surgery.

Benefits are not payable for services provided in connection with complications arising from a non-authorized or Cosmetic Procedure.

Retail Health Clinic

$20 Copayment Preferred Provider (Office Visit)
80% Preferred Provider (Other Services)
60% Non-Preferred Provider

There is a $20 Copayment for the visit portion of the Physician's bill which applies toward the Maximum Calendar Year Medical Financial Responsibility limits. Other Physician services rendered during an office visit in a Retail Health Clinic are paid at 80% of the Allowable Amount and services received from Non-Preferred Providers have no Coinsurance limits.

The $20 Copayment applies to services and supplies provided by Physician assistants and/or nurse practitioners who provide basic medical services in a Retail Health Clinic. This Copayment applies to the charge for the Physician visit only.

Skilled Nursing and Rehabilitation Care

First 10 days: 80% Preferred Provider
Next 90 days: 70% Preferred Provider
For all Non-Preferred Provider services: 60%

Skilled nursing and Rehabilitation Care services are subject to the Maximum Calendar Year Medical Financial Responsibility limits; however, services received from Non-Preferred Providers have no Coinsurance limits.

Admission and services in connection with confinement in a Skilled Nursing Facility must be precertified by the Review Center as soon as possible, but no later than 3 business days before admission. Failure to obtain Precertification from the Review Center under the terms and conditions specified in this Evidence of Coverage and within the specified time frame may result in increasing your Coinsurance and liability responsibility by the application of financial sanctions (see page 32) and/or denial of benefits.

Benefits are provided for Medically Necessary confinement in a Skilled Nursing Facility, if necessary, instead of Hospital confinement, up to 100 days combined for both Preferred Providers and Non-Preferred Providers, during each Calendar Year. Room and board charges in excess of the facility's established semi-private room rate are not covered. These benefits will only be provided if services are:

1. prescribed by the patient's Physician;
2. for skilled and not Custodial Care; and
3. for the continued treatment of an injury or illness.

Smoking Cessation Program

This Plan covers without cost-sharing: screening for tobacco use; and, for those who use tobacco products, at least two tobacco cessation attempts per year.

A smoking cessation attempt includes coverage for: four tobacco cessation counseling sessions of at least 10 minutes each (including telephone counseling, group counseling and individual counseling) without prior authorization; and all Food and Drug Administration (FDA)-approved tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a Provider without prior authorization.

In addition to the smoking cessation attempts described in the preceding paragraph, the Plan will reimburse a Member **up to a maximum of $100 per Calendar Year** for behavior modifying smoking cessation counseling or classes or alternative treatments, such as acupuncture or biofeedback, for the treatment of nicotine dependency or tobacco use when not covered under benefits stated elsewhere in this Evidence of Coverage. A legible copy of dated receipts for expenses must be submitted along with a claim form to Anthem Blue Cross to obtain reimbursement.

Costs associated with smoking cessation programs not covered under the Plan without cost sharing do not apply toward the Maximum Calendar Year Medical Financial Responsibility limits.

Substance Abuse

Inpatient Care

80% Preferred Provider (Tier 1 Hospital)
70% Preferred Provider (Tier 2 Hospital)
60% Non-Preferred Provider

Inpatient care for substance abuse services are subject to the Maximum Calendar Year Medical Financial Responsibility limits; however, services received from Non-Preferred Providers have no Coinsurance limits.

Precertification from the Review Center must be obtained 3 business days before admission, or within 24 hours or by the end of the first business day following an emergency admission, whichever is later. Failure to obtain Precertification from the Review Center under the terms and conditions specified in this Evidence of Coverage

and within the specified time frame may result in increasing your Coinsurance and liability responsibility by the application of financial sanctions (see page 32) and/or denial of benefits.

Benefits are provided for Hospital and Physician services Medically Necessary for short-term medical management of detoxification or withdrawal symptoms. Inpatient programs and Inpatient Stays at residential treatment facilities are not covered.

Note: Whenever possible, you should request that all of your care be provided by Preferred Providers upon entering a Preferred Hospital or Outpatient Hospital Setting. For example, you may be admitted to a Preferred Hospital or Outpatient Hospital Setting and some Physicians, such as anesthesiologists, radiologists and pathologists, on the Hospital's staff are Non-Preferred Providers.

Refer to page 72-73 for Benefit Limitations, Exceptions and Exclusions related to this benefit.

Outpatient Care (Facility-Based)

80% Preferred Provider (Tier 1 Hospital)
70% Preferred Provider (Tier 2 Hospital)
60% Non-Preferred Provider

Outpatient care for substance abuse services are subject to the Maximum Calendar Year Medical Financial Responsibility limits; however, services received from Non-Preferred Providers have no Coinsurance limits.

For benefits to be payable, the provider must be a currently licensed Physician or mental health provider.

All covered Outpatient facility-based care provided by a Residential Treatment Facility must be precertified by the Review Center at least 3 business days before services are rendered. Failure to obtain Precertification from the Review Center under the terms and conditions specified in this Evidence of Coverage and within the specified time frame may result in increasing your Coinsurance and liability responsibility by the application of financial sanction (see page 32) and/or denial of benefits. For information on Precertification, refer to page 66.

The intent of this benefit is to provide Medically Necessary treatment to stabilize an acute substance abuse condition.

Outpatient Care (Physician Office Visits, Physician Outpatient Hospital Visits, and Physician Urgent Care Visits)

$20 Copayment, Preferred Provider (Office Visit)
80% Preferred Provider (Other Services)
60% Non-Preferred Provider

Includes:
- Individual and group sessions
- Physician/psychiatrist visits for mental health medication management
- Physician/psychiatrist Outpatient consultations

There is a $20 Copayment for each office visit which applies toward the Maximum Calendar Year Medical Financial Responsibility limits. Other Physician services rendered during an office visit, Outpatient Hospital visit, or Urgent Care visit are paid at 80% of the Allowable Amount and services received from Non-Preferred Providers have no Coinsurance limits.

The $20 Copayment applies to non-emergency Physician services received in the emergency room of a Hospital. This Copayment applies to the charge for the Physician visit only.

For benefits to be payable, the provider must be a currently licensed Physician or mental health provider.

The intent of this benefit is to provide Medically Necessary treatment to stabilize an acute substance abuse condition.

Refer to pages 72-73 for Benefit Limitations, Exceptions and Exclusions of this benefit.

Telemedicine Program

$20 Copayment, consultation or second opinion by Anthem Blue Cross' Telemedicine Network Specialty Center

80% all other services by Anthem Blue Cross' Telemedicine Network

There is a $20 Copayment for each Telemedicine Network provider consultation or second opinion portion of the Specialty Center's bill. This Copayment and any applicable Coinsurance for services provided by a Telemedicine Network Presentation Site or Specialty Center will apply toward the Maximum Calendar Year Medical Financial Responsibility limits.

Coverage will be provided for Telemedicine, as defined on page 117, for Plan Members residing in rural areas of California only when provided by Anthem Blue Cross' Telemedicine Network of designated providers specifically equipped and trained to provide Telemedicine health care services. To find out if you're eligible to access care through the Telemedicine Program or the location of Presentation Sites and Specialty Centers, call Anthem Blue Cross Telemedicine Department toll-free at 1-866-855-2271.

Transplant Benefits

If you have a general question about your scheduled transplant, you may directly contact the Transplant Customer Service Department at 1-888-574-7215.

Cornea and Skin Transplants

Hospital Services	80% Preferred Provider (Tier 1 Hospital) 70% Preferred Provider (Tier 2 Hospital) 60% Non-Preferred Provider
Evaluations and Diagnostic Tests	80% Preferred Provider 60% Non-Preferred Provider

Transplant benefits are subject to the Maximum Calendar Year Medical Financial Responsibility limits; however, services received from Non-Preferred Providers have no Coinsurance limits.

Precertification for skin transplants must be obtained from the Review Center as soon as possible, but no later than 3 business days before services are provided. Failure to obtain Precertification from the Review Center under the terms and conditions specified in this Evidence of Coverage and within the specified time frame may result in increasing your Coinsurance and liability responsibility by the application of financial sanctions (see page 32) and/or denial of benefits.

Hospital and professional services provided in connection with human organ transplants are a benefit only to the extent that:

1. they are Medically Necessary and medically appropriate for the patient;
2. they are provided in connection with the transplant of a cornea, or skin; and
3. the recipient of such transplant is a Subscriber or Family Member.

Covered expenses for the donor, including donor testing and donor search, are limited to those incurred for Medically Necessary medical services only. Charges for Medically Necessary services incident to obtaining the transplanted material from a living donor or a human organ transplant "bank" will be covered. Such charges, including complications from the donor procedure for up to 6 weeks from the date of procurement, are covered. Services for treatment of a condition that is not directly related to, or a direct result of, the transplant are not covered.

Special Transplant Benefit

Hospital Services	80% at Centers of Medical Excellence
Evaluations and Diagnostic Tests	80% at Centers of Medical Excellence

Special transplant benefits are subject to the Maximum Calendar Year Medical Financial Responsibility limits.

Centers of Medical Excellence for Special Transplants were developed in collaboration with expert Physicians and medical organizations to provide a full range of special transplant services as specified below. Additional value-added services provided through this program include global pricing. The selection criteria used in designating a Centers of Medical Excellence for Special Transplants include:

- An established transplant program, actively performing the procedures listed below for the most recent 24-month period and performing a required minimum volume of transplant procedures.
- Appropriate experience and credentialing of its transplant team.
- An established Acute Care Inpatient facility, including intensive care, emergency and a full range of services.
- Full accreditation by a Centers for Medicare and Medicaid Services (CMS)-deemed national accreditation organization.
- Evaluation of patient and graft aggregate outcomes including sufficiently low graft failures and mortality rates.
- A comprehensive quality management program.
- Documented patient care and follow-up procedures at admission and discharge, including referral back to primary care Physicians.

The Special Transplant Benefit is limited to the procedures listed below. These benefits will be covered only when the procedure is in accordance with Anthem Blue Cross Medical Policy, and prior **written** authorization has been obtained from Anthem Blue Cross' Corporate Medical Director, and the services are performed at an approved Centers of Medical Excellence (CME). Anthem Blue Cross' Corporate Medical Director shall review all requests for prior approval and shall approve or deny benefits based on (a) the medical necessity and medical appropriateness of the transplant for the patient, (b) the qualifications of the Physicians who will perform the procedure, and (c) the referral of the Subscriber or Family Member to a facility that is an approved CME.

Pre-transplant evaluation and diagnostic tests, transplantation, and follow-ups will be allowed only at a CME. Non-acute/non-emergency evaluations, transplantations and follow-ups at facilities other than a CME will **not** be covered. Evaluation of potential candidates by a CME is covered subject to prior authorization. In general, more than one evaluation (including tests) within a short time period and/or at more than one CME will not be authorized unless the medical necessity of repeating the service is documented and the Review Center has reviewed the documentation and precertified the service.

For information on CMEs, call 1-800-451-6780.

Failure to obtain Precertification from the Review Center under the terms and conditions specified in this Evidence of Coverage and within the specified time frame may result in increasing your Coinsurance and liability responsibility by the application of financial sanctions (see page 32) and/or denial of benefits.

The Special Transplant Benefit provision only applies to:

- Human heart transplants
- Human lung transplants
- Human heart and lung transplants in combination
- Human liver transplants
- Human pancreas transplants
- Human kidney transplants
- Human kidney and pancreas transplants in combination
- Human bone marrow transplants, peripheral stem cell transplantation, or umbilical cord transplants
- Human small bowel transplants
- Human small bowel and liver transplants in combination

CME agrees to accept the negotiated rate for transplant facilities as payment for covered services. Plan Members are responsible for the remaining 20% of the lesser of Billed Charges or the negotiated rate for covered services and all charges for non-covered services.

Benefits for an organ donor are as follows:

- When the person donating the organ and the person getting the organ are covered Members, each will get benefits under their Plans.
- When the person donating the organ is **NOT** a covered Member, but the person getting the organ is a covered Member, benefits for the organ donor (who is not a covered Member) under this Plan are limited to benefits not available to the donor from any other source. Other source includes, but is not limited to, other insurance, grants, foundations, and government programs.
- If the Member, covered under this Plan, is donating the organ to someone who is **NOT** a covered Member, benefits for the covered Member donating the organ are not available under this Plan.

Covered expenses for the donor, including donor testing and donor search, are limited to those incurred for Medically Necessary medical services only. Charges for Medically Necessary services incident to obtaining the transplanted material from a living donor or an organ transplant "bank" will be covered. Such charges, including complications from the donor procedure for up to six (6) weeks from the date of procurement, are covered. Services for treatment of a condition that is not directly related to, or a direct result of, the transplant are not covered.

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

Payment for unrelated donor searches for covered bone marrow transplants, peripheral stem cell transplantation or umbilical cord transplants will not exceed $30,000 per transplant.

The Review Center's Transplant Coordinator can assist in facilitating your access to a CME. Please notify the Review Center at 1-800-451-6780 as soon as your provider recommends a transplant for your medical care.

CME providers are not available outside California; therefore, Plan Members who do not live or receive services in California will be referred by Anthem Blue Cross' Transplant Coordinator to other qualified facilities.

Travel Benefits for Special Transplant Services

Certain travel expenses incurred by the Member may be covered in connection with an authorized special transplant (heart, liver, lung, combination heart-lung, kidney, pancreas, simultaneous kidney-pancreas, or bone marrow, including autologous bone marrow transplant, peripheral stem cell replacement and similar procedures) performed at a CME when 250 miles or more from the recipient's or donor's place of residence.

Travel expenses must be authorized in advance by the Review Center's Transplant Coordinator. Prior authorization can be obtained by calling toll free (888) 613-1130. A legible copy of dated receipts for all expenses must be submitted along with a travel reimbursement form to Anthem Blue Cross to obtain reimbursement. No benefits are payable for unauthorized travel expenses. Details regarding reimbursement can be obtained by calling Customer Service at 1-877-737-7776.

The Calendar Year Deductible will not apply, and no Copayments or Coinsurance will be required for authorized transplant travel expenses. Anthem Blue Cross will provide benefits for meal, lodging and ground transportation, up to the limits set forth in the Internal Revenue Code as determined by Anthem Blue Cross, at the time expenses are incurred.

Payment will not exceed $10,000 per transplant for the following travel expenses incurred by the recipient and 1 companion* or the donor:

- Ground transportation to and from the CME when the designated CME is 75 miles or more from the recipient's or donor's place of residence.

- Coach airfare to and from the CME when the designated CME is 300 miles or more from the recipient's or donor's residence.
- Lodging, limited to one room, double occupancy.
- Other necessary expenses, such as meals.

*Note: When the Member recipient is under 18 years of age, this benefit will apply to the recipient and 2 companions or caregivers.

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

Urgent Care

Physician Visits

$20 Copayment Preferred Provider
60% Non-Preferred Provider

There is a $20 Copayment for each Physician visit to a Preferred Provider for Urgent Care which applies toward the Maximum Calendar Year Medical Financial Responsibility limits. Other Physician services rendered by a Preferred Provider during an Urgent Care visit are paid at 80% of the Allowable Amount (see Other Physician Services below).

Visits to a Non-Preferred Provider are subject to the Calendar Year Deductible, and you are responsible for the remaining 40% and all charges in excess of the Allowable Amount. Services received from Non-Preferred Providers have no Coinsurance limits.

Other Physician Services

80% Preferred Provider
60% Non-Preferred Provider

Other Physician services by a Preferred Provider received during an Urgent Care visit (e.g., lab work or stitching a wound) are subject to the Calendar Year Deductible and paid at 80% of the Allowable Amount. You are responsible for the remaining20% up to the Maximum Calendar Year Medical Financial Responsibility limits.

Services received from a Non-Preferred Provider are subject to the Calendar Year Deductible, and you are responsible for the remaining 40% and all charges in excess of the Allowable Amount. Services received from Non-Preferred Providers have no Coinsurance limits.

Urgent Care is those services for diagnosis and treatment of a sudden, serious, or unexpected illness, injury or condition, other than one which is life threatening (see definition for Urgent Care on page 117). For the purposes of this benefit, "urgent care centers" are Physician offices open for extended hours which provide care on a first-come, first-serve basis. You can access a listing of urgent care centers that are Preferred Providers on the Anthem Blue Cross Web site at www.anthem.com/ca/calpers, or call Customer Service at 1-877-737-7776. Office hours and days of operation vary, and you should call the provider before going to their office.

Urgent Care does not require the use of a Hospital or emergency room. Some urgent care facilities are affiliated with a Hospital or hospital group and you may incur a separate facility charge. Charges for facility/Hospital based services are not covered under this Urgent Care benefit. Please refer to the Hospital benefit on pages 50-51 for details regarding facility/Hospital based urgent care centers. Choosing to visit a Hospital or an Urgent Care affiliated with a Hospital or hospital group, for Urgent Care services may result in increased Copayment or Coinsurance responsibility and/or denial of benefits.

UTILIZATION REVIEW

Utilization review is designed to involve you in an educational process that evaluates whether health care services are Medically Necessary, provided in the most appropriate setting, and consistent with acceptable treatment patterns found in established managed care environments. Anthem Blue Cross' Review Center reviews Inpatient hospitalizations, including emergencies but excluding maternity admissions under a 48-hour Stay for a normal delivery or a 96-hour Stay for a Cesarean delivery and admissions for mastectomy or lymph node dissection. The Review Center also reviews other medical services, including treatment of mental disorders, substance abuse and Outpatient surgical procedures. Precertification by the Review Center is required before these benefits will be payable.

Contacting the Review Center when necessary, before receiving services, and complying with the Review Center's recommendations can help you receive maximum benefit coverage and thus minimize your financial responsibility. The Review Center may monitor your care during treatment and throughout a hospitalization to help ensure that quality medical care is efficiently delivered.

Services which are determined by the Review Center not to be Medically Necessary or efficiently delivered may not be covered under the Plan. Failure to obtain Precertification from the Review Center under the terms and conditions specified in this Evidence of Coverage and within the specified time frame may result in increasing your Coinsurance and liability responsibility by the application of financial sanctions (see page 32) and/or denial of benefits.

The Review Center's services provide you with specific advantages:

- You will be provided with information that can help you qualify for the highest level of benefits under the Plan, thus minimizing your financial responsibility.
- You will have telephone access to a clinical professional who can coordinate the review of your care. This Coordinator can assist in answering questions you may have about your proposed treatment.

For Precertification of hospitalizations and of the procedures/services and Outpatient surgeries specified under Precertification, contact the Review Center at 1-800-451-6780. Although your provider may notify the Review Center of an upcoming non-emergency hospitalization or Outpatient surgery/service requiring Precertification, it is ultimately your responsibility, not your provider's, to call the Review Center. A Coordinator may need to speak with both you and your Physician during the medical necessity review process.

If you elect to receive services from a different facility or provider after the Review Center has precertified a procedure, you must contact the Review Center again to obtain Precertification.

