PERS Select

Basic Plan

Preferred Provider Organization

Evidence of Coverage

Effective January 1, 2012 – December 31, 2012

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, benefit information, identification cards, booklets, or claim forms, 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 17-19 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:

Caremark PCS Health, L.L.C. ("CVS Caremark")
1-877-542-0284 (worldwide)
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) Health Account Services Section (retirees). You also may write:

Health Account Services Section
CalPERS
P.O. Box 942714
Sacramento, CA 94229-2714

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), on-line at www.calpers.ca.gov, or submit a signed written notification, including identification number, old address, new address, phone number, and other pertinent information, to:

Health Account Services Section
CalPERS
P.O. Box 942714
Sacramento, CA 94229-2714

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

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 will be issued for viewing and/or distributed to each Member affected by the change.

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.

Patient Protection and Affordable Care Act

Health Care Reform

The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Affordability Reconciliation Act of 2010, expands health coverage for various groups and provides mechanisms to lower costs and increase benefits for Americans with health insurance. As federal regulations are released for various measures of the law, CalPERS may need to modify benefits accordingly. For up-to-date information about CalPERS and Health Care Reform, please refer to the Health Care Reform page at www.calpers.ca.gov.

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

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.

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The following is a brief summary of benefit and administrative changes that will take effect January 1, 2012. Be sure to refer to the Medical and Hospital Benefits section beginning on page 35, Outpatient Prescription Drug Programs section beginning on page 58, Outpatient Prescription Drug Coverage Management Programs section beginning on page 65, Outpatient Prescription Drug Exclusions section beginning on page 66, Benefit Limitations, Exceptions and Exclusions section beginning on page 68, Prescription Drug Appeal Procedure section beginning on page 89, and Definitions section beginning on page 95 for more information.

- **Allergy Testing and Treatment.** The $400 maximum per calendar year for antigens has been deleted.
- **Durable Medical Equipment.** The $6,000 calendar year maximum for durable medical equipment has been deleted. The purchase of durable medical equipment priced at $1,000 or more, however, requires precertification.
- **Emergency.** The definition of Emergency will now include a psychiatric emergency medical condition.
- **Eye Examinations.** The Eye Examinations exclusion has been renamed as Vision Care.
- **Hearing Aids.** Hearing aids will be limited to one hearing aid every 36 months.
- **Home Health Care.** The $6,000 maximum for home health care has been changed to 45 visits per calendar year.
- **Outpatient Cardiac Rehabilitation.** the $1,500 maximum for outpatient cardiac rehabilitation has been changed to 40 visits per calendar year.
- **Psychiatric Emergency Medical Condition.** The definition of Psychiatric Emergency Medical Condition has been added.
- **TMJ and Maxillomandibular Musculokeletal Treatment.** Reference to this benefit and any applicable maximums has been deleted. TMJ and Maxillomadibular Musculoskeletal treatment will be paid according to the benefits provided under the plan.
- **Hospital – Outpatient.** The following maximums will apply to the services when provided in a outpatient hospital setting.
  - Colonoscopy services are limited to **a maximum payment of one thousand five hundred dollars ($1,500)** per procedure.
  - Cataract surgery services are limited to **a maximum payment of two thousand dollars ($2,000)** per procedure.
  - Arthroscopy services are limited to **a maximum payment of six thousand dollars ($6,000)** per procedure.
- **CVS Caremark.** Your pharmacy benefits manager will now be CVS Caremark. See the website www.caremark.com/calpers to locate a participating pharmacy near you.
- **Member Pays the Difference.** For brand name medications, where a U.S. Food and Drug Administration (FDA) approved generic equivalent is available, the Member will pay the difference in cost between the brand medication and its generic equivalent, plus the applicable generic copayment.
- **Prescription Drug Co-Payments for Preferred Brand Name Drugs.** Your prescription drug co-payments have been changed as follows:
  - For Participating Retail Pharmacy/CVS Caremark Specialty Pharmacy $20
  - For Participating Retail Pharmacy and Maintenance Medications filled at non-Maintenance Choice® after 2nd fill $40
  - For CVS Caremark Mail Service and Mail Service/Maintenance Choice®..... $40

BENEFIT AND ADMINISTRATIVE CHANGES

- **Prescription Drug Co-Payments for Non-Preferred Brand Name Drugs.** Your prescription drug co-payments have been changed as follows:
  - For Participating Retail Pharmacy/CVS Caremark Specialty Pharmacy $50
  - For Participating Retail Pharmacy and Maintenance Medications filled at non-Maintenance Choice® after 2nd fill $100
  - For CVS Caremark Mail Service and Mail Service/Maintenance Choice®..... $100

PERS Select SUMMARY OF BENEFITS

The following chart is only a summary of benefits under your PERS Select Plan. Please refer to the Medical and Hospital Benefits section beginning on page 35 and the Outpatient Prescription Drug Program section beginning on page 58 for specific information and limitations. 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 27 for services not subject to the deductible.)