Precertification

Precertification is required no later than 3 business days or 30 business days (see Services Requiring Precertification on the following page) before the procedure, service or surgery is provided or for specific Durable Medical Equipment. Note: Precertification is required for home health care, home infusion therapy services and advanced imaging procedures including, but not limited to, MRI, CAT scan, PET scan, MRS scan, MRA scan, Echocardiography and Nuclear Cardiac Imaging, but are not restricted to the specified 3 or 30 business day time frames.

It is your responsibility, not your provider's, to call the Review Center. Failure to obtain Precertification from the Review Center under the terms and conditions specified in this Evidence of Coverage and within the specified time frames may result in an increase in your Coinsurance and financial sanctions (see page 32) and/or denial of benefits if it is determined that the services were not Medically Necessary or not a covered benefit of the Plan.

UTILIZATION REVIEW

Services Requiring Precertification

For home health care, home infusion therapy services and advanced imaging procedures Precertification is required, but not within specific time frames. Such imaging procedures include, but are not limited to, MRI, CAT scan, PET scan, MRS scan, MRA scan, Echocardiography and Nuclear Cardiac Imaging. restricted.

The following is a summary of the services requiring Precertification within a certain time frame.

3-Day Requirement	30-Day Requirement
Precertification is required no later than 3 business days prior to the start of the following procedures, services and surgeries or purchase of Durable Medical Equipment: • Inpatient hospitalization • Acute Inpatient Rehabilitation • Skilled Nursing Facility (see page 58) • All Inpatient mental health or substance abuse treatment (see pages 52 and 58-59) • All Outpatient facility-based care for mental health or substance abuse treatment (see page 52-53 and 59) • Temporomandibular disorder treatment and diagnostic services, including MRIs and surgeries • Maxillomandibular musculoskeletal surgeries • Septoplasty and sinus-related surgeries • Penile implant surgeries • Specific Durable Medical Equipment (see pages 43-44) • Bariatric surgeries • Any plastic or reconstructive procedures/ surgeries • Skin transplants • Any anesthesia administered by an anesthesiologist or nurse anesthetist during a colonoscopy • Hip and knee joint replacement surgeries • Additional Physical Therapy and Occupational Therapy visits beyond those provided under the Plan • Additional Speech Therapy visits beyond those provided under the Plan • Gender reassignment surgery including travel expense	Precertification is required no later than 30 business days prior to the start of the following procedures and surgeries: • Hepatic Activation/Chronic Intermittent Intravenous Insulin Infusion Therapy/Pulsatile Intravenous Insulin Infusion Therapy Treatments

If you fail to obtain Precertification from the Review Center for the services listed above, or if there are serious questions on the Plan's part as to the medical necessity or purpose for which a service was provided, the Review Center may review the services provided to you after they have been rendered. This is known as retrospective review. This review may result in a determination that reimbursement will be reduced or even denied under certain circumstances. Any subsequent adjustment in benefit levels as a result of retrospective review will be communicated to you in writing.

Even though services that require Precertification may ultimately be approved after retrospective review, financial sanctions (see page 32) may nevertheless be applied if the Member failed to obtain Precertification from the Review Center.

Precertification for Treatment of Mental Disorders and Substance Abuse

You must call Anthem Blue Cross' Review Center at 1-800-451-6780 for Precertification of any facility-based treatment for mental disorders and substance abuse. Normal business hours are from 7:30 a.m. to 5:30 p.m. PST (Pacific Standard Time) Monday through Friday. If you have an urgent situation that requires immediate attention outside normal business hours, call 1-800-451-6780 and select the appropriate after-hours option.

Licensed mental health professionals are available to take your call after normal business hours, and during weekends and holidays.

When you call the Review Center, an intake representative:

- will verify eligibility and obtain demographic information;
- will evaluate whether you need to speak immediately with a licensed mental health professional (care manager) at the Review Center; and
- if appropriate, may refer you to a mental health provider in your area.

Following this screening process, the representative may also authorize initial visits with a mental health provider. The provider will:

- evaluate, diagnose and identify your specific treatment needs in a face-to-face interview; and
- develop an appropriate Treatment Plan for you.

A written Treatment Plan may be requested. A care manager at the Review Center will evaluate the medical necessity and appropriateness of the Treatment Plan submitted by your provider. If the Plan is accepted, the care manager will precertify additional services if necessary. In other words, a specific number of visits, days, or treatments will be authorized.

Precertification for Diagnostic Services

You must call Anthem Blue Cross' Review Center at 1-800-451-6780 for Precertification of select Outpatient diagnostic imaging services. Advanced imaging procedures including, but not limited to, MRI, CAT scan, PET scan, MRS scan, MRA scan, Echocardiography, and Nuclear Cardiac Imaging are subject to Precertification review to determine medical necessity.

Emergency Admission

The Review Center must be notified of an emergency Inpatient admission within 24 hours or by the end of the first business day following admission, whichever is later, unless extraordinary circumstances prevent such notification within that time period. In determining "extraordinary circumstances," the Review Center may take into account whether your condition was severe enough to prevent you from notifying them, or whether no one was available to provide the notification for you. You may have to prove that such extraordinary circumstances were present at the time of the emergency.

The Hospital, your Physician, a Family Member, or a friend may call the Review Center if you are unable to call yourself. However, it is still your responsibility to make sure that the Review Center has been contacted. After the Review Center has been notified, a Coordinator will contact the Hospital or your Physician to obtain information on the recommended Treatment Plan.

UTILIZATION REVIEW

Non-Emergency Admission

The Review Center must be contacted for Precertification at least 3 business days prior to a non-emergency Inpatient Hospital Stay or Outpatient surgery/service requiring Precertification. Precertification is not required for maternity admissions or admissions for mastectomy or lymph node dissection.

Staff in the Review Center may need to speak with both you (or the patient) and your Physician prior to making their decision regarding medical necessity. During your Hospital Stay or ongoing treatment, the Review Center's staff will continue to manage and follow your care (known as concurrent review).

Although Precertification is not required for Inpatient Hospital Stays for maternity care, concurrent review will be performed if you remain in the Hospital longer than 48 hours following a normal delivery or 96 hours following a Cesarean section delivery.

Staff in the Review Center will not contact you in the Hospital regarding their recommendation without your permission. You may, however, advise the Review Center if you wish to be contacted in the Hospital or if you wish to designate someone else to be contacted.

If you disagree with the Review Center's recommendation regarding continuing care, you or your Physician may request a concurrent appeal by calling the Review Center. You do not need to leave the Hospital or discontinue treatment; however, you may be liable for expenses beyond the date of the Review Center's Precertification.

Refer to pages 76-78 for more information on medical claims review and appeals process.

Financial sanctions may be applied if the proposed Hospital admission, Outpatient surgery or other service is scheduled less than 3 business days from the date you notify the Review Center. In this case, if you wish to meet the notification requirements, you may wish to discuss the pros and cons of postponing the service with your Physician.

Case Management

Case Management is a voluntary program to assist seriously ill or injured PERS Select Members, who require extensive medical services and have exceptional or complex needs, in obtaining high quality, cost-effective care. A Member may be identified for possible Case Management through the Plan's utilization review procedures or claims reports. The Member, the Member's Physician or the Plan may also request that the Review Center perform Case Management services for a Member who has multiple medical problems, or requires extensive health care services, or would benefit from assistance with coordination of health care services. Case management services are performed after receiving the Plan Member's consent to participate in Case Management.

A case manager is responsible for evaluating and monitoring the efficiency, appropriateness and quality of all aspects of health care. To achieve this objective, Case Management works in collaboration with your team of health care professionals to provide feedback, support and assistance during the utilization and case management process. In some instances Case Management enables the Review Center to authorize you to obtain medically appropriate care in a more economical, cost-effective and coordinated manner during prolonged periods of intensive medical care. Case Management has the right, through a case manager, to work with your health care provider to identify an alternative plan of treatment. It is not your right to receive personal Case Management, nor does PERS Select have an obligation to provide it. These services are provided at the sole and absolute discretion of the Plan.

Benefits for Case Management will be considered only when the following criteria are met:

1. You require extensive long-term treatment;
2. It is anticipated that such treatment utilizing services or supplies covered under PERS Select will result in considerable cost;
3. Anthem Blue Cross Review Center's cost-benefit analysis determines that the benefits payable under PERS Select for the alternative plan of treatment can be provided at a lower overall cost than the benefits you would otherwise receive under this Plan while maintaining the same standards of care;

4. You (or your legal guardian) and your health care provider agree, in a letter of agreement, with the recommended substitution of benefits and with the specific terms and conditions under which alternative benefits are to be provided; and

5. You consent to receive Case Management services from the Review Center.

If Case Management determines that your needs could be met more efficiently, an alternative Treatment Plan may be recommended by your health care provider. A case manager will review the medical records and discuss your treatment with the attending Physician, you, and your family.

If you have exhausted benefits for such services, Case Management will authorize benefit substitution when additional services need to be provided and you have a remaining Skilled Nursing Facility (SNF) benefit. For example, the Skilled Nursing and Rehabilitation Care benefit may be substituted for Medically Necessary home health care if the Home Health Care benefit maximum has been reached. Benefits without dollar, day and/or visit maximum(s) shall not be substituted for any other service, treatment or program. For example, Hospital Benefits for Inpatient services will not be substituted for confinement in a Skilled Nursing Facility, even if the maximum payment under the Skilled Nursing and Rehabilitation Care benefit has been reached. In addition, benefits are not created where they do not exist. Benefits payable are limited to the maximum amount of the SNF benefit being substituted. Using the example cited at the beginning of this paragraph, the Skilled Nursing and Rehabilitation Care benefit may be substituted for home health care, but payment will not exceed the dollar amount equivalent to the maximum day limit under the Skilled Nursing and Rehabilitation Care benefit.

Your health care provider makes treatment recommendations only; any decision regarding treatment belong to you and your Physician. The Plan will, in no way, compromise your freedom to make such decisions.

Effect on Benefits

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

2. 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 another Member.

3. The Case Management program does not prevent the Plan from strictly applying the expressed benefits, exclusions and limitations of PERS Select at any other time or for any other Member.

If Case Management services are requested for and accepted by a PERS Select Member, the Member will avoid higher financial expenses by compliance and cooperation with the Review Center's Case Management services. All services are subject to review for medical necessity by the Review Center for the Member in Case Management even though the services under review may not be listed in the PERS Select Evidence of Coverage as requiring review.

BENEFIT LIMITATIONS, EXCEPTIONS AND EXCLUSIONS

No one has the right to receive any benefits of this Plan following termination of coverage, except as specifically provided under the Benefits After Termination or Continuation of Group Coverage provisions in this booklet.

Administrative remedies for requests for exemption from benefit limitations, exceptions or exclusions are available only under the following circumstances: If a service or procedure has been denied for the reason that it is not a covered benefit of the Plan, or that it is a limitation, exception or exclusion of the Plan, the Member must demonstrate that the limitation, exception or exclusion is prohibited by law and establish that the service or procedure is Medically Necessary according to Anthem Blue Cross Medical Policy.

Benefits are subject to review for medical necessity before, during and/or after services have been rendered. Refer to page 21 for the Medical Necessity provision and to pages 64-68 for utilization review standards and procedures.

The title of each exclusion is not intended to be fully descriptive of the exclusion; rather, it is provided solely to assist the Plan Member to easily locate particular items of interest or concern. Remember, a particular condition may be affected by more than one exclusion.

Under no circumstances will the Plan be liable for payment of costs incurred by a Plan Member for treatment deemed by CalPERS or its Plan administrators to be Experimental or Investigational or otherwise not eligible for coverage.

General Exclusions

Benefits of this Plan are not provided for, or in connection with*, the following:

1. **Aids and Environmental Enhancements**

   a. The rental or purchase of aids, including, but not limited to, ramps, elevators, stairlifts, swimming pools, spas, hot tubs, air filtering systems or car hand controls, whether or not their use or installation is for purposes of providing therapy or easy access.

   b. Any modification made to dwellings, property or motor vehicles, whether or not their use or installation is for purposes of providing therapy or easy access.

2. **Benefit Substitution/Flex Benefit/In Lieu Of**. Any program, treatment, service, or benefit cannot be substituted for another benefit, except as specifically stated under Case Management on pages 67-68, nor be covered through a non-existing benefit. For example, a Member may not receive Inpatient Hospital services benefits for an admission to a Skilled Nursing Facility.

3. **Botulinum Toxins (all forms) Injections, "Botox", Collagen, or filling material**. Any services or supplies for any injections of botulinum toxin, collagen or filling material to primarily improve the appearance (including appearance altered by disease, trauma, or aging) e.g., to remove acne scarring, fine wrinkling, etc. This exclusion will not apply to botulinum toxin injection procedures that comply with Anthem Blue Cross Medical Policy and are Medically Necessary for an indication approved by the FDA.

4. **Clinical Trials.** Services and supplies in connection with clinical trials are not covered except as specifically provided in the Clinical Trials benefit description on pages 40-41.

5. **Close-Relative Services**. Charges for services performed by a Close Relative or by a person who ordinarily resides in the Plan Member's home.

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* **The phrase "in connection with" means any medical condition associated with an excluded medical condition** (i.e., an integral part of the excluded medical condition or derived from it).

6. **Convenience Items and Non-Standard Services and Supplies**. Services and supplies determined by the Plan as not Medically Necessary or not generally furnished for the diagnosis or treatment of the particular illness, disease or injury; or services and supplies which are furnished primarily for the convenience of the Plan Member, irrespective of whether or not prescribed by a Physician.

7. **Cosmetic**. Any surgery, service, Drug or supply primarily to improve the appearance (including appearance altered by disease, trauma, or aging) of parts or tissues of an individual. This exclusion does not apply to Reconstructive Surgery to restore a bodily function or to correct deformities resulting from documented injury or disease or caused by congenital anomalies, or surgery which is Medically Necessary following documented injury or disease to restore function.

8. **Custodial Care**

   a. Inpatient room and board charges in connection with a Hospital Stay primarily for environmental change (for example assisting the patient in meeting his or her activities of daily living) or Physical Therapy.

   b. Custodial Care or rest cures provided either in the home or in a facility, unless provided under the Hospice Care Benefit.

   c. Services provided by a rest home, a home for the aged, a custodial nursing home, or any similar facility.

   d. Services provided by a Skilled Nursing Facility, unless specifically stated under the Skilled Nursing and Rehabilitation Care benefit.

9. **Dental Implants**. Dental implants and any related services, except as specifically provided in the Cleft Palate benefit description on page 40.

10. **Dental Services**. Dental services, as determined by the Plan, include, but are not limited to, services customarily provided by dentists in connection with the care, treatment, filling, removal, or replacement of teeth; treatment of gums (other than for tumors); treatment of dental abscess or granuloma; dentures; and preparation of the mouth for dentures (e.g., vestibuloplasty). Services related to bone loss from denture wear or structures directly supporting the teeth are excluded.

    Also excluded are dental services in connection with prosthodontics (dental prosthetics, denture prosthetics designed for the replacement of teeth or the correction, alteration or repositioning of the occlusion), orthodontia (dental services to correct irregularities or malocclusion Classes I through IV of the teeth) for any reason, orthodontic appliances, braces, bridges (fixed or removable), dental plates, pedodontics (treatment of conditions of the teeth and mouth in children) or periodontics, and dental implants (endosteal, subperiosteal or transosteal).

    Dental services or supplies as a result of an Accidental Injury, including dental surgery and dental implants, are not covered.

    Acute Care hospitalization and general anesthesia services are covered in connection with dental procedures when hospitalization is required because of the individual's underlying medical condition and clinical status. This applies if (1) the Member is less than seven years old, (2) the Member is developmentally disabled, or (3) the Member's health is compromised and general anesthesia is Medically Necessary. Services of a dentist or oral surgeon are excluded.

    This exclusion will not apply to services or supplies provided under the Cleft Palate benefit description on page 40.

11. **Dermabrasion**. Any surgical procedure, abrasion, chemical peel, aerosol sprays, slushes, wire brushes, sandpaper, or laser surgery for the removal of the top layers of skin, that is furnished primarily to improve the appearance (including appearance altered by disease, trauma or aging) of parts or tissues of an individual (e.g., to remove acne scarring, fine wrinkling, rhytids, keratosis, pigmentation, and tattoos).

12. **Durable Medical Equipment**. Appliances, devices, and equipment not covered by the Plan include, but are not limited to: speech devices, except as specifically provided in the Durable Medical Equipment benefit description on pages 43-44; dental braces and other orthodontic appliances, except as specifically provided in the Cleft Palate benefit description on page 39; all orthopedic shoes (except when joined to braces) or shoe inserts (orthotics), with the exception of one pair custom molded and cast shoe inserts per Calendar Year, regardless of the diagnosis or medical condition; items for environmental control such as air conditioners, humidifiers, dehumidifiers or air purifiers; exercise or special sports equipment; any equipment which is not manufactured specifically for medical use; furniture such as lift chairs; and items for comfort, hygiene or beautification, including any form of hair replacement, except one scalp hair prosthetic per Calendar Year as provided in the Durable Medical Equipment benefit description on pages 43-44. Prosthetic and Durable Medical Equipment replacement and repair resulting from loss, misuse, abuse and/or accidental damage are not covered.

13. **Excess Charges**. Any expense incurred for covered services in excess of Plan benefits or maximums.

14. **Experimental or Investigational**. Experimental or Investigational practices or procedures, and services in connection with such practices or procedures. Costs incurred for any treatment or procedure deemed by Anthem Blue Cross Medical Policy to be Experimental and Investigational, as defined on page 111, are not covered.

15. **Eye Surgery, Corrective**. Any procedure done solely or primarily to correct a refractive error, including, but not limited to, surgeries such as laser vision correction surgery (i.e., LASIK or PRK), radial keratotomy, optical keratoplasty, or myopic keratomileusis. Contact lenses and eyeglasses required as a result of such surgeries.

16. **Feet, Procedures Affecting**. Callus or corn paring or excision, or toenail trimming, except as specifically provided in the Physician Services benefit description on page 55. Any manipulative procedure for weak or fallen arches, flat or pronated foot, or foot strain.

17. **Government-Provided Services**. Any services actually given to you by a local, state, or federal government agency, or public school system or school district, unless reimbursement by this Plan for such services is required by state or federal law. The Plan will not cover payment for these services if you are not required to pay for them or they are given to you for free. You are not required to seek any such services prior to receiving Medically Necessary health care services that are covered by the Plan.

18. **Health Club Memberships.** Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas.

19. **Hearing Conditions**

    a. Purchase of hearing aid batteries or other ancillary equipment, except those covered under the terms of the initial hearing aid purchase.

    b. Charges for a hearing aid which exceeds specifications prescribed for correction of hearing loss.

    c. Replacement parts for hearing aids or repair of hearing aids after the covered one-year warranty period.

    d. Replacement of a hearing aid more than once in any period of 36 months.

    e. Surgically implanted hearing devices except when Medically Necessary in accordance with Anthem Blue Cross Medical Policy as specifically provided in the Durable Medical Equipment benefit description on pages 43-44.

20. **Infertility, Diagnosis/Treatment**. Laboratory, X-ray procedures, Medication or surgery solely for the purpose of diagnosing and/or treating infertility of a Plan Member, including, but not limited to, reversal of surgical sterilization, artificial insemination, in vitro fertilization, or complications of such procedures.

21. **Marriage and Family Counseling**. Counseling for the sole purpose of resolving conflicts between a Subscriber and his or her spouse, domestic partner or children.

22. **Maternity**. Maternity benefits are not provided for services subsequent to termination of coverage under this Plan unless the patient qualifies for an extension of benefits as described under Benefits After Termination on pages 87-88, or qualifies under the provisions described under Consolidated Omnibus Budget Reconciliation Act (COBRA) beginning on page 85, or CalCOBRA Continuation of Group Coverage beginning on page 86. See Emergency Care Services on pages 44-45 for benefit coverage of emergency maternity admissions.

23. **Medical Trainee Services**. Services performed in any Inpatient or Outpatient setting by house officers, residents, interns and others in training.

24. **Natural Childbirth Classes**. Natural childbirth classes will be reimbursed only when given by certified ASPO/Lamaze childbirth educators, see page 53. Classes devoted solely to individual perinatal specialties, other than Lamaze, are not covered.

25. **Nicotine Addiction**. Any programs, services, or devices related to the treatment of nicotine addiction, except as specifically provided in the Smoking Cessation Program benefit description on page 58.

26. **Non-Listed Benefits**. Services not specifically listed as benefits or not reasonably medically linked to or connected with listed benefits, whether or not prescribed by a Physician.

27. **Nutrition**. Vitamins, minerals, medical foods and nutritional supplements (except enteral feeding) or as required by law whether or not prescribed by a licensed Prescriber; nutritional counseling, except as specifically provided under the Diabetes Self-Management Education Program benefit on page 43 or when provided as part of a Medically Necessary comprehensive outpatient eating disorder program supervised by a Physician to enable the Member to properly manage anorexia nervosa or bulimia nervosa; or food supplements taken orally, except as specifically provided under the Outpatient Prescription Drug Program section.

28. **Organ Transplants**. Charges incident to organ transplants, except as specifically provided under Cornea and Skin Transplants or Special Transplant Benefits.

29. **Personal Development Programs**. For or incident to vocational, recreational, art, dance, music, reading therapy, or exercise programs (formal or informal).

30. **Personal Items.** Services for your personal care, such as: help in walking, bathing, dressing, feeding, or preparing food. Any supplies for comfort, hygiene or beautification.

31. **Private-Duty Nursing**

a. Private-duty skilled nursing, unless provided under the Home Health Care or Hospice Care benefits.

b. Private-duty unskilled nursing.

32. **Psychiatric or Psychological Care**

a. Treatment of the following conditions is excluded under this Plan:

1. sexual disorders, except as provided in the Gender Reassignment Surgery benefit description on pages 46-47;
2. abuse of Drugs, except as provided in the Substance Abuse benefit description on pages 58-59;
3. development disorders, except as provided in the Autism Spectrum Disorder benefit description on page 36; and
4. abnormal behavior which is not directly attributed to a mental disorder.

b. Services on court order or as a condition of parole or probation unless the services are otherwise covered by the Plan.

c. Marriage and family counseling for the sole purpose of resolving conflicts between a Subscriber and his or her spouse, or domestic partner or children.

d. Non-therapeutic treatment, Custodial Care and educational programs.

NOTE: Any dispute regarding a psychiatric condition will be resolved with reference to the Fifth Edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5, Washington, DC: American Psychiatric Association, 2013). Use of DSM-5 to resolve dispute is subject to change as new editions are published.

33. Rehabilitation or Rehabilitative Care

a. Inpatient charges in connection with a Hospital Stay primarily for environmental change, or treatment of chronic pain unless provided under the Hospice Benefit.

b. Outpatient charges in connection with conditioning exercise programs (formal or informal).

c. Any testing, training or Rehabilitation for educational, developmental or vocational purposes, except as specifically provided under the Autism Spectrum Disorder benefit description on page 36.

34. Reports or Forms. Billed preparation of reports or forms of patient's status, history, treatment, or progress notes for Physicians, agencies, insurance carriers, or others, even if completion of a report is mandatory for regulatory requirement or Medication monitoring.

35. Residential Treatment Facility. Charges associated with an Inpatient Stay at a Residential Treatment Facility (defined on page 116), transitional living center, or board and care facility for the treatment of substance abuse. Charges associated with an Inpatient Stay at a Residential Treatment Facility, transitional living center or board and care facility for the treatment of mental health services that are not deemed to be Medically Necessary. This exclusion does not apply to precertified Outpatient day or evening services as provided in the Mental Health Benefits description on pages 52-53 and Substance Abuse benefit description on pages 58-59.

36. Self-injectable Drugs. Injectable Drugs which are self-administered by the subcutaneous route (under the skin) by the patient or Family Member. Drugs with FDA labeling for self-administration. Hypodermic syringes and/or needles when dispensed for use with self-injectable Drugs or Medications. Self-injectable Drugs are covered under your Outpatient Prescription Drug Program.

37. Speech Therapy. No benefits are provided for:

a. the correction of stammering, stuttering, lisping, tongue thrust;

b. the correction of developmental speech delays;

c. functional maintenance using routine, repetitious, and/or reinforced procedures that are neither diagnostic nor therapeutic (e.g., practicing word drills for developmental articulation errors);

d. procedures that may be carried out effectively by the patient, family, or caregivers (e.g., maintenance therapy);

e. Inpatient charges in connection with a Hospital Stay solely for the purpose of receiving Speech Therapy.

Outpatient Speech Therapy, speech correction or speech pathology services are not covered except as provided in the Speech Therapy benefit description on pages 54-55 or provided in the Autism Spectrum Disorder benefit description on page 36.

38. Surrogate Mother Services. Any services or supplies provided to a person not covered under the Plan in connection with a surrogate pregnancy including, but not limited to, the bearing of a child by another woman for an infertile couple.

39. Telephone, Facsimile Machine, and E-mail Consultations. Telephone, facsimile machine, and electronic mail consultations for any purpose, whether between the Physician or other health care provider and the Plan Member or Plan Member's family, or involving only Physicians or other health care providers. This exclusion does not apply to Telemedicine services specified as covered under the Telemedicine Program benefit description on page 59.

40. Totally Disabling Conditions. Services or supplies for the treatment of a Total Disability, if benefits are provided under the extension of benefits provisions of (a) any group or blanket disability insurance policy, or (b) any health care service plan contract, or (c) any Hospital service plan contract, or (d) any self-insured welfare benefit plan.

41. Transportation and Travel Expense. Expense incurred for transportation, except as specifically provided in the Ambulance benefit on pages 33-34, the Travel Benefits for Bariatric Surgery on pages 37-38, Travel Benefits for Gender Reassignment Surgery on pages 46-47, Travel Benefits for Hip and Knee Joint Replacement Surgery on page 48, and the Travel Benefits for Special Transplant Services on pages 62-63. Mileage reimbursement except as specifically provided in the Travel Benefits for Bariatric Surgery on pages 37-38, Travel Benefits for Gender Reassignment Surgery on pages 46-47, Travel Benefits for Hip and Knee Joint Replacement Surgery on page 48, and the Travel Benefits for Special Transplant Services on pages 62-63 and approved by Anthem Blue Cross. Charges incurred in the purchase or modification of a motor vehicle. Charges incurred for child care, telephone calls, laundry, postage, or entertainment. Frequent flyer miles; coupons, vouchers or travel tickets; prepayments of deposits.

42. Treatment Plan. A written or oral Treatment Plan submitted or given for the purpose of claim or medical necessity review. Services or a plan of treatment preauthorized by the Plan during a Contract Period must be commenced during the same Contract Period. To qualify for continuing treatment in a subsequent Contract Period, the services or plan of treatment must be reauthorized. Otherwise, only the benefits in effect during a Contract Period are available or covered.

43. Vasectomy or Tubal Ligation. Services for or incident to the reversal of a vasectomy or tubal ligation, or for repeat vasectomy or tubal ligation.

44. Vision Care. Eyeglasses; contact lenses; eye refraction or other examinations in preparation for eyeglasses or contact lenses; eyeglasses or contact lenses prescriptions; vision therapy; orthoptics; and related services. In limited circumstances, certain benefits related to vision care may be covered following cataract surgery or for the repair or alleviation of Accidental Injury.

45. Voluntary Payment of Non-Obligated Charges. Services for which the Plan Member is not legally obligated to pay, or services for which no charge is made to the Plan Member in the absence of health plan coverage, except services received at a non-governmental charitable research Hospital. Such a Hospital must meet the following guidelines:

a. It must be internationally known as being devoted mainly to medical research;

b. At least 10% of its yearly budget must be spent on research not directly related to patient care;

c. At least one-third of its gross income must come from donations or grants other than gifts or payments for patient care;

d. It must accept patients who are unable to pay; and

e. Two-thirds of its patients must have conditions directly related to the Hospital's research.

46. Weight Control. Any program, treatment, service, supply, or surgery for dietary control, weight control, or complications arising from weight control, or obesity, whether or not prescribed or recommended by a Physician, including, but not limited to:

a. exercise programs (formal or informal) and equipment;

b. surgeries, such as:

1. bariatric surgery in children less than 18 years of age,
2. biliopancreatic bypass,
3. duodenal switch,
4. gastric banding,
5. gastric bubble, gastric stapling, or liposuction,
6. jejunoileal bypass,
7. lap band,
8. long limb gastric bypass, and
9. mini gastric bypass.

This exclusion will not apply to Medically Necessary surgical treatment of adult morbid obesity as specifically provided in the Bariatric Surgery benefit description on pages 37-38.

47. **Workers' Compensation, Services Covered By**. Services incident to any injury or disease arising out of, or in the course of, any employment for salary, wage or profit if such injury or disease is covered by any workers' compensation law, occupational disease law or similar legislation. However, if the Plan provides payment for such services, it shall be entitled to establish a lien upon such other benefits up to the amount paid by the Plan for the treatment of the injury or disease.

Limitations Due to Major Disaster or Epidemic

In the event of any major disaster or epidemic, Preferred Providers shall render or attempt to arrange for the provision of covered services insofar as practical, according to their best judgment, within the limitations of such facilities and personnel as are then available; but neither the Plan, Anthem Blue Cross, nor Preferred Providers have any liability or obligation for delay or failure to provide any such services due to lack of available facilities or personnel if such lack is the result of such disaster or epidemic.

MEDICAL CLAIMS REVIEW AND APPEALS PROCESS

The procedures outlined below are designed to ensure you have a full and fair consideration of claims submitted to the Plan.

The following procedures shall be used to resolve any dispute which results from any act, failure to act, error, omission or medical judgment determination by Anthem Blue Cross' Review with respect to any medical claim filed by you or on your behalf. The procedures should be followed carefully and in the order listed.

The cost of copying and mailing medical records required for Anthem Blue Cross to review its determination is your or your Authorized Representative's responsibility.

1. Objection to Claim Processing

You or your Authorized Representative may object by writing to Anthem Blue Cross' Customer Service Department within 60 days of the discovery of any act, failure to act, error, or omission with regard to a properly submitted claim. The objection must set forth all reasons in support of the proposition that an act with regard to the claim, failure to act on the claim, error, or omission occurred. The objection should be sent to:

Anthem Blue Cross
Attention: Grievances and Appeals
P.O. Box 60007
Los Angeles, CA 90060-0007
Telephone: 1-877-737-7776
Fax#: 818-234-3824

Anthem Blue Cross will acknowledge receipt of the objection by written notice to you and/or your Authorized Representative within 5 days of receipt of the objection. Anthem Blue Cross will then affirm its decision regarding the claim, take action on the claim or resolve the error or omission within 30 days of receipt of the objection.

If Anthem Blue Cross affirms its decision regarding the claim or fails to respond within 30 days after receiving the request for review, and you and/or your Authorized Representative still objects to Anthem's act, failure to act, error, or omission as stated above, you and/or your Authorized Representative may proceed to Administrative Review as outlined in item 6. below.

2. Notice of Claim Denial – Adverse Benefit Determination (ABD)

In the event any claim for benefits is denied, in whole or in part, Anthem Blue Cross will notify you and/or your Authorized Representative of such denial in writing within 30 days. Any denial of a claim for benefits is considered an "Adverse Benefit Determination" (ABD) and can be based on the fact that it is not a covered benefit, the treatment is not Medically Necessary, or the treatment is Experimental/Investigational. The denial can be the result of Utilization Review for a prospective service, a service that is currently being pursued, or a service that has already been provided. (See Utilization Review on pages 64-68.) The ABD shall contain specific reasons for the denial and an explanation of the Plan's review and appeal procedure. Any ABD is subject to Internal Review upon request.

3. Internal Review

You and/or your Authorized Representative may request a review of an ABD by writing or calling Anthem Blue Cross' Customer Service Department within 180 days of receipt of an ABD. Your appeal or grievance must clearly state your issue, such as the reasons you disagree with the ABD or why you are dissatisfied with the Services you received. If you would like Anthem Blue Cross to consider your grievance on an urgent basis, please write "urgent" on the request and provide the rationale. (See definition of "Urgent Review" on page 84.) Requests for review should be sent to:

Anthem Blue Cross
Attention: Grievances and Appeals
P.O. Box 60007
Los Angeles, CA 90060-0007
Telephone: 1-877-737-7776
Fax#: 818-234-3824

You and/or your Authorized Representative may submit written comments, documents, records, scientific studies, and other information relating to the claim that resulted in an ABD in support of the request for Internal Review. You and/or your Authorized Representative will be provided, upon request and free of charge, reasonable access to records and other information relevant to your claim for benefits, including the right to review the claim file and submit evidence.

Anthem Blue Cross will acknowledge receipt of a request for Internal Review by written notice to you and/or your Authorized Representative within 5 business days. Anthem Blue Cross will then either uphold or reject the ABD within 30 days of the request for Internal Review if it involves an authorization of services (pre-service appeal or concurrent appeal) or within 60 days for services that have already been provided (post-service appeal).

If Anthem Blue Cross upholds the ABD within the timeframes described above, that decision becomes a "Final Adverse Benefit Determination" (FABD), and you and/or your Authorized Representative may pursue the independent External Review process described in section 5. below. You and/or your Authorized Representative may also request an independent External Review if Anthem Blue Cross fails to render a decision within the timelines specified above for Internal Review.

4. Urgent Review

An urgent grievance is resolved within 72 hours upon receipt of the request, but only if Anthem Blue Cross determines the grievance meets one of the following:

- The standard appeal timeframe could seriously jeopardize your life, health, or ability to regain maximum function; **OR**
- The standard appeal timeframe would, in the opinion of a Physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without extending your course of covered treatment; **OR**
- A Physician with knowledge of your medical condition determines that your grievance is urgent.

If Anthem Blue Cross determines the grievance request does not meet one of the above requirements, the grievance will be processed as a standard request. If your situation is subject to an urgent review, you and/or your Authorized Representative can simultaneously request an independent External Review described below.

5. Request for Independent External Review

If the FABD includes a decision based on Medical Judgment, the FABD will include the Plan's standard for Medical Necessity or other Medical Judgment related to that determination, and describe how the treatment fails to meet the Plan's standard. You and/or your Authorized Representative will be notified that you may request an independent External Review of that determination by an Independent Review Organization (IRO). This review is at no cost to you. Examples of Medical Judgment include, but are not limited to:

- The appropriate health care setting for providing medical care to an individual (such as Outpatient versus Inpatient care or home care versus rehabilitation facility; or
- Whether treatment by a specialist is Medically Necessary or appropriate pursuant to the Plan's standard for Medical Necessity or appropriateness); or
- Whether treatment involved "emergency care" or "Urgent Care", affecting coverage or the level of Coinsurance.

For more information about the Plan's standard for Medical Necessity, please see page 21.

You and/or your Authorized Representative may request an independent External Review no later than 4 months from the date of receipt of the FABD. The type of services in dispute must be a covered benefit. For cases involving Medical Judgment, you and/or your Authorized Representative must exhaust the independent External Review prior to requesting a CalPERS Administrative Review. (See CalPERS Administrative Review and Administrative Hearing on pages 79-80)

You and/or your Authorized Representative may also request an independent External Review if Anthem Blue Cross fails to render a decision within the timelines specified above for Internal Review. For a more complete description of independent External Review rights, please see 45 Code of Federal Regulations section 147.136.

6. Request for CalPERS Administrative Review Process

If you remain dissatisfied after exhausting the Internal Review process for benefit decisions and the independent External Review in cases involving Medical Judgment, you and/or your Authorized Representative may request a CalPERS Administrative Review. You and/or your Authorized Representative may also request Administrative Review in connection with an objection to the processing of a claim by Anthem. Please see section 1. above.

CalPERS ADMINISTRATIVE REVIEW AND ADMINISTRATIVE HEARING

1. Administrative Review

If you remain dissatisfied after exhausting the Internal Review process for benefit decisions and the independent External Review in cases involving Medical Judgment, you and/or your Authorized Representative may submit a request for CalPERS Administrative Review. The California Code of Regulations, Title 2, Section 599.518 requires that you exhaust Anthem Blue Cross' or CVS/caremark's internal grievance process, and the independent External Review process, when applicable, prior to submitting a request for CalPERS Administrative Review.

This request must be submitted in writing to CalPERS within 30 days from the date of the FABD for benefit decisions or the independent External Review decision in cases involving Medical Judgment. For objections to claim processing, the request must be submitted within 30 days of Anthem Blue Cross affirming its decision regarding the claim or within 60 days from the date you sent the objection regarding the claim to Anthem Blue Cross and Anthem Blue Cross failed to respond within 30 days of receipt of the objection.

The request must be mailed to:

CalPERS Health Plan Administration Division
Health Appeals Coordinator
P.O. Box 1953
Sacramento, CA 95812-1953

If you are planning to submit information Anthem Blue Cross or CVS/caremark may have regarding your dispute with your request for Administrative Review, please note that Anthem Blue Cross or CVS/caremark may require you to sign an authorization form to release this information. In addition, if CalPERS determines that additional information is needed after Anthem Blue Cross or CVS/caremark submits the information it has regarding your dispute, CalPERS may ask you to sign an Authorization to Release Health Information (ARHI) form.

If you have additional medical records from Providers that you believe are relevant to CalPERS review, those records should be included with the written request. You should send **copies** of documents, not originals, as CalPERS will retain the documents for its files. You are responsible for the cost of copying and mailing medical records required for the Administrative Review. Providing supporting information to CalPERS is voluntary. However, failure to provide such information may delay or preclude CalPERS in providing a final Administrative Review determination.

CalPERS cannot review claims of medical malpractice, i.e. quality of care.