Emergency Room Deductible .... **$50 per visit**
(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 Copayment/Coinsurance Responsibility for Preferred Provider Services*

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

For each family **$6,000**

(Non-Preferred Provider coinsurance is not applied toward this amount and are the Member's responsibility. See page 28 for more information.)

*Anthem Blue Cross has designated certain hospitals in California as participating in Tier 1 or Tier 2 of the Select PPO Preferred Provider network. If PERS Select members use a Tier 2 Preferred Provider hospital for inpatient or outpatient hospital services, the maximum calendar year coinsurance responsibility will be $6,000 for each Member and $12,000 for each family.

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	Member Pays			Contact Review Center
		Preferred Provider Tier 1	Preferred Provider Tier 2	Non-Preferred Provider	
Ambulance p. 35	Air or ground ambulance services when medically necessary.	20%	Not applicable	20%	No
Ambulatory Surgery Center p. 36	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 pages 49-50.)	20%	Not applicable	40% (maximum plan payment $350 applies to facility charges)	No (unless listed on page 23)
Bariatric Surgery p. 36-37	Bariatric Surgery only at Centers of Medical Excellence.	20%	Not applicable	20%	Yes
Cancer Clinical Trials p. 37-38	Services related to cancer clinical trials for Members with cancer who have been accepted into phase I, II, III, or IV cancer clinical trials.	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	Member Pays			Contact Review Center
		Preferred Provider Tier 1	Preferred Provider Tier 2	Non-Preferred Provider	
Cardiac Care p. 38-39	Hospital and professional services provided in connection with cardiac care.	20%	Not applicable	40%	Yes
Chiropractic and Acupuncture p. 39	Services provided by a licensed chiropractor, certified acupuncturist or any other qualified health professional. Benefits are limited to 15 visits per calendar year for any combination of chiropractic and acupuncture services.	20%	Not applicable	40%	No
Christian Science Treatment p. 39	Treatment for a covered illness or injury when services are provided by a Christian Science practitioner, Christian Science nurse, or Christian Science hospital.	20%	Not applicable	20%	No
Diagnostic X-ray/Laboratory p. 40	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 23)
Durable Medical Equipment p. 40-41	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 (equipment $1,000 or more)
Emergency Care Services p. 41	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. 42	Services for voluntary sterilization and medically necessary abortions.	20%	Not applicable	40%	No
Hearing Aid Services p. 42	Hearing evaluation and hearing aid supplies; visits for fitting, counseling, adjustment, and repair. Up to one hearing aid, every 36 months for hearing aid(s).	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	Member Pays			Contact Review Center
		Preferred Provider Tier 1	Preferred Provider Tier 2	Non-Preferred Provider	
Hip and Knee Joint Replacement Surgery* p. 42-43	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. 43	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. 43-44	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%	Yes
Hospice Care p. 44	Hospice care for the palliative treatment of pain and other symptoms associated with a terminal disease.	20%	Not applicable	20%	No
Hospital* Inpatient p. 44-45	Room and board, general nursing care services, operating and special care room fees, diagnostic X-ray and laboratory services.	20%	30%	40%	Yes
Outpatient p. 45	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 23)

*Anthem Blue Cross has designated certain hospitals in California as participating in Tier 1 or Tier 2 of the Select PPO Preferred Provider network. If PERS Select members use a Tier 2 Preferred Provider hospital for inpatient or outpatient hospital services, the Member's coinsurance responsibility will be 30% and the maximum calendar year coinsurance responsibility will be $6,000 for each Member and $12,000 for each family. Please refer to the section Choosing A Physician/Hospital on pages 13-14 for more information regarding the Select PPO Preferred Provider network.

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	Member Pays			Contact Review Center
		Preferred Provider Tier 1	Preferred Provider Tier 2	Non-Preferred Provider	
Maternity Care* p. 45-46	Prenatal and postnatal care; deliveries, hospitalization and newborn nursery care.	20%	30%	40%	No
Mental Health* Inpatient p. 46	Hospital/physician services to stabilize an acute psychiatric condition.	20%	30%	40%	Yes
Outpatient p. 46-47	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. 47	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. 48	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. 48	Up to 40 visits per calendar year.	20%	Not applicable	40%	No
Outpatient Pulmonary Rehabilitation p. 48	Up to $1,500 per calendar year.	20%	Not applicable	40%	No
Physical Therapy p. 48	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)

*Anthem Blue Cross has designated certain hospitals in California as participating in Tier 1 or Tier 2 of the Select PPO Preferred Provider network. If PERS Select members use a Tier 2 Preferred Provider hospital for inpatient or outpatient hospital services, the Member's coinsurance responsibility will be 30% and the maximum calendar year coinsurance responsibility will be $6,000 for each Member and $12,000 for each family. Please refer to the section Choosing A Physician/Hospital on pages 13-14 for more information regarding the Select PPO Preferred Provider network.

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	Member Pays			Contact Review Center
		Preferred Provider Tier 1	Preferred Provider Tier 2	Non-Preferred Provider	
Physician Services p. 49-50	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. 50	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. 51	Hospital and physician services provided in connection with reconstructive surgery.	20%	Not applicable	40%	Yes
Skilled Nursing and Rehabilitation Care p. 51	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. 52	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
Speech Therapy p. 49	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. 52	Hospital/physician services for short-term medical management of detoxification or withdrawal symptoms.	20%	30%	40%	Yes

*Anthem Blue Cross has designated certain hospitals in California as participating in Tier 1 or Tier 2 of the Select PPO Preferred Provider network. If PERS Select members use a Tier 2 Preferred Provider hospital for inpatient or outpatient hospital services, the Member's coinsurance responsibility will be 30% and the maximum calendar year coinsurance responsibility will be $6,000 for each Member and $12,000 for each family. Please refer to the section Choosing A Physician/Hospital on pages 13-14 for more information regarding the Select PPO Preferred Provider network.

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	Member Pays			Contact Review Center
		Preferred Provider Tier 1	Preferred Provider Tier 2	Non-Preferred Provider	
Substance Abuse* Outpatient p. 52-53	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. 53	Services provided by a Telemedicine Network Presentation Site or Specialty Center	$20 + 20% of all other charges			No
Transplant Benefits p. 54-56	Kidney, Cornea, and Skin — see page 53.	20%	Not applicable	40%	Yes (kidney and skin only)
	Special Transplants only at Centers of Medical Excellence — see pages 54-55.	20%	Not applicable	20%	Yes
Unreplaced Blood	Unreplaced blood	20%	Not applicable	20%	No
Urgent Care p. 57	Outpatient urgent care visits to a physician. Note: The $20 copayment applies to the charge for the physician visit only.	$20 copay (office visit only)	Not applicable	40%	No
	Other physician services provided during the visit, such as lab work or sutures.	20%	Not applicable	40%	No

*Anthem Blue Cross has designated certain hospitals in California as participating in Tier 1 or Tier 2 of the Select PPO Preferred Provider network. If PERS Select members use a Tier 2 Preferred Provider hospital for inpatient or outpatient hospital services, the Member's coinsurance responsibility will be 30% and the maximum calendar year coinsurance responsibility will be $6,000 for each Member and $12,000 for each family. Please refer to the section Choosing A Physician/Hospital on pages 13-14 for more information regarding the Select PPO Preferred Provider network.

PERS Select SUMMARY OF BENEFITS

Benefits	Covered Services	Member Pays
Prescription Drugs p. 58-67	**Retail Pharmacy Program** for short-term use up to a 30-day supply	$5 generic $20 Preferred (On CVS Caremark's Preferred Drug List) brand-name medications $50 Non-Preferred (Not on CVS Caremark's Preferred Drug List) brand-name medications**** $40 for Partial Waiver of Non-Preferred Brand copayment *** 50% Discretionary Drugs
	Maintenance medications*, if refilled at a retail pharmacy** after 2nd fill	$10 generic $40 Preferred (On CVS Caremark's Preferred Drug List) brand-name medications $100 Non-Preferred (Not on CVS Caremark's Preferred Drug List) brand-name medications**** $70 for Partial Waiver of Non-Preferred Brand copayment ** 50% Discretionary Drugs
	Mail-Order Program for maintenance medications* up to a 90-day supply **Out-of-Pocket Maximum, per person each calendar year: $1,000** (excluding Non-Preferred Brand-Name Medication copayments, Discretionary Drug coinsurance, and "Member Pays the Difference" differential).	$10 generic $40 Preferred (On CVS Caremark's Preferred Drug List) brand-name medications $100 Non-Preferred (Not on CVS Caremark's Preferred Drug List) brand-name medications**** $70 for Partial Waiver of Non-Preferred Brand copayment *** 50% Discretionary Drugs
	* Maintenance medications are drugs that do not require frequent dosage adjustments, which are usually prescribed for long-term use, such as birth control, or for a chronic condition, such as arthritis, diabetes, or high blood pressure. These drugs are usually taken longer than sixty (60) days. Refer to the Outpatient Prescription Drug Program section beginning on page 58 for more information. ** Maintenance medications may be filled or refilled at CVS/pharmacy or Longs Drugs locations even after the 2nd refill through the Maintenance Choice® program. See page 58 for details regarding Maintenance Choice®.	*** In order to obtain a Partial Waiver of the Non-Preferred Brand copayment, your physician must document the necessity for the Non-Preferred product vs. the Preferred product(s) and the available generic alternative(s) through CVS Caremark's formal appeals process outlined on pages 89-90. ****Member Pays the Difference. For brand name medications, where a U.S. Food and Drug Administration (FDA) approved generic equivalent is available, the Member will pay the difference in cost between the brand medication and its generic equivalent, plus the applicable generic copayment.