CalPERS will attempt to provide a written determination within 60 days from the date all pertinent information is received by CalPERS. For claims involving urgent care, CalPERS will make a decision as soon as possible, taking into account the medical exigencies, but no later than 3 business days from the date all pertinent information is received by CalPERS.

2. Administrative Hearing

You must complete the CalPERS Administrative Review process prior to being offered the opportunity for an Administrative Hearing. Only claims involving covered benefits are eligible for an Administrative Hearing.

You and/or your Authorized Representative must request an Administrative Hearing in writing within 30 days of the date of the Administrative Review determination. Upon satisfactory showing of good cause, CalPERS may grant additional time to file a request for an Administrative Hearing, not to exceed 30 days.

The request for an Administrative Hearing must set forth the facts and the law upon which the request is based. The request should include any additional arguments and evidence favorable to your case not previously submitted for Administrative Review or External Review.

CalPERS ADMINISTRATIVE REVIEW AND ADMINISTRATIVE HEARING

If CalPERS accepts the request for an Administrative Hearing, it will be conducted in accordance with the Administrative Procedure Act (Government Code section 11500 et seq.). An Administrative Hearing is a formal legal proceeding held before an Administrative Law Judge (ALJ); you and/or your Authorized Representative may, but is not required to, be represented by an attorney. After taking testimony and receiving evidence, the ALJ will issue a Proposed Decision. The CalPERS Board of Administration (Board) will vote regarding whether to adopt the Proposed Decision as its own decision at an open (public) meeting. The Board's final decision will be provided in writing to you and/or your Authorized Representative within two weeks of the Board's open meeting.

3. Appeal Beyond Administrative Review and Administrative Hearing

If you are still dissatisfied with the Board's decision, you may petition the Board for reconsideration of its decision, or may appeal to the Superior Court.

You may not begin civil legal remedies until after exhausting these administrative procedures.

Summary of Process and Rights of Members under the Administrative Procedure Act

- **Right to records, generally.** You may, at your own expense, obtain copies of all non-medical and non-privileged medical records from the administrator and/or CalPERS, as applicable.
- **Records subject to attorney-client privilege.** Communication between an attorney and a client, whether oral or in writing, will not be disclosed under any circumstances.
- **Attorney Representation.** At any stage of the appeal proceedings, you may be represented by an attorney. If you choose to be represented by an attorney, you must do so at your own expense. Neither CalPERS nor the administrator will provide an attorney or reimburse you for the cost of an attorney even if you prevail on appeal.
- **Right to experts and consultants.** At any stage of the proceedings, you may present information through the opinion of an expert, such as a Physician. If you choose to retain an expert to assist in presentation of a claim, it must be at your own expense. Neither CalPERS nor the administrator will reimburse you for the costs of experts, consultants or evaluations.

Service of Legal Process

Legal process or service upon the Plan must be served in person at:

CalPERS Legal Office
Lincoln Plaza North
400 "Q" Street
Sacramento, CA 95814

ADVERSE BENEFIT DETERMINATION (ABD) CHART

Adverse Benefit Determination (ABD)

Appeals Process
Member Receives ABD

Standard Process
180 Days to File Appeal

Internal Review –
Final Adverse Benefit Determination (FABD) issued within 30 days for Pre-Service or Concurrent Appeals or 60 days for Post-Service Appeals

Request for External Review
Member must request External Review by IRO within **4 months** of FABD*

External Review
FABD must be reviewed within **50 days (5 days for submittal to IRO)** from date External Review requested for Pre-Service, Concurrent, and Post-Service appeals

CalPERS Administrative Review (AR)
Member must file within 30 days of FABD for benefit decisions or Independent External Review decision for cases involving Medical Judgment. CalPERS will attempt to notify Member of AR determination within 60 days

Expedited Process
180 Days to File Appeal

Internal Review –
Final Adverse Benefit Determination (FABD) issued within reasonable timeframes given medical condition but in no event longer than **72 hours** from receipt

Request for External Review
Member should submit request for Urgent External Review as soon as possible, but in no event longer than **4 months** of FABD*

External Review
FABD must be reviewed within reasonable timeframes given medical condition but in no event longer than **72 hours** from receipt of request

CalPERS Administrative Review (AR)
Member should file as soon as possible, but in no event longer than 30 days of independent External Review decision. CalPERS will notify Member of AR determination within**3 business days** of receipt of all pertinent information

*For FABDs that involve "Medical Judgment," you must request an independent External Review prior to submitting for a CalPERS Administrative Review.

Process continued on following page

ADVERSE BENEFIT DETERMINATION (ABD) CHART

Administrative Hearing Process

Request for Administrative Hearing
Member may request Administrative Hearing within 30 days of CalPERS AR determination.

↓

Administrative Hearing
CalPERS submits statement of issues to Administrative Law Judge. Member has right to attorney, to present witnesses and evidence.

↓

Proposed Decision
After hearing, ALJ issues a proposed decision pursuant to California Administrative Procedures Act.

↓

CalPERS Board of Administration
Adopts, rejects, or returns proposed decision for additional evidence.
If adopts, decision becomes final decision.

↓

Member May Request
Reconsideration by Board or appeal final decision to Superior Court by Writ of Mandate

ADVERSE BENEFIT DETERMINATION (ABD) CHART

Adverse Benefit Determination (ABD)
Appeals Process Definitions

The flow chart above and definitions below are included to assist you with understanding your rights and the provisions of this Plan related to Internal Claims and Appeals, and the independent External Review process available in the event a denial is based on Medical Judgment. The information provided here is general and simplified, consistent with accuracy, but is not intended to be the definitive statement of state or federal law.

Administrative Hearing (AH) – A legal hearing conducted by the Office of Administrative Hearings and governed by the rules established in the California Administrative Procedure Act, (Government Code section 11370). You may avail yourself of these administrative rights by appealing a FABD or independent External Review decision to CalPERS for Administrative Review. If CalPERS upholds the FABD or independent External Review decision, CalPERS will notify you that you may formally appeal that decision and request an Administrative Hearing.

Administrative Review (AR) – A review conducted by CalPERS after Anthem Blue Cross' or CVS/caremark's Internal Review process or after you elect to participate in the independent External Review process. If you wish to appeal an independent External Review decision, you must submit your appeal to CalPERS for Administrative Review to proceed to Administrative Hearing and exhaust your administrative rights under California law.

Adverse Benefit Determination (ABD) – Any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or part) for, a benefit, including any such denial, reduction, termination or failure to provide or make payment based on a determination of your eligibility to participate in a plan, and any denial, reduction or termination of, or failure to provide or make payment for, a benefit resulting from the application of any Utilization Review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate.

Authorized Representative – A person or entity you designate to act on your behalf regarding your appeal or grievance, AR or AH.

Concurrent Appeal – An appeal of a claim for approval of medical care, treatment or Medication during the time such care, treatment or Medication is being rendered.

External Review – A Member who receives a Final Adverse Benefit Determination (FABD) is eligible to submit the FABD to an independent External Review if the Plan's decision involved making a medical judgment as to the Medical Necessity, appropriateness, health care setting, level of care or effectiveness of health care service or treatment requested. You will receive notice of your right to request an independent External Review at the time the Plan issues the FABD. The independent External Review is conducted by an Independent Review Organization (IRO), as defined below; the IRO's independent External Review decision is binding on the Plan. An independent External Review decision that upholds the FABD, or denial of benefit, may be submitted to CalPERS for Administrative Review. The independent External Review process is optional and must be elected by you within 4 months of the FABD (defined below).

Final Adverse Benefit Determination (FABD) – An ABD that has been upheld by a plan or issuer at the completion of the Internal Review process.

Independent Review Organization (IRO) – An entity that is accredited by a nationally recognized private accrediting organization that conducts Independent External Reviews of FABDs.

Internal Review – The review conducted by Anthem Blue Cross or CVS/caremark for an ABD.

Medical Judgment – An ABD or FABD that is based on the Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, or its determination that a treatment is Experimental or Investigational, or a rescission of coverage (retroactive cancellation of coverage due to a reduction in time base).

Pre-Service Appeal – An appeal of a claim for approval of medical care, treatment or Medication prior to the time such care, treatment or Medication is rendered.

ADVERSE BENEFIT DETERMINATION (ABD) CHART

Post-Service Appeal – An appeal of a claim for approval of medical care, treatment or Medication after the time such care, treatment or Medication has been rendered.

Urgent Review – The process to review a claim for medical care, treatment or Medication with respect to which the application of the time period for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function; or, in the opinion of a Physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Decisions regarding these claims must be made as soon as possible consistent with the medical exigencies involved, but in no event longer than 72 hours upon receipt of the request by Anthem Blue Cross or CVS/caremark, or 3 business days upon receipt of all pertinent information by CalPERS for the Administrative Review.

CONTINUATION OF GROUP COVERAGE

Continuation of Group Coverage

Eligibility for Continuation of Group Coverage under PERS Select is dependent upon your Employer's participation in the CalPERS Health Benefits Program. If an Employer terminates participation in the CalPERS Health Benefits Program, an active or retired Employee currently enrolled in COBRA or CalCOBRA may choose to continue coverage under COBRA or CalCOBRA with the group health plan providing health care coverage to the Employer. A participant in COBRA or CalCOBRA may not continue coverage under PERS Select if the Employer ceases to participate in the CalPERS Health Benefits Program.

Please examine your options carefully before declining this continuation of coverage.

Other Coverage Options Besides COBRA Continuation Coverage

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan). Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.coveredca.com or www.healthcare.gov.

Consolidated Omnibus Budget Reconciliation Act (COBRA)

The Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation of group coverage is provided through federal legislation and allows an enrolled active or retired Employee or his or her enrolled Family Members who lose their regular group coverage because of certain qualifying events to elect continuation of coverage for 18, 29, or 36 months.

An eligible active or retired Employee or his or her Family Member(s) is entitled to elect this coverage provided an election is made within 60 days of notification of eligibility and the required premiums are paid. The benefits of the continuation of coverage are identical to the group Plan, and the cost of coverage may not exceed 102% of the applicable group premiums rate, except for the Employee or enrolled Family Member who is eligible to continue group coverage to 29 months because of entitlement to Social Security disability benefits. In this case, the cost of coverage for months 19 through 29 shall not exceed 150% of the applicable group premiums rate. No Employer contribution is available to cover the premiums.

Qualifying Events

Two qualifying events allow Employees to request the continuation of coverage for 18 months: (This coverage may be continued for up to 29 months for an Employee that is federally recognized disabled.)

1. the covered Employee's separation from employment (other than by reason of gross misconduct);
2. reduction in the covered Employee's work hours to less than half-time (or a permanent intermittent Employee not working the required hours during a control period).

The following five qualifying events allow enrolled Family Member(s) to elect the continuation of coverage for up to 36 months:

1. the active Employee's or retired Employee's death (and the surviving Family Member is not eligible for a monthly survivor allowance from CalPERS);
2. the divorce or legal separation of the covered spouse from the active Employee or retired Employee;
3. the termination of a domestic partnership, defined in Government Code Section 22771;
4. the primary COBRA Subscriber becomes entitled to Medicare;
5. a dependent child ceases to be a dependent child.

Children born to or placed for adoption with the Plan Member during a COBRA continuation period may be added as dependents, provided the Employer is properly notified of the birth or placement for adoption, and such children are enrolled within 30 days of the birth or placement for adoption.

Effective Date of the Continuation of Coverage

If elected, COBRA continuation of coverage is effective on the date coverage under the group Plan terminates.

Termination of Continuation of Group Coverage

The COBRA continuation of coverage will remain in effect for the specified period of time, or until any one of the following events terminates the coverage:

1. termination of all Employer-provided group health plans; or
2. the enrollee fails to pay the required premiums on a timely basis; or
3. the enrollee, after electing COBRA, becomes covered under another group health plan; or
4. the enrollee, after electing COBRA, becomes entitled to Medicare benefits; or
5. the continuation of coverage was extended to 29 months, and there has been a final determination that the enrollee is no longer federally recognized disabled.

Notification of a Qualifying Event

You will receive notice of your eligibility for COBRA continuation of coverage from your Employer if your employment is terminated or your number of work hours is reduced.

The active Employee, retired Employee, or affected Family Member is responsible for requesting information about COBRA continuation of coverage in the event of divorce, legal separation, termination of domestic partnership, or a dependent child's loss of eligibility.

Contact your employing agency (former) or CalPERS directly if you need more information about your eligibility for COBRA continuation of coverage.

CalCOBRA Continuation of Group Coverage

COBRA enrollees who became eligible for federal COBRA coverage on or after January 1, 2003, and have exhausted their 18 month or 29 month maximum continuation coverage available under federal COBRA provisions may be eligible to further continue coverage for medical benefits under the California COBRA Program (CalCOBRA) for a maximum period of 36 months from the date the Plan Member's federal COBRA coverage began.

Qualifying Events

COBRA enrollees must exhaust all the COBRA coverage to which they are entitled before they can become eligible to continue coverage under CalCOBRA.

Notification Requirements

You will receive notice from Anthem Blue Cross of your right to possibly continue coverage under CalCOBRA within 180 days prior to the date your federal COBRA will end. To elect CalCOBRA coverage, you must notify Anthem Blue Cross in writing within 60 days of the date your coverage under federal COBRA ends or the date of notification of eligibility, if later.

Effective Date of CalCOBRA Continuation of Coverage

If elected, this continuation will begin after the federal COBRA coverage ends and will be administered under the same terms and conditions as if COBRA had remained in force.

Premiums

Premiums for this continuation coverage may not exceed:

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

The first payment is due along with the enrollment form within 45 days after electing CalCOBRA continuation coverage. This payment must be sent to Anthem Blue Cross at P.O. Box 629, Woodland Hills, CA 91365-0629 by certified mail or other reliable means of delivery, in an amount sufficient to pay any required premiums and premiums due. Failure to submit the correct amount within this 45-day period will disqualify the former Employee or Family Member from receiving continuation coverage under CalCOBRA. Succeeding premiums are due on the first day of each following month.

The amount of monthly premiums may be changed by Anthem Blue Cross as of any premiums due date. Anthem Blue Cross will provide enrollees with written notice at least 30 days prior to the date any increase in premiums goes into effect.

Termination of CalCOBRA Continuation of Coverage

This CalCOBRA continuation of coverage will remain in effect for the specified period of time, or until any one of the following events automatically terminates the coverage:

1. the Employer ceases to maintain any group health plan; or
2. the enrollee fails to pay the required premiums on a timely basis; or
3. the enrollee becomes covered under any other health plan; or
4. the enrollee becomes entitled to Medicare; or
5. the enrollee becomes covered under a federal COBRA continuation; or
6. the enrollee moves out of Anthem Blue Cross' service area; or
7. the enrollee commits fraud.

In no event will continuation of group coverage under COBRA, CalCOBRA or a combination of COBRA and CalCOBRA be extended for more than 3 years from the date the qualifying event has occurred which originally entitled the Plan Member to continue group coverage under this Plan.

Benefits After Termination

1. In the event the Plan is terminated by the Board or by PERS Select, PERS Select shall provide an extension of benefits for a Plan Member who is totally disabled at the time of such termination, subject to the following provisions:

   a. For the purpose of this benefit, a Plan Member is considered totally disabled when confined in a Hospital or Skilled Nursing Facility or confined pursuant to an alternative care arrangement when, as a result of Accidental Injury or disease, the Member is prevented from engaging in any occupation for compensation or profit or is prevented from performing substantially all regular and customary activities usual for a person of the Member's age and family status, or when diagnosed as totally disabled by the Member's Physician and such diagnosis is accepted by PERS Select.

   b. The services and benefits under this Plan shall be furnished solely in connection with the condition causing such Total Disability and for no other condition not reasonably related to the condition causing the Total Disability, illness or injury. Services and benefits of this Plan shall be provided only when written certification of the Total Disability and the cause thereof has been furnished to Anthem Blue Cross by the Plan Member's Physician within 30 days from the date the coverage is terminated. Proof of continuation of the Total Disability must be furnished by the Member's Physician not less frequently than at 60 day intervals during the period that the termination services and benefits are available.

      Extension of coverage shall be provided for the shortest of the following periods:

      - Until Total Disability ceases;
      - For a maximum period of 12 months after the date of termination, subject to PERS Select maximums; or
      - Until the Plan Member's enrollment under any replacement Hospital or medical plan without limitation to the disabling condition.

2. If on the date a Plan Member's coverage terminates for reasons other than termination of the Plan by the Board or by PERS Select or voluntary cancellation, and the date of such termination of coverage occurs during the Member's certified confinement (in a Hospital, Skilled Nursing Facility or alternative care arrangement), the services and benefits of this Plan shall be furnished solely in connection with the conditions causing such confinement.

   Extension of coverage shall be provided for the shortest of the following periods:

   - For a maximum period of 91 days after such termination; or
   - Until the Plan Member can be discharged from the Hospital or Skilled Nursing Facility as determined by PERS Select; or
   - Until the Plan's maximum benefits are paid.

GENERAL PROVISIONS

Coordination of Benefits

(Not Applicable to the Outpatient Prescription Drug Program)

Coordination of Benefits provides maximum coverage for medical and Hospital bills at the lowest cost by avoiding excessive payments. A Plan Member who is covered under more than one group plan will not be permitted to make a "profit" by collecting benefits on any claim in excess of the billed amount. Benefits will be coordinated between the plans to provide appropriate payment, not to exceed 100% of the Allowable Expense.

Anthem Blue Cross will send you a questionnaire annually regarding other health care coverage or Medicare coverage. ***You must provide this information to Anthem Blue Cross within 30 calendar days.*** If you do not respond to the questionnaire, claims will be denied or delayed until Anthem Blue Cross receives the information. You may provide the information to Anthem Blue Cross in writing or by telephoning Customer Service.

(The meanings of key terms used in these Coordination of Benefits provisions are shown on the next page under Definitions.)

Effect on Benefits

If this Plan is determined to be the primary carrier, this Plan will provide its benefits in accordance with the plan design and without reductions due to payments anticipated by a secondary carrier. Physician Members and other Preferred Providers may request payment from the secondary carrier for any difference between their Billed Charges and this Plan's payment.

If the other carrier has the primary responsibility for claims payment, your claim submission under this Plan must include a copy of the primary carrier's Explanation of Benefits together with the itemized bill from the provider of service. Your claim cannot be processed without this information. HMO plans often provide benefits in the form of health care services within specific provider networks and may not issue an Explanation of Benefits for covered services. If the primary carrier does not provide an Explanation of Benefits, you must submit that plan's official written statement of the reason for denial with your claim.

When this Plan is the secondary carrier, its benefits may be reduced so the combined benefit payments and services of all the plans do not exceed 100% of the Allowable Expense. The benefit payment by this Plan will never be more than the sum of the benefits that would have been paid if you were covered under this Plan only.

If this Plan is a secondary carrier with respect to a Plan Member and Anthem Blue Cross is notified that there is a dispute as to which plan is primary, or that the primary carrier has not paid within a reasonable period of time, this Plan will provide the benefits that would have been paid if it were the primary carrier, **only** when the Plan Member:

1. Assigns to this Plan the right to receive benefits from the other plan to the extent that this Plan would have been obligated to pay as secondary carrier, **and**
2. Agrees to cooperate fully in obtaining payment of benefits from the other plan, **and**
3. Allows Anthem Blue Cross to obtain confirmation from the other plan that the benefits claimed have not previously been paid.

Order of Benefits Determination

When the other plan does not have a Coordination of Benefits provision, it will always be the primary carrier. Otherwise, the following rules determine the order of benefit payments:

1. A plan which covers the Plan Member as other than a dependent shall be the primary carrier.
2. When a plan covers a dependent child whose parents are not separated or divorced and each parent has a group plan which covers the dependent child, the plan of the parent whose birth date (excluding year of birth) occurs earlier in the Calendar Year shall be primary carrier. If either plan does not have the birthday rule provision of this paragraph regarding dependent children, primary carrier shall be determined by the plan that does not include this provision.

3. When a claim involves expenses for a dependent child whose parents are separated or divorced, plans covering the child as a dependent will determine their respective benefits in the following order:
   a. the plan of the parent with custody of the child;
   b. if the custodial parent has remarried, the plan of the stepparent married to the parent with custody of the child;
   c. the plan of the noncustodial parent of the child;
   d. if the noncustodial parent has remarried, the plan of the stepparent married to the parent without custody of the child.
4. Regardless of paragraph 3 above, if there is a court decree that otherwise establishes a parent's financial responsibility for the medical, dental or other health care expenses of the child, then the plan which covers the child as a dependent of that parent shall be the primary carrier.
5. If the above rules do not apply, the plan which has covered the Plan Member for the longer period of time shall be the primary carrier, except for:
   a. A plan covering a Plan Member as a laid-off or retired Employee or the dependent of a laid-off or retired Employee will determine its benefits after any other plan covering that person as other than a laid-off or retired Employee or their dependent (This does not apply if either plan does not have a provision regarding laid-off or retired Employees.); or
   b. Two plans that have the same effective date will split Allowable Expense equally between the two plans.

Definitions

Allowable Expense — A charge for services or supplies which is considered covered in whole or in part under at least one of the plans covering the Plan Member.

Explanation of Benefits — The statement sent to a Member by their health insurance company listing services provided, amount billed, eligible expenses and payment made by the health insurance company. HMO plans often provide health care services for Members within specific provider networks and may not provide an Explanation of Benefits for covered services.

Other Plan — Any blanket or franchise insurance coverage, group service plan contracts, group practice or any other prepayment coverage on a group basis, any coverage under labor-management trusteed plans, union welfare plans, employer organization plans, Employee benefit organization plans, or Medicare.

Primary Carrier — A plan which has primary responsibility for the provision of benefits according to the "Order of Benefit Determination" provisions above and will have its benefits determined first without regard to the possibility that another plan may cover some expenses.

Secondary Carrier — A plan which has secondary responsibility for the provision of benefits according to the "Order of Benefit Determination" provisions above and may reduce its benefit payments after the primary carrier's benefits are determined first.

Benefits for Medicare-Eligible Members

Note: The information provided below is based on federal laws and regulations. Therefore this information is subject to change based on changes in those laws and regulations or their interpretation by either the federal government or the courts.

Active Employees and Their Family Members. Except as noted below, an actively employed Subscriber who is eligible for Medicare and the spouse of such Subscriber will receive the full benefits of this Plan while the Subscriber remains actively employed.

This Plan will no longer be the primary payer for a Subscriber who is an active Employee or a Family Member of an active Employee who is entitled to Medicare because of permanent kidney failure, also known as "End-Stage Renal Disease", after 30 months has elapsed from the date that the Subscriber or Family Member would have been eligible for Medicare Part A on the basis of permanent kidney failure.

Note: If you are under age 65 and have been diagnosed with Lou Gehrig's Disease (ALS), you may be eligible for Medicare during the first month of your eligibility for Social Security Disability benefits. To check eligibility and obtain more information about disability benefits, look at www.ssa.gov on the Web, or call the Social Security Administration at 1-800-772-1213.

This Plan may be the primary payer for those Subscribers who are actively employed and their Family Members who (1) are under age 65 and (2) have Medicare coverage because of a disability.

Retirees and Their Spouses. If you are a retired Subscriber, or the spouse of a retired Subscriber, and are eligible for Medicare because you made the required number of quarterly contributions to the Social Security System, this Plan will be considered secondary to Medicare and payment will be determined according to the provisions outlined under Coordination of Benefits on pages 89-90.

Retired Employees and their spouses are required to enroll in a supplement to original Medicare plan upon becoming eligible for Medicare Parts A and B. You must contact CalPERS no later than the date you first become eligible for Medicare. You will be provided with information regarding your enrollment into a supplement to original Medicare plan.

Select PPO Plan Provider Reimbursement

Physicians and other professional providers are paid on a fee-for-service basis, according to an agreed schedule. A Physician designated as participating in the Select PPO Preferred Provider network may, after notice from Anthem Blue Cross, be subject to a reduced Negotiated Amount in the event the Physician fails to make routine referrals to Preferred Providers, except as otherwise allowed (such as for emergency services). Hospitals and other health care facilities may be paid either a fixed fee or on a discounted fee-for-service basis.

Continuity of Care

If Anthem Blue Cross (or a Blue Cross and/or Blue Shield Plan outside California) terminates its contractual relationship with a Preferred Provider and you are undergoing a course of treatment from that provider at the time the contract is terminated, you may be able to continue to receive services from that provider (but only if such provider agrees to continue to comply with the same contractual requirements that applied prior to termination).

To qualify, you must have an Acute Condition or a serious chronic condition, a high-risk pregnancy, or a pregnancy that has reached the second or third trimester.

In cases involving an Acute Condition or a serious chronic condition, the Plan shall furnish the enrollee with health care services on a timely and appropriate basis from the terminated provider for up to 90 days, or a longer period if necessary for a safe transfer to another provider as determined by the Plan in consultation with the terminated provider, consistent with good professional practice. Coverage is provided according to the terms and conditions of this Plan applicable to Preferred Providers.

In the case of pregnancy, the Plan shall furnish the enrollee with health care services on a timely and appropriate basis from the terminated provider until postpartum services related to the delivery are completed, or a longer period if necessary for a safe transfer to another provider as determined by the Plan in consultation with the terminated provider, consistent with good professional practice. Coverage is provided according to the terms and conditions of this Plan applicable to Preferred Providers.

You may request this continuity of care by calling the Customer Service telephone number printed on your ID card.

LIABILITIES

Third-Party Liability

If a Plan Member receives medical services covered by PERS Select for injuries caused by the act or omission of another person (a "third party"), the Plan Member agrees to:

1. promptly assign his or her rights to reimbursement from any source for the costs of such covered services; and
2. reimburse PERS Select, to the extent of benefits provided, immediately upon collection of damages by him or her for such injury from any source, including any applicable automobile uninsured or underinsured motorist coverage, whether by action of law, settlement, or otherwise; and
3. provide PERS Select with a lien, to the extent of benefits provided by PERS Select, upon the Member's claim against or because of the third party. The lien may be filed with the third party, the third party's agent, the insurance company, or the court; and
4. the release of all information, medical or otherwise, which may be relevant to the identification of and collection from parties responsible for the Member's illness or injury; and
5. notify Anthem Blue Cross of any claim filed against a third party for recovery of the cost of medical services obtained for injuries caused by the third party; and
6. cooperate with CalPERS and Anthem Blue Cross in protecting the lien rights of PERS Select against any recovery from the third party; and
7. obtain written consent from CalPERS prior to settling any claim with the third party that would release the third party from the lien or limit the rights of PERS Select to recovery.

Pursuant to Government Code section 22947, a PERS Select Member (or his/her attorney) must immediately notify the Plan, via certified mail, of the existence of any claim or action against a third party for injuries allegedly caused by the third party. Notices of third party claims and actions must be sent to:

PERS Select Health Plan
Anthem Blue Cross
P.O. Box 60007
Los Angeles, CA 90060-0007

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

Plan Member Liability When Payment is Made by PERS Select

When covered services have been rendered by a Preferred Provider or Participating Pharmacy and payment has been made by PERS Select, the Plan Member is responsible only for any applicable Deductible and/or Copayment/Coinsurance. However, if covered services are rendered by a Non-Preferred Provider or a Non-Participating Pharmacy, the Member is responsible for any amount PERS Select does not pay.

When a benefit specifies a maximum payment and the Plan's maximum has been paid, the Plan Member is responsible for any charges above the benefit maximum, regardless of the status of the provider who renders the services.

LIABILITIES

In the Event of Insolvency

If PERS Select should become insolvent and no payment, or partial payment, is made for covered services, the Plan Member is responsible for any charges incurred, regardless of the status of the provider who renders the services. Providers may bill the Plan Member directly, and the Member will have no recourse against the California Public Employees' Retirement System, its officers, or employees for reimbursement of his or her expenses.

Plan Liability for Provider Services

In no instance shall PERS Select, Anthem Blue Cross, or the contracted Blue Cross and/or Blue Shield Plan be liable for negligence, wrongful acts or omissions of any person, Physician, Hospital or hospital employee providing services.

Maintenance of Preferred Provider Reimbursement Levels

If a Preferred Provider breaches or terminates its contract with Anthem Blue Cross or a Blue Cross and/or Blue Shield Plan for Preferred Provider services, PERS Select may, based upon medical necessity, approve continuation of care at the Preferred Provider level of reimbursement. Upon PERS Select's approval, reimbursement shall be made at the Preferred Provider level of reimbursement and the balance will be the obligation of the Plan Member.

In the event that a Preferred Provider is unwilling or unable to provide continuing care to a Plan Member, then it shall be the responsibility of the Member to choose an alternative provider and to determine the Preferred Provider status of that provider.

OUTPATIENT PRESCRIPTION DRUG PROGRAM

Outpatient Prescription Drug Benefits

The Outpatient Prescription Drug Benefit Program is administered by CVS/caremark. This program will pay for Prescription Medications which are: (a) prescribed by a Prescriber (defined on page 114) in connection with a covered illness, condition, or Accidental Injury; (b) dispensed by a registered pharmacist; and (c) approved through the Coverage Management Programs described in the Prescription Drug Coverage Management Programs section on pages 101-102. All Prescription Medications are subject to clinical utilization review when dispensed and to the exclusions listed in the Outpatient Prescription Drug Exclusions on pages 103-104.

Covered Outpatient Prescription Medications prescribed by a Prescriber in connection with a covered illness, condition or Accidental Injury and dispensed by a registered pharmacist may be obtained either through the CVS/caremark Retail Pharmacy Program or the CVS/caremark Mail Service Program.

The Plan's Outpatient Prescription Drug Benefit Program is designed to save you and the Plan money without compromising safety and effectiveness standards. You are encouraged to ask your Physician to prescribe Generic Medications or Medications on CVS/caremark's Preferred Drug List whenever possible. Members can still receive any covered Medication, and your Physician still maintains the choice of Medication prescribed but this may increase your financial responsibility.

Although Generic Medications (defined on page 111) are not mandatory, the Plan encourages you to purchase Generic Medications whenever possible. Generic equivalent Medications may differ in color, size, or shape, but the U.S. Food and Drug Administration (FDA) requires that they have the same quality, strength, purity and stability as the Brand-Name Medications (defined on page 109). Prescriptions filled with Generic equivalent Medications generally have lower Copayments and also help to manage the increasing cost of health care without compromising the quality of your pharmaceutical care.

Copayment Structure

The Plan's Incentive Copayment structure includes Generic, Preferred and Non-Preferred Brand-Name Medications. The Member has an incentive to use generic and Preferred Brand-Name Drugs, and Mail Service or CVS/pharmacy for Maintenance Medications. Your Copayment will vary depending on whether you use retail or Mail Service/ CVS/pharmacy, and whether you select generic, Preferred or Non-Preferred Brand-Name Medications, or whether you refill Maintenance Medications at a non-CVS/pharmacy after the second fill.

The following table shows the Copayment structure for the retail Pharmacy and mail service programs:

	Up to 30 – day supply	**Up to 90 – day supply**
	Participating Retail Pharmacy (short-term use Medications) CVS/caremark Specialty Pharmacy	**CVS/caremark Mail Service/ CVS/pharmacy (long term use – Maintenance Medications*)**
Generic	$5	$10
Preferred Brand (on CVS/ caremark's Preferred Drug List)	$20	$40
Non-Preferred Brand (Not on CVS/caremark's Preferred Drug List)	$50	$100
Partial Copay Waiver of Non-Preferred Brand (Partial Copay Waiver, see CVS/caremark's appeal process pages 105-107)	$40	$70
Member-Pays the Difference (MPD)	Member Pays the Difference (pg. 96)	Member Pays the Difference (pg. 96)
Erectile or Sexual Dysfunction Drugs	50% Coinsurance	50% Coinsurance

OUTPATIENT PRESCRIPTION DRUG PROGRAM

The Maximum Calendar Year Pharmacy Financial Responsibility each Calendar Year at Retail Pharmacies (not CVS/pharmacy) is $2,000 per Member and $4,000 per family.

The Maximum Calendar Year Pharmacy Financial Responsibility per person each Calendar Year for Mail Service/Maintenance Choice® at CVS/pharmacy is $1,000 (only includes Generic and Preferred Brands).

Erectile or Sexual Dysfunction Drug and Member Pays the Difference (MPD) Copayments **DO NOT APPLY** to the Maximum Calendar Year Pharmacy Financial Responsibility.

Maintenance Medications* filled at a non-CVS/pharmacy after 2nd fill are limited to a 30-day supply and are charged the higher Copayment.

* A Maintenance Medication should not require frequent dosage adjustments and is prescribed for a long-term or chronic condition, such as diabetes, and high blood pressure or is otherwise prescribed for long-term use (as an example, birth control). Ask your Physician if you will be taking a prescribed Medication longer than 60 days. If you continue to refill a Maintenance Medication at a non-CVS/pharmacy after the second fill, you will be charged a higher Copayment, which is the applicable Mail Service Copayment described above. Please note that while Medications can be filled at a retail Pharmacy, long-term Medications (Medications taken for 60 days or more) will cost more if refilled at a retail Pharmacy after the second fill. Members can refill the same Medications by Mail Service or at a CVS/pharmacy at a cost savings.

NOTE: The list of Medications subject to a higher Copayment after the second fill at a retail Pharmacy and the list of Specialty Medications available only through CVS/caremark Specialty Pharmacy are subject to change. To find out which Medications are impacted, Members can visit CVS/caremark on-line at www.caremark.com/calpers or call CVS/caremark Customer Care at 1-800-237-2767, 24 hours a day 7 days a week.

Examples of common long-term Medication or chronic conditions:
Birth control
High blood pressure
High cholesterol
Diabetes

Examples of common short-term or Acute Conditions:
Influenza (the “Flu”)
Pneumonia
Urinary tract infection

The Copayment applies to each Prescription Order and to each refill. The Copayment is not reimbursable and cannot be used to satisfy any Deductible requirement. (Under some circumstances your Prescription may cost less than the actual Copayments, and you will be charged the lesser amount.)

All Prescriptions will be filled with a FDA-approved bioequivalent generic, if one exists, unless your Physician specifies otherwise. A maximum $1,000 per person per Calendar Year Copayment applies to Mail/Maintenance Choice® Prescriptions of only Generic and Preferred Brands.

Maintenance Choice®

Maintenance Medications for long-term or chronic conditions may be obtained at CVS/pharmacy locations, for up to a 90 day supply, through Maintenance Choice®. Maintenance Choice® offers the face-to-face experience and quick service of retail, with the lower Mail Service Copayment structure. Prescriptions for 84 to 90 day supplies of Maintenance Medications can be filled under Maintenance Choice® and your Copayment will be the same as it would be for a Mail Service order. To utilize Maintenance Choice®, visit a CVS/pharmacy location and follow the procedure described on page 97 under “Participating Pharmacy.”

Coordination of Benefits provisions do not apply to the Outpatient Prescription Drug Program.

Coinsurance, "Member Pays the Difference" and "Partial Copay Waiver"

- Erectile or Sexual Dysfunction Drugs are subject to a 50% Coinsurance.
- "Member Pays the Difference" program: If a Non-Preferred Brand-Name Medication is selected when a generic equivalent is available, Members will pay the difference in cost between the Brand Name Medication and the generic equivalent, plus the generic Copayment. Exceptions to the Member Pays the Difference program will only be considered for Physician requested Brand Name Medication with a generic equivalent for Medical Necessity.

Examples of Member Pays the Difference Claims for Non-Preferred Brand-Name Medications*

Drug	Brand Plan cost	Generic Plan cost	Difference	Generic copay	Member pays*
Zocor®	$100 -	$15 =	$85 +	$5	$90
Valium®	$79.64 -	$7.50 =	$72.14 +	$5	$77.14

*Dollar amounts listed are for illustration only and will vary depending on your particular Prescription.

- You may apply for a Partial Copay Waiver Exception of a Non-Preferred Brand-Name Copayment or a Member Pays the Difference Exception by contacting CVS/caremark Customer Care at 1-877-542-0284 (1-800-863-5488 [TDD]) to request an Exception form. Your Physician must document the Medical Necessity for the Non-Preferred product(s) versus the Preferred product(s) and the available generic alternative(s). The Partial Copay Waiver Exception and Member Pays the Difference Exception is only available for Non-Preferred Brands and excludes Erectile or Sexual Dysfunction Medications.
- Partial Copay Waiver Exception and Member Pays the Difference Exception authorizations will be entered from the date of the approval. Retroactive reimbursement requests will not be granted.

Retail Pharmacy Program

Medication for a short duration, up to a 30-day supply, may be obtained from a Participating Pharmacy by using your PERS Select ID card.

There are many Participating Pharmacies outside California that will also accept your PERS Select ID card. At Participating Pharmacies, simply show your ID card and pay either a $5.00 Copayment for Generic Medications, a $20.00 Copayment for Preferred Brand-Name Medications, or a $50.00 Copayment for Non-Preferred Brand-Name Medications, or no cost for preventive immunizations. Non-Preferred Brand-Name Medications can be purchased for a $40.00 Copayment with an approved partial copay waiver (page 96). If the Pharmacy does not accept your ID card and is a Non-Participating Pharmacy (defined on page 112), there is an additional cost to you.

If you refill a Maintenance Medication at a non-Maintenance Choice retail Pharmacy after the second fill, you will be charged a higher Copayment, which is the applicable Mail Service Copayment described above under Copayment Structure.

To find a Participating Pharmacy close to you, simply visit the CVS/caremark Web site at www.caremark.com/calpers, or contact CVS/caremark Customer Care at 1-877-542-0284 (1-800-863-5488 [TDD]). If you want to utilize a Non-Participating Pharmacy, please follow the procedure for using a Non-Participating Pharmacy described on page 97. For covered Medications you take on a long-term basis (60 days or more), use CVS/caremark Mail Service, or a CVS/pharmacy for a lower Copayment. For more information on CVS/caremark Mail Service, see How To Use CVS/caremark Mail Service on pages 98-100, visit the CVS/caremark Web site at www.caremark.com/calpers, or call CVS/caremark Customer Care at 1-877-542-0284 (1-800-863-5488 [TDD]).

OUTPATIENT PRESCRIPTION DRUG PROGRAM

How To Use The Retail Pharmacy Program Nationwide

Participating Pharmacy

Take your Prescription to any Participating Pharmacy*. Present your PERS Select ID card to the pharmacist. The pharmacist will fill the Prescription for up to a 30-day supply of Medication. Verify that the pharmacist has accurate information about you and your covered dependents, including date of birth and gender.

*Limitations may apply.

Non-Participating Pharmacy/Out-of-Network/Foreign Prescription Claims

If you fill Medications at a Non-Participating Pharmacy, either inside or outside California, **you will be required to pay the full cost of the Medication at the time of purchase**. To receive reimbursement, complete a CVS/caremark Prescription Reimbursement Claim Form and mail it to the address indicated on the form. **Claims must be submitted within 12 months from the date of purchase to be covered. Any claim submitted outside the 12 month time period will be denied.**

Payment will be made directly to you. It will be based on the amount that the Plan would reimburse a Participating Pharmacy minus the applicable Copayment.

Example of Direct Reimbursement Claim for a Preferred Brand-Name Medication*

1.	Pharmacy charge to you (Retail Charge)	$ 48.00
2.	Minus CVS/caremark's Negotiated Network Amount on a Preferred Brand-Name Medication	($ 30.00)
3.	Amount you pay in excess of allowable amount due to using a Non-Participating Pharmacy or not using your ID Card at a Participating Pharmacy	$ 18.00
4.	Plus your Copayment for a Preferred Brand-Name Medication	$ 20.00
5.	Your total financial cost would be	$ 38.00

If you had used your ID Card at a Participating Pharmacy, the Pharmacy would only charge the Plan $30.00 for the Drug, and your financial cost would only have been the $20.00 Copayment. Please note that if you paid a higher Copayment after your second fill at retail for a Maintenance Medication, you will not be reimbursed for the higher amount.

As you can see, using a Non-Participating Pharmacy or not using your ID card at a Participating Pharmacy results in substantially more cost to you than using your ID card at a Participating Pharmacy. Under certain circumstances your Copayment amount may be higher than the cost of the Medication, and no reimbursement would be allowed.

*Dollar amounts listed are for illustration only and will vary depending on your particular Prescription.

Foreign Prescription Drug Claims: There are no participating pharmacies outside of the United States. To receive reimbursement for Outpatient Prescription Medications purchased outside the United States, complete a CVS/caremark Prescription Reimbursement Claim Form and mail the form along with your Pharmacy receipt to CVS/caremark Inc. The Non-Participating Pharmacy must still have a valid pharmacy ID (NPI) in order for the Plan to approve the paper claim. This can be obtained from the Pharmacy that you filled the Prescription. To obtain a claim form, visit the CVS/caremark web site at www.caremark.com/calpers, or contact CVS/caremark Customer Care at 1-877-542-0284 (1-800-863-5488 [TDD]).

Reimbursement for Drugs will be limited to those obtained while you are traveling or temporarily outside of the United States and will be subject to the same restrictions and coverage limitations as set forth in this Evidence of Coverage document. Excluded from coverage are foreign Drugs for which there is no approved U.S. equivalent, Experimental or Investigational Drugs, or Drugs not covered by the Plan (e.g., Drugs used for cosmetic purposes, Drugs for weight loss, etc.). Please refer to the list of covered and excluded Drugs outlined in the Outpatient Prescription Drug Program section starting on page 97 and Outpatient Prescription Drug Exclusions section on pages 103-104.

50% Coinsurance applies for Medications used to treat erectile or sexual dysfunction. **Claims must be submitted within 12 months from the date of purchase.**

Direct Reimbursement Claim Forms

To obtain a CVS/caremark Prescription Reimbursement Claim Form and information on Participating Pharmacies, visit the CVS/caremark Web site at www.caremark.com/calpers, or contact CVS/caremark Customer Care at 1-877-542-0284 (1-800-863-5488 [TDD]). You must sign any Prescription Reimbursement Claim Forms prior to submitting the form (and Prescription Reimbursement Claim Forms for Plan Members under age 18 must be signed by the Plan Member's parent or guardian).

Compound Medications

Compound Medications, in which two or more ingredients are combined by the pharmacist, are covered by the Plan's Prescription Drug Program if at least one of the active ingredients: (a) requires a Prescription; (b) is FDA-approved; and (c) is covered by CalPERS. Compound Medications are subject to Coverage Management Programs described in pages 101-102, and Outpatient Prescription Drug Exclusions listed on page 104 #26. Only products that are FDA-approved and commercially available will be considered Preferred for purposes of determining copay. The Copayment for a compound Medication is based off the pricing of each individual Drug used in the compound. The Copayment is determined by the ingredient used in the compound that is on the highest tier of the Prescription Drug Benefit Copayment Structure (see pages 94-95 for chart). Compounds that include a Brand Name Drug with a generic equivalent will be subjected to the Member Pays the Difference rule. Compound powders will have Non-Preferred Brand-Name Copayment. There are three ways to obtain compounded Medications through the Plan's Prescription Drug Program: (1) through CVS/caremark Mail Service; (2) through a Participating Retail Pharmacy; or (3) from a Non-Participating compounding Pharmacy. The CVS/caremark Mail Service provides compounding services for many Medications; however, CVS/caremark does not compound some Medications. These compounds must be obtained through a Participating Retail Pharmacy or another compounding Pharmacy. If a Participating Pharmacy or a Non-Participating Pharmacy is not able to bill on-line, you will be required to pay the full cost of the compound Medications at the time of purchase and then submit a direct claim for reimbursement. You will be required to pay the full cost of the Medications at the time of purchase, then submit a direct claim for reimbursement. To receive reimbursement, complete a CVS/caremark Prescription Reimbursement Claim Form and mail it to the address indicated on the form. Certain fees charged by compounding pharmacies may not be covered by your insurance. Please call CVS/caremark Customer Services 1-877-542-0284 (1-800-863-5488 [TDD]) for details.

Mail Service Program

Maintenance Medications for long-term or chronic conditions may be obtained by mail, for up to a 90 day supply, through CVS/caremark's Mail Service Program. Mail Service offers additional savings, specialized clinical care and convenience if you need Prescription Medication on an ongoing basis. For example:

- **Additional Savings**: You can receive up to a **90 day supply** of Medication for only $10.00 for each Generic Medication, $40.00 for each Preferred Brand-Name Medication, $100.00 for each Non-Preferred Brand-Name Medication, or $70.00 for each Partial Copay Waiver of Non-Preferred Brand-Name Copayment. In addition to financial cost savings, you save additional trips to the Pharmacy.
- **Convenience:** Your Medication is delivered to your home by mail.
- **Security:** You can receive up to a 90-day supply of Medication at one time.
- **A toll-free customer service number:** Your questions can be answered by contacting a CVS/caremark Customer Care Representative at 1-877-542-0284 (1-800-863-5488 [TDD]).
- **The Maximum Calendar Year Pharmacy Financial Responsibility:** Your maximum Calendar Year Copayment (per person) through the Mail Service Program is $1,000. This only applies to Copayments for Generic and Preferred Brands.

How To Use CVS/caremark Mail Service

If you must take Medication on an ongoing basis, CVS/caremark Mail Service is ideal for you. To use this program, just follow these steps:

1. Ask your Physician to prescribe Maintenance Medications for up to a 90 day supply (i.e., if once daily, quantity of 90; if twice daily, quantity of 180; if three times daily, quantity of 270, etc.), plus refills if appropriate.

2. Send the following to CVS/caremark in the pre-addressed Mail Service envelope:

   a. The original Prescription Order(s) – **Photocopies are not accepted**.

   b. A completed CVS/caremark Mail Service Order Form. The CVS/caremark Mail Service Order Form can be obtained by visiting the CVS/caremark Web site at www.caremark.com/calpers, or by contacting CVS/caremark Customer Care at 1-877-542-0284 (1-800-863-5488 [TDD]) and using the automated phone system or requesting to speak with a customer service representative.

   c. A check or money order for an amount that covers your Copayment for each Prescription: $10 generic, $40 Preferred Brand-Name, $100 Non-Preferred Brand-Name or $70 Partial Copay Waiver of Non-Preferred Brand-Name should be included with your prescription. Checks or money orders should be made payable to CVS/caremark. CVS/caremark also has a safe, convenient way for you to pay for your orders called Electronic Check Processing. Electronic Check Processing is an electronic funds transfer system that automatically deducts your Copayment from your checking account. For more information or to enroll on-line, visit www.caremark.com/calpers or call Customer Care at 1-877-542-0284 (1-800-863-5488 [TDD]). If you prefer to pay for all of your orders by credit card, you may want to join CVS/caremark's automatic payment program. You can enroll by visiting the CVS/caremark Web site at www.caremark.com/calpers or by calling toll-free 1-877-542-0284 (1-800-863-5488 [TDD]).

3. You may also have your Physician fax your Prescriptions or send them electronically (often called e-prescribing) to CVS/caremark.

   a. Physicians may fax new Prescription(s) using "Fast Start" to CVS/caremark at 1-800-378-0323. (CVS/caremark can only accept faxes from your Physician.)

   b. To send Prescriptions electronically, your Physician may enter the Prescription on an electronic handheld device or computer.

4. To order your Mail Service refill:

   a. Use CVS/caremark's Web site
   Visit **www.caremark.com/calpers**, your on-line Prescription service, to order Prescription refills or inquire about the status of your order. You will need to register on the site and log in. When you register you will need the cardholder's ID number which is located on the combined medical and prescription drug ID card.

   b. Call CVS/caremark's Automated Refill Phone System
   CVS/caremark's automated telephone service gives you a convenient way to refill your Prescriptions at any time of the day or night. Call 1-877-542-0284 (1-800-863-5488 [TDD]) for CVS/caremark's fully automated refill phone service. When you call, be ready to provide the cardholder's ID number, Member's year of birth, and your credit card number along with the expiration date.

   c. Refill by Mail
   Order your refill three weeks in advance of your current Prescription running out. Refill dates will be included on the Prescription label you receive from CVS/caremark and the refill order forms that will be included with all Prescriptions for which refills remain. Mark the appropriate box on the CVS/caremark Mail Service Order Form and mail it, along with your payment to CVS/caremark in the pre-addressed envelope included with your previous shipment.

5. Medications will not be released by CVS/caremark Mail Service without a form of payment on file.

How to submit a payment to CVS/caremark

You should always submit a payment to CVS/caremark when you order Prescriptions through CVS/caremark Mail Service, just as if you were ordering a Prescription from a retail Pharmacy. CVS/caremark accepts the following as types of payment methods:

- Electronic Check
- Check/Money Order
- Credit Card/Debit Card - Visa®, MasterCard®, Discover®/NOVUS, American Express®
- BillMeLater® - (Visit www.caremark.com/calpers or call CVS/caremark Customer Care to find out if this option is available to you.) BillMeLater® is an easy way to pay in full or over time without using your credit card. BillMeLater® is subject to credit approval as determined by the lender, CIT Bank, Salt Lake City, Utah and is available to U.S. customers who are of legal age in their state of residence.

CVS/caremark recommends placing a credit card on file if you will be ordering ongoing Prescriptions through CVS/caremark Mail Service. A credit card can be placed on your account by logging in to your account at www.caremark.com/calpers, calling Customer Care or filling out the credit card information on CVS/caremark Mail Service Order Form when you mail in your Prescription Order. If “Default Payment Method” is selected during order, your chosen payment method will automatically be charged every time that a new Prescription or refill is ordered.

If you have questions regarding CVS/caremark Mail Service or to find out if your Medication is on CVS/caremark’s Preferred Drug List, visit the CVS/caremark Web site at www.caremark.com/calpers, or contact CVS/caremark Customer Care at 1-877-542-0284 (1-800-863-5488 [TDD]). All Prescriptions received through Mail Service will be filled with an FDA-approved bioequivalent generic substitute if one exists.

PRESCRIPTION DRUG COVERAGE MANAGEMENT PROGRAMS

Coverage Management Programs

The Plan's Prescription Drug Coverage Management Programs include, but are not limited to the High Performance Generic Step Therapy and Prior Authorization Program/Point of Sale Utilization Review Program. Additional programs may be added at the discretion of the Plan. **The Plan reserves the right to exclude, discontinue or limit coverage of Drugs or a class of Drugs, at any time following a review.**

The Plan may implement additional new programs designed to ensure that Medications dispensed to its Members are covered under this Plan. **As new Medications are developed, including generic versions of Brand-Name Medications, or when Medications receive FDA approval for new or alternative uses, the Plan reserves the right to review the coverage of those Medications or class of Medications under the Plan. Any benefit payments made for a Prescription Medication will not invalidate the Plan's right to make a determination to exclude, discontinue or limit coverage of that Medication at a later date.**

The purpose of Prescription Drug Coverage Management Programs, which are administered by CVS/caremark in accordance with the Plan, is to ensure that certain Medications are covered in accordance with specific Plan coverage rules.

High Performance Generic Step Therapy

The High Performance Generic Step Therapy program helps you and your doctor choose a lower-cost, generic medicine as the first step in treating your health condition. Before certain targeted Brand Name Drugs are covered, this program requires that you try a generic medicine as the first step in treating your health condition. If you cannot or will not make the change, there are the following options:

- If the change is not clinically appropriate, your Prescriber may request a prior authorization.
- If you do not make the change, your targeted Brand Drug will not be covered and you will have to pay the full cost of the Drug.

High Performance Generic Step Therapy is available for the following conditions: Depression, Glaucoma, High Blood Pressure, High Cholesterol, Acid Reflux, Acne, Allergy, Headache, Insomnia, Osteoporosis, Pain, Prostate Enlargement and Urinary Incontinence. To obtain a complete list of Medications, contact CVS/caremark Customer Care at 1-877-542-0284 (1-800-863-5488 [TDD]) or visit www.caremark.com/calpers.

Prior Authorization/Point of Sale Utilization Review Program

If your Prescription requires a prior authorization, the dispensing pharmacist is notified by an automated message before the Drug is dispensed. **The dispensing pharmacist may receive a message such as "Plan Limits Exceeded" or "Prior Authorization Required" depending on the Drug category.** Your Physician should contact CVS/caremark to determine if the prescribed Medication meets the Plan's approved coverage rules. Approvals for prior authorizations are typically granted for one year; however, the time frame may be greater or less than one year depending on the Drug. This process is usually completed within 48 hours. You and your Prescriber will receive notification from CVS/caremark of the prior authorization outcome. Some Drugs that require prior authorization may be subject to a quantity limitation that may differ from the 30-day supply.

Please visit the CVS/caremark Web site at www.caremark.com/calpers, or contact CVS/caremark Customer Care at 1-877-542-0284 (1-800-863-5488 [TDD]) to determine if your Medication requires prior authorization.

CVS/caremark's Specialty Pharmacy Services

CVS/caremark's Specialty Pharmacy offers convenient access and delivery of Specialty Medications (as defined in this EOC), many of which are injectable, as well as personalized service and educational support. A CVS/caremark patient care representative will be your primary contact for ongoing delivery needs, questions, and support.

PRESCRIPTION DRUG COVERAGE MANAGEMENT PROGRAMS

To obtain Specialty Medications, you or your Physician should call 1-800-237-2767. CVS/caremark's Specialty Pharmacy hours of operation are 7:30 AM to 7:30 PM PST, Monday through Friday; however, pharmacists are available for clinical consultation 24 hours a day, 7 days a week.

Please contact CVS/caremark's Specialty Pharmacy at 1-800-237-2767 for specific coverage information.

Specialty Medications will be limited to a maximum 30 day supply.

Specialty Preferred Medication - Specialty Preferred Medication strategies control costs and maintain quality of care by encouraging prescribing toward a clinically effective therapy. This program requires a Member to try the preferred Specialty Medication(s) within the Drug class prior to receiving coverage for the non-preferred Medication. If you don't use a preferred Specialty Medication, your Prescription may not be covered and you may be required to pay the full cost. The Member has the opportunity to have the Prescriber change the Prescription to the preferred Medication or have the Prescriber submit a request for coverage through an exception. Clinical exception requests are reviewed to determine if the non-preferred Medication is Medically Necessary for the Member.

OUTPATIENT PRESCRIPTION DRUG EXCLUSIONS

The following are excluded under the Outpatient Prescription Drug Program:

1. Non-medical therapeutic devices, Durable Medical Equipment, appliances and supplies, including support garments, even if prescribed by a Physician, regardless of their intended use.*
2. Drugs not approved by the U.S. Food and Drug Administration (FDA)
3. Off label use of FDA approved Drugs**, if determined inappropriate through CVS/caremark's Coverage Management Programs.
4. Any quantity of dispensed Medications that is determined inappropriate as determined by the FDA or through CVS/caremark's Coverage Management Programs.
5. Drugs or medicines obtainable without a Prescriber's Prescription, often called Over-the-Counter Drugs (OTC) or Behind-the-Counter Drugs (BTC), except insulin, diabetic test strips and lancets, and Plan B.
6. Dietary and herbal supplements, minerals, health aids, homeopathics, any product containing a medical food, and any vitamins whether available over the counter or by Prescription (e.g., prenatal vitamins, multi-vitamins, and pediatric vitamins), except Prescriptions for single agent vitamin D, vitamin K and folic acid.
7. A Prescription Drug that has an over-the-counter alternative.
8. Prescription single agent non-sedating antihistamines.
9. Anorexiants and appetite suppressants or any other anti-obesity Drugs.
10. Supplemental fluorides (e.g., infant drops, chewable tablets, gels and rinses) except as required by law.
11. Charges for the purchase of blood or blood plasma.
12. Hypodermic needles and syringes, except as required for the administration of a covered Drug.
13. Drugs which are primarily used for cosmetic purposes rather than for physical function or control of organic disease.
14. Drugs labeled "Caution – Limited By Federal Law to Investigational Use" or non-FDA approved Investigational Drugs. Any Drug or Medication prescribed for experimental indications.
15. Any Drugs prescribed solely for the treatment of an illness, injury or condition that is excluded under the Plan.
16. Any Drugs or Medications which are not legally available for sale within the United States.
17. Any charges for injectable immunization agents (except when administered at a Participating Pharmacy), desensitization products or allergy serum, or biological sera, including the administration thereof. *
18. Professional charges for the administration of Prescription Drugs or injectable insulin. *
19. Drugs or medicines, in whole or in part, to be taken by, or administered to, a Plan Member while confined in a Hospital or Skilled Nursing Facility, rest home, sanatorium, convalescent Hospital or similar facility. *
20. Drugs and Medications dispensed or administered in an Outpatient setting (e.g., injectable Medications), including, but not limited to, Outpatient Hospital facilities, and services in the Member's home provided by Home Health Agencies and Home Infusion Therapy Providers. *
21. Medication for which the cost is recoverable under any workers' compensation or occupational disease law, or any state or governmental agency, or any other third-party payer; or Medication furnished by any other Drug or medical services for which no charge is made to the Plan Member.

OUTPATIENT PRESCRIPTION DRUG EXCLUSIONS

22. Any quantity of dispensed Drugs or medicines which exceeds a 30 day supply at any one time, unless obtained through CVS/caremark Mail Service or the Maintenance Choice® program. Prescriptions filled using CVS/caremark Mail Service or the Maintenance Choice® program are limited to a maximum 90 day supply of covered Drugs or medicines as prescribed by a Prescriber. Specialty Medications are limited up to a 30 day supply.

23. Refills of any Prescription in excess of the number of refills specified by a Prescriber as allowed per federal/state laws.

24. Any Drugs or Medicines dispensed more than one year following the date of the Prescriber's Prescription Order as allowed per federal/state laws. Note, controlled substances may be less than one year depending on federal/state laws.

25. Any charges for special handling and/or shipping costs incurred through a Participating Pharmacy, a Non-Participating Pharmacy, or the CVS/caremark Mail Service program.

26. Compounded Medications if: (1) there is a medically appropriate formulary alternative, or (2) the compounded Medication contains any ingredient not approved by the FDA. Compounded Medications that do not include at least one Prescription Drug, as defined on page 114, are not covered.

27. Replacement of lost, stolen or destroyed Prescription Drugs.

28. Drugs or Medications used solely for the purpose of diagnosing and/or treating infertility

NOTE: While not covered under the Outpatient Prescription Drug Program benefit, items marked by an asterisk (*) are covered as stated under the Hospital Benefits, Home Health Care, Hospice Care, Home Infusion Therapy and Professional Services provisions of Medical and Hospital Benefits, and Description of Benefits (see Table of Contents), subject to all terms of this Plan that apply to those benefits.

**Drugs awarded DESI (Drug Efficacy Study Implementation) Status by the FDA were approved between 1938 and 1962 when drugs were reviewed on the basis of safety alone; efficacy (effectiveness) was not evaluated. The FDA allows these products to continue to be marketed until evaluations of their effectiveness have been completed. DESI Drugs may continue to be covered under the CalPERS outpatient pharmacy benefit until the FDA has ruled on the approval application.

Services Covered By Other Benefits

When the expense incurred for a service or supply is covered under another benefit section of the Plan, it is not a Covered Expense under the Outpatient Prescription Drug Program benefit.

PRESCRIPTION DRUG CLAIM REVIEW AND APPEALS PROCESS

CVS/caremark manages both the administrative and clinical prescription drug appeals process for CalPERS. If you wish to request a coverage determination, you or your Authorized Representative, may contact CVS/caremark's Customer Care at 1-877-542-0284 (1-855-479-3660 [TTY]). Customer Care will provide you with instructions and the necessary forms to begin the process. The request for a coverage determination must be made in writing to CVS/caremark. The written response from CVS/caremark is an initial determination and will include your appeal rights. A denial of the request is an Adverse Benefit Determination (ABD), and may be appealed through the Internal Review process described below. Denials of requests for Partial Copayment Waivers and Member Pay the Difference Exceptions are ABDs, and you may appeal them through the Internal Review process. If the appeal is denied through the Internal Review process, it becomes a Final Adverse Benefit Determination (FABD) and for cases involving Medical Judgment, you may pursue an independent External Review as described below, or for benefit decisions may request a CalPERS Administrative Review.

The cost of copying and mailing medical records required for CVS/caremark to review its determination is the responsibility of you or your Authorized Representative requesting the review.

1. Denial of claims of benefits

Any denial of a claim is considered an ABD and is eligible for Internal Review as described in section 2. below. FABD resulting from the Internal Review process may be eligible for independent External Review in cases involving Medical Judgment, as described in section 4. below.

a. Denial of a Drug Requiring Approval Through Coverage Management Programs

You may request an Internal Review for each Medication denied through Coverage Management Programs within 180 days from the date of the notice of initial benefit denial sent by CVS/caremark. This review is subject to the Internal Review process described in section 2. below.

b. All Denials of Direct Reimbursement Claims

Some direct reimbursement claims for Prescription Drugs are not payable when first submitted to CVS/caremark. If CVS/caremark determines that a claim is not payable in accordance with the terms of the Plan, CVS/caremark will notify you in writing explaining the reason(s) for nonpayment.

If the claim has erroneous or missing data that may be needed to properly process the claim, you may be asked to resubmit the claim with complete information to CVS/caremark. If after resubmission the claim is determined to be payable in whole or in part, CVS/caremark will take necessary action to pay the claim according to established procedures. If the claim is still determined to be not payable in whole or in part after resubmission, CVS/caremark will inform you in writing of the reason(s) for denial of the claim.

If you are dissatisfied with the denial made by CVS/caremark, you may request an Internal Review as described in section 2. below.

2. Internal Review

You may request a review of an ABD by writing to CVS/caremark within 180 days of receipt of the ABD. Requests for Internal Review should be directed to:

CVS/caremark
P. O. Box 52084
Phoenix, AZ 85072-2084
Fax: 1-866-689-3092

The request for review must clearly state the issue of the review and include the identification number listed on the CVS/caremark Identification Card, and any information that clarifies or supports your position. For pre-service requests, include any additional medical information or scientific studies that support the Medical Necessity of the service. If you would like us to consider your grievance on an urgent basis, please write "urgent" on your request and provide your rationale. (See definition of "Urgent Review" on page 84.)

You may submit written comments, documents, records, scientific studies and other information related to the claim that resulted in the ABD in support of the request for Internal Review. All information provided will be taken into account without regard to whether such information was submitted or considered in the initial ABD.

You will be provided, upon request and free of charge, a copy of the criteria or guidelines used in making the decision and any other information related to the determination. To make a request, contact CVS/caremark Customer Care at 1-877-542-0284 or 1-800-863-5488 [TTY].

CVS/caremark will acknowledge receipt of your request within 5 calendar days. For standard reviews of prior authorization of Prescription services (Pre-Service Appeal or Concurrent Appeal), CVS/caremark will provide a determination within 30 days of the initial request for Internal Review and includes the following steps:

- 15 days for a determination regarding claim or benefit; and
- an additional15 days for a determination regarding Medical Judgment.

For standard reviews of Prescriptions or services that have been provided (Post-Service Appeal), CVS/caremark will provide a determination within 60 days of the initial request for Internal Review.

If CVS/caremark upholds the ABD, that decision becomes the Final Adverse Benefit Decision (FABD).

Upon receipt of an FABD, the following options are available to you:

- For FABDs involving medical judgment, you may pursue the independent External Review process described in section 4. below;
- For FABDs involving benefit, you may pursue the CalPERS Administrative Review process as described in section 5. below.

3. Urgent Review

An urgent grievance is resolved within 72 hours upon receipt of the request, but only if CVS/caremark determines the grievance meets one of the following:

- The standard appeal timeframe could seriously jeopardize your life, health, or ability to regain maximum function; **OR**
- The standard appeal timeframe would, in the opinion of a Physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without extending your course of covered treatment; **OR**
- A Physician with knowledge of your medical condition determines that your grievance is urgent.

If CVS/caremark determines the grievance request does not meet one of the above requirements, the grievance will be processed as a standard request. If your situation is subject to an urgent review, you can simultaneously request an independent External Review described below.

4. Request for Independent External Review

FABD's that are eligible for independent External Review are those that involve an element of Medical Judgment. An example of Medical Judgment would be where there has been a denial of a prior authorization on the basis that it is not Medically Necessary. If the FABD decision is based on Medical Judgment, you will be notified that you may request an independent External Review of that determination by an Independent Review Organization (IRO). This review is at no cost to you. You may request an independent External Review, in writing, no later than 4 months from the date of the FABD. The Prescription in dispute must be a covered benefit. For cases involving Medical Judgment, you must exhaust the independent External Review prior to requesting a CalPERS Administrative Review.

You may also request an independent External Review if CVS/caremark fails to render a decision within the timelines specified above for Internal Review. For a more complete description of independent External Review rights, please see 45 Code of Federal Regulations section 147.136.

5. Request for CalPERS Administrative Review

If you remain dissatisfied after exhausting the Internal Review process for benefit decisions and the independent External Review in cases involving Medical Judgment, you may submit a request for CalPERS Administrative Review. You must exhaust CVS/caremark's Internal Review process and the independent External Review process, when applicable, prior to submitting a request for a CalPERS Administrative Review. See the section entitled "CalPERS Administrative Review and Administrative Hearing" on pages 79-80.

DEFINITIONS

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

Accidental Injury — definite trauma resulting from a sudden, unexpected and unplanned event, occurring by chance, caused by an independent external source.

Acute Condition/Care — care provided in the course of treating an illness, injury or condition marked by a sudden onset or change of status requiring prompt attention, which may include hospitalization, but which is of limited duration and not expected to last indefinitely.

Administrator —

1. denotes CalPERS as the global administrator of the Plan through the Self-Funded Health Plans Unit of the Office of Health Policy and Plan Administration of CalPERS, also referred to as "the Plan"; and

2. denotes entities under contract with CalPERS to administer the Plan, also known as "third-party administrators" or "administrative service organizations."

Allowable Amount — the Anthem Blue Cross (applying to covered services rendered in California or Out-of-Area, as described under Foreign Medical Claims on page 20) or the local Blue Cross and/or Blue Shield Plan (applying to services rendered outside California) allowance or Negotiated Amount as defined below for the service(s) rendered, or the provider's Billed Charge, whichever is less. The allowance is:

1. the amount that Anthem Blue Cross or the local Blue Cross and/or Blue Shield Plan has determined is an appropriate payment for the service(s) rendered in the provider's geographic area, based on such factors as the Plan's evaluation of the value of the service(s) relative to the value of other services, market considerations, and provider charge patterns; or

2. such other amount as the Preferred Provider and Anthem Blue Cross or the local Blue Cross and/or Blue Shield Plan have agreed will be accepted as payment for the service(s) rendered; or

3. if an amount is not determined as described in either (1) or (2) above, the amount that Anthem Blue Cross or the local Blue Cross and/or Blue Shield Plan determines is appropriate considering the particular circumstances and the services rendered.

Alternative Birthing Center —

1. a birthing room located physically within a Hospital to provide homelike Outpatient maternity facilities, or

2. a separate birthing center that is certified or approved by a state department of health or other state authority and operated primarily for the purpose of childbirth.

Ambulatory Surgery Center — an independent entity not affiliated with a Hospital or a surgery center where there is a 51% majority physician ownership. The center is freestanding and operates under its own tax identification number (TIN), separate from a Hospital's TIN. These centers do not provide services or accommodations for patients to Stay overnight.

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

Anthem Blue Cross — the claims administrator responsible for administering medical benefits and providing utilization review services under this Plan. As used in this Evidence of Coverage booklet, the term "Anthem Blue Cross" shall be used to refer to both Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company. Anthem Blue Cross, as defined, is a separate and distinct entity from references to the Blue Cross and Blue Shield Association or Blue Cross and/or Blue Shield Plan providers.

DEFINITIONS

Anthem Blue Cross Medical Policy — general medical policies that reflect the current scientific data and clinical thinking guidance for medical necessity and Experimental/Investigational determinations for new medical technologies, procedures, and certain injectable Drugs and/or the new application of existing medical technologies, procedures, and certain injectable Drugs. The Anthem Blue Cross Web site provides access to Anthem Blue Cross Medical Policy at www.anthem.com/ca. You can also call or write Anthem Blue Cross to obtain medical policy in writing.

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

Autism Spectrum Disorder — as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.

Behind-the-Counter Drugs (BTC) — a Drug product that does not require a Prescription under federal or state law and is available to Members only through facilitation of the pharmacist or Pharmacy staff. The PERS Select outpatient prescription drug program does not cover BTC products.

Billed Charges — the amount the provider actually charges for services provided to a Member.

Board — the Board of Administration of the California Public Employees' Retirement System (CalPERS).

Brand–Name Medication(s) (Brand-Name Drug(s)) — a Drug which is under patent by its original innovator or marketer. The patent protects the Drug from competition from other Drug companies.

Calendar Year — a period commencing at 12:01 a.m. on January 1 and terminating at 12 midnight Pacific Standard Time on December 31 of the same year.

Centers of Medical Excellence (CME) — are the following facilities that have a Centers of Medical Excellence Agreement in effect with Anthem Blue Cross at the time services are rendered. CME agrees to accept the Plan payment plus applicable Member Deductibles and Copayments and/or Coinsurance as payment in full for covered services.

1. **Transplant Facilities.** Transplant facilities have been organized to provide services for the following specified transplants: heart, liver, lung, combination heart-lung, kidney, pancreas, simultaneous pancreas-kidney, or bone marrow/stem cell and similar procedures.
2. **Bariatric Facilities.** Hospital facilities have been organized to provide services for bariatric surgical procedures, such as gastric bypass and other surgical procedures for weight loss programs.
3. **Cardiac Care Facilities.** Hospital facilities developed in collaboration with expert Physicians and medical organizations to provide cardiac care.

A Preferred Provider in the Select PPO Preferred Provider network is not necessarily a CME. A provider's participation in the Select PPO Preferred Provider network or other agreement with Anthem Blue Cross is not a substitute for a Centers of Medical Excellence Agreement.

Christian Science Nurse — A Christian Science Nurse approved as such by The First Church of Christ Scientist, in Boston, Massachusetts and listed in the Christian Science Journal.

Christian Science Nursing Facility — A Christian Science Nursing Facility accredited by The Commission for Accreditation of Christian Science Nursing Organization/Facilities, Inc.

Christian Science Practitioner — A Christian Science Practitioner approved as such by The First Church of Christ Scientist, in Boston, Massachusetts, and listed in the Christian Science Journal.

Close Relative — the spouse, domestic partner, child, brother, sister or parent of a Subscriber or Family Member.

DEFINITIONS

Coinsurance — is a set percentage (e.g., 20% / 40%) defined in the Plan and paid by the Member for certain covered services, often after the Member pays the Calendar Year Deductible. See pages 3-10 for a list of the Member's applicable Coinsurance for certain covered services. When using a Preferred Provider, the Member will need to pay the set percentage Coinsurance until the Member meets the Maximum Calendar Year Financial Responsibility. When using a Non-Preferred Provider, the percentage the Member pays for covered services is higher, and the Coinsurance does NOT accumulate toward the Maximum Calendar Year Financial Responsibility.

Contract Period — the period of time from January 1, 2016, through December 31, 2016.

Copayment — is a set fixed dollar amount (i.e., office visit copay) defined in the Plan and paid by the Member for certain covered services, often after the Member pays the Calendar Year Deductible. See pages 3-10 for a list of the Member's applicable Copayments for certain covered services.

Cosmetic Procedure — any surgery, service, Drug or supply primarily to improve the appearance (including appearance altered by disease, trauma, or aging) of parts or tissues of an individual. This definition does not apply to Reconstructive Surgery to restore a bodily function or to correct deformities resulting from injury or disease or caused by congenital anomalies, or surgery which is Medically Necessary following injury or disease to restore function.

Custodial Care — care provided either in the home or in a facility primarily for the maintenance of the patient or which is designed essentially to assist the patient in meeting his or her activities of daily living and which is not primarily provided for its therapeutic value in the treatment of illness or Accidental Injury. Custodial care includes, but is not limited to, help in walking, bathing, dressing, feeding (including the use of some feeding tubes not requiring skilled supervision), preparation of special diets, and supervision over self-administration of Medication not requiring constant attention of trained medical personnel.

Deductible — The amount you owe for health care services the Plan covers before it begins to pay.

Disability — an injury, an illness (including any mental disorder), or a condition (including pregnancy); however,

1. all injuries sustained in any one accident will be considered one disability;
2. all illnesses existing simultaneously which are due to the same or related causes will be considered one disability;
3. if any illness is due to causes which are the same as or related to the causes of any prior illness, the succeeding illness will be considered a continuation of the previous disability and not a separate disability.

Drug(s) — see definition under Prescription Drugs on page 114.

Durable Medical Equipment (Includes Prosthetic Appliances and Home Medical Equipment) — equipment which is: (1) determined to be Medically Necessary to treat an illness, injury or condition; (2) of no further use when medical needs end; (3) for the exclusive use of the patient; (4) not primarily for comfort or hygiene; (5) not for environmental control or for exercise; and (6) manufactured specifically for medical use. Home Medical Equipment includes items such as wheelchairs, hospital beds, respirators, and other items that the Plan determines are Home Medical Equipment.

Emergency Care Services — those services required for the alleviation of the sudden onset of severe pain, or a Psychiatric Emergency Medical Condition, or the immediate diagnosis and treatment of an unforeseen illness or injury which could lead to further significant Disability or death, or which would so appear to a prudent layperson.

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

DEFINITIONS

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

Experimental or Investigational — any treatment, therapy, procedure, Drug or Drug usage for non-FDA approved indications, facility or facility usage, equipment or equipment usage, device or device usage, or supplies which are 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 at issue. Additionally, any services that 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, shall be considered experimental or investigational. Any services that are not approved or recognized as being in accord with accepted professional medical standards, but nevertheless are authorized by law or a government agency for use in testing, trials, or other studies on human patients, shall be considered experimental or investigational. Any issue as to whether a protocol, procedure, practice, medical theory, treatment, or Prescription Drug is Experimental or Investigational will be resolved by Anthem Blue Cross or CVS/caremark, as applicable, which will have discretion to make an initial determination on behalf of the Plan.

Family Member — is defined in accordance with the definition currently in effect in PEMHCA and Regulations.

FDA — U.S. Food and Drug Administration.

Generic Medication(s) (Generic Drug(s)) — a Prescription Drug manufactured and distributed after the patent of the original Brand-Name Medication has expired. The Generic Drug must have the same active ingredient, strength and dosage form as its Brand-Name Medication counterpart. A Generic Drug costs less than a Brand-Name Medication.

Health Professional — dentist; optometrist; podiatrist or chiropodist; clinical psychologist; chiropractor; acupuncturist; clinical social worker; marriage, family and child counselor; physical therapist; speech pathologist; audiologist; licensed occupational therapist; Physician assistant; registered nurse; registered dietitian only for the provision of diabetic medical nutrition therapy or nutritional counseling as part of a comprehensive eating disorder program under Physician supervision for management of anorexia nervosa and bulimia nervosa; a nurse practitioner and/or nurse midwife providing services within the scope of practice as defined by the appropriate clinical license and/or regulatory board.

Homebound — Members are considered to be “homebound” if they have a condition due to an illness or injury that restricts their ability to leave their place of residence.

Home Health Agencies — home health care providers which are licensed according to state and local laws to provide skilled nursing and other services on a visiting basis in your home and recognized as home health providers under Medicare.

Home Health Aide — (In California) an aide who has successfully completed a training program approved by the California Department of Health Services pursuant to applicable federal and state regulation, is employed by a home health agency or hospice program, provides personal care services in the patient’s home, and is certified pursuant to Section 1736.1 of the Health and Safety Code. (Outside California) an aide who has successfully completed a state-established or other training program that meets certain federal requirements.

Home Infusion Therapy — refers to a course of treatment whereby a liquid substance is introduced into the body for therapeutic purposes. The infusion is done in the home at a continuous or intermittent rate.

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

Home Medical Equipment (Durable Medical Equipment) — see definition under Durable Medical Equipment.

Hospice Care — care received under a program that is: (1) designed to provide palliative and supportive care to individuals who have received a diagnosis of Terminal Illness; (2) supportive to the covered Family Members by providing certain services; (3) licensed or certified in the jurisdiction where the program is established; (4) directed and coordinated by medical professionals; and (5) approved by the Plan.

Hospital —

1. a licensed facility which is primarily engaged in providing, for compensation, medical, diagnostic and surgical facilities for the care and treatment of ill and injured persons on an Inpatient basis, and which provides such facilities under the supervision of a staff of Physicians and 24-hour-a-day nursing service by registered nurses. An institution which is principally a rest home, nursing home or home for the aged is not included; or
2. a psychiatric Hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations; or
3. a facility operated primarily for the treatment of substance abuse and accredited by the Joint Commission on Accreditation of Healthcare Organizations; or
4. a psychiatric health facility as defined in Section 1250.2 of the California Health and Safety Code.

Incentive Copayment Structure — Members may receive any covered Drug with copayment differentials between a Generic Medication, Preferred Brand-Name Medication, and Non-Preferred Brand-Name Medication.

Inpatient — an individual who has been admitted to a Hospital as a registered acute bed patient (overnight) and who is receiving services which could not be provided on an Outpatient basis, under the direction of a Physician.

Intensive Behavioral Intervention — any form of Applied Behavioral Analysis that is comprehensive, designed to address all domains of functioning, and provided in multiple settings for no more than 40 hours per week, across all settings, depending on the individual's needs and progress. Interventions can be delivered in a one-to-one ratio or small group format, as appropriate.

Maintenance Medications — Drugs that do not require frequent dosage adjustments, which are usually prescribed to treat a long-term condition, such as birth control, or a chronic condition, such as arthritis, diabetes, or high blood pressure. These Drugs are usually taken longer than sixty (60) days.

Medically Necessary — see the Medical Necessity provision on page 21.

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

Medication(s) — see Prescription Drug.

Member — see definition under Plan Member.

Negotiated Amount — the amount agreed upon between Anthem Blue Cross or the local Blue Cross and/or Blue Shield Plan and the Preferred Hospitals they have contracted with to provide Medically Necessary contractual benefits as described in this Evidence of Coverage booklet.

Negotiated Network Amount — the rate that the Prescription Drug benefit administrator has negotiated with Participating Pharmacies under a Participating Pharmacy Agreement for Prescription Drug covered expense. Participating Pharmacies have agreed to charge Members presenting their ID card no more than the negotiated network amount. It is also the rate which the Prescription Drug benefit administrator's Mail Service Program has agreed to accept as payment in full for Mail Service Prescription Drugs. In addition, if Medications are purchased at a Non-Participating Pharmacy, it is the maximum allowable amount for reimbursement.

Non-Participating Pharmacy — a Pharmacy which has not agreed to CVS/caremark's terms and conditions as a Participating Pharmacy. Members may visit the CVS/caremark Web site at www.caremark.com/calpers or contact CVS/caremark's Customer Care at 1-877-542-0284 (1-800-863-5488 [TDD]) to locate a Participating Pharmacy.

Non-Preferred Brand-Name Medication(s) (Non-Preferred Brand-Name Drug(s)) — Medications not listed on CVS/caremark's Preferred Drug List. If you would like to request a copy of CVS/caremark's Preferred Drug List, please visit the CVS/caremark Web site at www.caremark.com/calpers, or contact CVS/caremark Customer Care at 1-877-542-0284 (1-800-863-5488 [TDD]). Medications that are recognized as non-preferred and that are covered under your Plan will require the highest (third tier) copayment.

Non-Preferred Provider — a Physician, Hospital or other Health Professional that (1) does not participate in Anthem Blue Cross' Select PPO Preferred Provider network at the time services are rendered, or (2) does not participate in a Blue Cross and/or Blue Shield Plan network outside California at the time services are rendered. Any of the following types of providers may be Non-Preferred Providers: Physicians, Hospitals, Ambulatory Surgery Centers, Home Health Agencies, facilities providing diagnostic imaging services, Durable Medical Equipment providers, skilled nursing facilities, clinical laboratories, Urgent Care providers and Home Infusion Therapy Providers. An individual Preferred Provider may be considered a Non-Preferred Provider if (1) services are rendered at a location other than specified in the Prudent Buyer Plan Participating Provider Agreement or (2) the tax identification number used for billing purposes is different than specified in the Prudent Buyer Plan Participating Provider Agreement.

Occupational Therapy — treatment under the direction of a Physician and provided by a licensed occupational therapist utilizing arts, crafts or specific training in daily living skills to improve and maintain a patient's ability to function.

Other Providers — providers that are not represented in the Select PPO Preferred Provider network in California or in a Blue Cross and/or Blue Shield network of Preferred Providers outside California. In California, contact Anthem Blue Cross for information regarding which providers are represented in the Select PPO Preferred Provider network. When you are traveling outside California, call 1-800-810-BLUE (1-800-810-2583) for information regarding which providers are represented in a Blue Cross and/or Blue Shield network outside California.

Outpatient — an individual receiving services under the direction of a Physician but not incurring overnight charges at the facility where services are provided.

Outpatient Hospital Setting — A surgery center, where there is a 51% majority Hospital ownership, either attached or freestanding, that operates under a Hospital's tax identification number (TIN).

Over-the-Counter Drugs (OTC) — A Drug product that does not require a Prescription under federal or state law. PERS Select outpatient prescription drug program does not cover OTC products, with the exception of insulin.

Participating Pharmacy — a Pharmacy which is under an agreement with CVS/caremark to provide Prescription Drug services to Plan Members. Members may visit the CVS/caremark Web site at www.caremark.com/calpers or contact CVS/caremark Customer Care at 1-877-542-0284 (1-800-863-5488 [TDD]) to locate a Participating Pharmacy.

Pharmacy — a licensed facility for the purpose of dispensing Prescription Medications.

Physical Therapy — treatment under the direction of a Physician and provided by a licensed physical therapist or occupational therapist utilizing physical agents, such as ultrasound, heat and massage, to improve a patient's musculoskeletal, neuromuscular and respiratory systems.

Physician — a doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is duly licensed and qualified under the law of jurisdiction in which treatment is received.

Physician Member — a licensed Physician who has contracted with Anthem Blue Cross to furnish services and to accept Anthem Blue Cross' payment, plus applicable Deductibles and Copayments or Coinsurance, as payment in full for covered services.

Plan — means PERS Select. PERS Select is a self-funded health plan established and administered by CalPERS.

Plan Member — any Employee, Annuitant or Family Member enrolled in PERS Select.

Precertification — the Plan's requirement for advance authorization of certain services to assess the medical necessity, efficiency and/or appropriateness of health care services or Treatment Plans. These services will be covered only on a case-by-case basis as determined by the Plan. This term does not include the determination of eligibility for coverage or the payment of benefits under the Plan.

Preferred Brand-Name Medication(s) Preferred Brand-Name Drug(s)) — A Medication found on CVS/caremark's Preferred Drug List and evaluated based on the following criteria: safety, side effects, Drug-to-Drug interactions, and cost effectiveness. If you would like to request a copy of CVS/caremark's Preferred Drug List, please visit CVS/caremark's Web site at www.caremark.com/calpers or contact CVS/caremark Customer Care at 1-877-542-0284 (1-800-863-5488 [TDD]).

Preferred Drug List — A list of Medications that are more cost effective and offer equal or greater therapeutic value than the other Medications in the same Drug category. CVS/caremark and its Pharmacy and Therapeutics Committee conducts a rigorous clinical analysis to evaluate and select each Preferred Drug List Medication for safety, side effects, Drug-to-Drug interactions and cost effectiveness. The preferred product must (1) meet participant's treatment needs, (2) be clinically safe relative to other Drugs with the same indication(s) and therapeutic action(s), (3) be effective for FDA approved indications, (4) have therapeutic merit compared to other effective Drug therapies, and (5) promote appropriate Drug use.

Preferred Hospital — a Hospital under contract with Anthem Blue Cross or a Blue Cross and/or Blue Shield Plan which has agreed to furnish services and to accept Anthem Blue Cross' payment or the local Blue Cross and/or Blue Shield Plan's payment, plus applicable Deductibles and Copayments or Coinsurance, as payment in full for covered services. Individual providers at a Preferred Hospital may not be Preferred Providers

Preferred Provider — a Physician, Hospital or other Health Professional that (1) participates in Anthem Blue Cross' Select PPO Preferred Provider network at the time services are rendered, provides a service at a location set forth in the Participating Provider Agreement, and bills Anthem Blue Cross utilizing the tax identification number (TIN) under the terms of that Agreement for those services rendered, or (2) participates in a Blue Cross and/or Blue Shield Plan network outside California at the time services are rendered. Any of the following types of providers may be Preferred Providers: Physicians, Hospitals, Ambulatory Surgery Centers, Home Health Agencies, facilities providing diagnostic imaging services, Durable Medical Equipment providers, skilled nursing facilities, clinical laboratories, Urgent Care providers and Home Infusion Therapy Providers.

Prescriber — a licensed health care provider with the authority to prescribe Medication.

Prescription(s) — a written order issued by a licensed Prescriber for the purpose of dispensing a Drug.

Prescription Drugs (Drug) — a Medication or Drug that is (1) a prescribed Drug approved by the U.S. Food and Drug Administration for general use by the public; (2) all Drugs which under federal or state law require the written Prescription of a Prescriber; (3) insulin; (4) hypodermic needles and syringes if prescribed by a Prescriber for use with a covered Drug; (5) glucose test strips; and (6) such other Drugs and items, if any, not set forth as an exclusion.

Prescription Order(s) — the request for each separate Drug or Medication by a Prescriber and each authorized refill of such request.

Preventive Care Services include routine examinations, screenings, tests, education, and immunizations administered with the intent of preventing future disease, illness, or injury. Services are considered preventive if you have no current symptoms or prior history of a medical condition associated with that screening or service. These services shall meet requirements as determined by federal and state law, and are to become effective in accordance with those laws, including but not limited to, the Patient Protection and Affordable Care Act (PPACA). Sources for determining which services are recommended include the following:

- Services with an "A" or "B" rating from the United States Preventive Services Task Force (USPSTF);
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
- Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration.

Please call the Customer Service number listed on your ID card for additional information about services that are covered by this plan as preventive care services. You may also refer to the following websites that are maintained by the U.S. Department of Health & Human Services.

- https://www.healthcare.gov/what-are-my-preventive-care-benefits
- http://www.ahrq.gov
- http://www.cdc.gov/vaccines/acip/index.html

Prosthetic Appliances — see definition under Prosthetic Devices.

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

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

Public Employees' Medical and Hospital Care Act (PEMHCA) — Title 2, Division 5, Part 5 (sections 22750 through 22944.3) of the Government Code of the State of California.

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

- Is employed and supervised by a Qualified Autism Service Provider,
- Provides treatment and implements services pursuant to a Treatment Plan developed and approved by the Qualified Autism Service Provider,
- Meets the criteria set forth in any applicable state regulations adopted pursuant to state law concerning the use of paraprofessionals in group practice provider behavioral intervention services, and
- Has adequate education, training, and experience, as certified by a Qualified Autism Service Provider.

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

- Provides behavioral health treatment,
- Is employed and supervised by a Qualified Autism Service Provider,
- Provides treatment according to a Treatment Plan developed and approved by the Qualified Autism Service Provider,
- Is a behavioral service provider approved as a vendor by a California regional center to provide services as an associate behavior analyst, behavior analyst, behavior management assistant, behavior management consultant, or behavior management program as defined in state regulation, and
- Has training and experience in providing services for Autism Spectrum Disorder pursuant to applicable state law.

Qualified Autism Service Provider — either of the following:

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

The network of Preferred Provider is limited to licensed Qualified Autism Service Providers who contract with Anthem Blue Cross and who may supervise and employ Qualified Autism Service Professionals or Qualified Autism Service Paraprofessionals who provide and administer Behavioral Health Treatment.

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

Reconstructive Surgery — surgery to correct deformities resulting from injury or disease, or surgery which is Medically Necessary following injury or disease to restore an individual to normal.

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

Rehabilitation or Rehabilitative Care — care furnished primarily to restore an individual's ability to function as normally as possible after a disabling disease, illness, injury or addiction. Rehabilitation or rehabilitative care services consist of the combined use of medical, social, educational, occupational/vocational treatment modalities and are provided with the expectation that the patient has restorative potential and will realize significant improvement in a reasonable length of time. Benefits for services for rehabilitation or rehabilitative care are limited to those specified under Precertification (see pages 64-67).

Residential Treatment Facility — a treatment facility where the individual resides in a modified community environment and follows a comprehensive medical treatment regimen for treatment and Rehabilitation as the result of a mental disorder or substance abuse. The facility must be licensed to provide psychiatric treatment of mental disorder or rehabilitative treatment of substance abuse according to state and local laws.

Respite Care — continuous care of the patient in the most appropriate setting for the primary purpose of providing temporary relief to the family from the duties of caring for the patient.

Retail Health Clinic — A facility that provides limited basic medical care services to Members on a "walk-in" basis. These clinics normally operate in major pharmacies or retail stores.

Skilled Care — skilled supervision and management of a complicated or extensive plan of care for a patient instituted and monitored by a Physician, in which there is a significantly high probability, as opposed to a possibility, that complications would arise without the skilled supervision or implementation of the treatment program by a licensed nurse or therapist.

Skilled Nursing Facility — a facility which is:

1. licensed to operate in accordance with state and local laws pertaining to institutions identified as such;
2. listed as a skilled nursing facility by the American Hospital Association and accredited by the Joint Commission on Accreditation of Healthcare Organizations and related facilities; or
3. recognized as a skilled nursing facility by the Secretary of Health and Human Services of the United States Government pursuant to the Medicare Act.

Specialty Medication(s) — Drugs that have one or more of the following characteristics: (1) therapy of chronic or complex disease; (2) specialized patient training and coordination of care (services, supplies, or devices) required prior to therapy initiation and/or during therapy; (3) unique patient compliance and safety monitoring requirements; (4) unique requirements for handling, shipping and storage; or (5) potential for significant waste due to the high cost of the Drug.

Specialty Pharmacy — a licensed facility for the purpose of dispensing Specialty Medications.

Speech Therapy — treatment under the direction of a Physician and provided by a licensed speech pathologist or speech therapist to improve or retrain a patient's vocal skills which have been impaired by illness or injury.

Standard Wheelchair — a fixed-arm wheelchair, with swing-away foot rests, that does not include any additional attachments and is not motorized, customized or considered lightweight.

Stay — an Inpatient confinement which begins when you are admitted to a facility and ends when you are discharged from that facility.

Subscriber — the person enrolled who is responsible for payment of premiums to PERS Select, and whose employment or other status, except family dependency, is the basis for eligibility for enrollment under this Plan.

Take-Home Prescription Drugs — Prescription Drugs which are dispensed prior to discharge from an Inpatient setting.

Telemedicine — diagnosis, consultation, treatment, transfer of medical data and medical education through the use of advanced electronic communication technologies such as interactive audio, video or other electronic media that facilitates access to health care services or medical specialty expertise. Standard telephone, facsimile or electronic mail transmissions, or any combination therein, in the absence of other integrated information or data adequate for rendering a diagnosis or treatment, do not constitute Telemedicine services.

Terminal Illness — an illness in which it is reasonably certain that the patient has less than six (6) months to live. The patient's treating Physician must provide written certification that the patient is terminally ill.

Total Disability —

1. with respect to an Employee or person otherwise eligible for coverage as an Employee, a Disability which prevents the individual from working with reasonable continuity in the individual's customary employment or in any other employment in which the individual reasonably might be expected to engage;
2. with respect to an Annuitant or a Family Member, a Disability which prevents the individual from engaging with normal or reasonable continuity in the individual's customary activities or in those in which the individual otherwise reasonably might be expected to engage.

Treatment Plan — services or a plan of treatment preauthorized by the Plan during a Contract Period that must be commenced during the same Contract Period. To qualify for continuing treatment in a subsequent Contract Period, the services or plan of treatment must be reauthorized. Otherwise, only the benefits in effect during a Contract Period are available or covered.

United States — in regard to services available through the BlueCard network, the United States is defined as all the states and the District of Columbia.

Urgent care — services received for a sudden and unexpected serious illness, injury or condition, other than one which is life threatening, which requires immediate care for the relief of severe pain or diagnosis and treatment of such condition.

Value Based Purchasing Design (VBPD) — a program that provides a set benefit maximum for certain common medical procedures that have low complication rates and that a Member can schedule in advance. The benefit maximum is the dollar amount or limit that this Plan will be charged for a particular procedure or service. For this Plan, the VBPD program applies to Inpatient services provided for hip and knee joint replacement (see Hip and Knee Joint Replacement Surgery benefit on pages 47-48).

FOR YOUR INFORMATION

Organ Donation

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

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

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

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

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

Long-Term Care Program

Your PERS Select health plan has strict limits on the long-term care services it provides. The Long-Term Care Program offered by CalPERS provides coverage for the extended care you could need due to a chronic disease, frailty of old age, or serious accident. It covers help with activities of daily living, such as bathing, eating and dressing. It also provides supervision and support for people with cognitive impairments such as Alzheimer's disease. Long-term care can be needed at any age.

The CalPERS Long-Term Care Program is not part of the PERS Select health plan. If you want long-term care protection, you must purchase it separately. Please contact the CalPERS Long-Term Care Program at 1-800-982-1775 if you are interested in long-term care coverage.

Health Insurance Portability and Accountability Act (HIPAA) Information

CalPERS and its plan administrators comply with the federal Health Insurance Portability and Accountability Act (HIPAA) and the privacy regulations that have been adopted under it. Your privacy rights under HIPAA are detailed in CalPERS' Notice of Privacy Practices (NOPP) which is mailed annually to each subscriber as part of the annual open enrollment mailing. In addition, the current NOPP is always available on CalPERS' Web site at www.calpers.ca.gov. If you have any questions regarding your rights under HIPAA, please contact the CalPERS HIPAA coordinator at **888 CalPERS** (or **888**-225-7377). If you are outside of the United States, you should contact the operator in the country you are in to assist you in making the call.

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PERS *Select*

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