Preventive Care Guidelines for Healthy Children, Adolescents, Adults, and Seniors

CalPERS wants to help you and your family stay healthy. Routine visits to the doctor are important. CalPERS has adopted the Preventive Care Guidelines for Healthy Children, Adolescents, Adults, and Seniors from the U.S. Preventive Services Task Force *Guide to Clinical Preventive Services*. Immunizations for infants and children are recommended in accordance with recommendations of the American Academy of Pediatrics, the American Academy of Family Physicians, and Anthem Blue Cross' adopted guidelines under Health & Wellness at www.anthem.com/ca. The CalPERS Preventive Care Guidelines are available on the CalPERS Website at www.calpers.ca.gov. To view these guidelines, visit www.calpers.ca.gov, type "Preventive Care Guidelines" in the search box at upper right. The CalPERS Preventive Care Guidelines are for your information only and may be subject to change. Please talk to your medical professional about recommended exams, screenings, vaccines and individual risk factors when making decisions about diagnostic tests. Benefits will be paid according to the Preventive Care benefits listed under the section Medical and Hospital Benefits on page 50.

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 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 Copayment And Coinsurance Responsibility on page 28, and Payment and Member Copayment And Coinsurance Responsibility beginning on page 30.) 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, you may:

- Call Customer Service at 1-877-737-7776 to verify that the provider you want to use is a Select PPO Preferred Provider.
- Ask your physician or provider if he or she participates in Anthem Blue Cross' Select PPO Preferred Provider network.
- Access the Web site at www.anthem.com/ca/calpers.
- Request a directory of Select PPO Preferred Providers 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 18-20.

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.

Subimo Healthcare Advisor

To assist PERS Select Members in obtaining information regarding health conditions, treatments and resources, the Anthem Blue Cross Web site, www.anthem.com/ca, offers a link to Healthcare Advisor™ by Subimo, an interactive Web site where you can:

- Find additional information about your health condition, treatment options and what to expect. You can research common complications and risks for a particular procedure and how quickly most people recover.
- Screen hospitals in a select area based on clinical quality and experience, reputation, performance data, or other hospital characteristics. Quality and medical data for hospitals throughout the United States is available.

  Note: The list of hospitals displayed will include those in the Preferred Provider network and Non-Preferred Providers. To receive the highest level of benefits available under this Plan, it is your responsibility to verify the provider you choose is a Preferred Provider.
- Get estimated costs for specific health care services or treatment.

™Healthcare Advisor is a Trade Mark of Subimo, LLC

You can access the hotlink to Subimo's Web site by visiting the Anthem Blue Cross Home Page, www.anthem.com/ca, logging in to MemberAccess, and selecting Search Hospital and Pharmacy Information from the menu options.

The Subimo Web site is owned and operated by Subimo, LLC, headquartered in River Forest, IL. Subimo, LLC, is solely responsible for its Web site and is not affiliated with Anthem Blue Cross or any affiliate of Anthem Blue Cross.

The information on the Subimo Web site is intended for general information and may not apply to your particular condition. It is not intended to replace or substitute for the opinion or advice of your treating healthcare professional regarding your medical condition or treatment. You should always seek prompt medical care from a qualified healthcare professional about the specifics of your individual situation if you have any questions regarding your medical condition or treatment.

Neither CalPERS nor the Plan is responsible for the information in the Subimo Web site and disclaim any liability with respect to information obtained from or through the Subimo Web site and the Member's use thereof.

™Healthcare Advisor is a Trade Mark of Subimo, LLC

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 the emergency room deductible **($50)**. However, this deductible will not apply if you are admitted to a hospital for outpatient medical observation or on an inpatient basis immediately following emergency room treatment. This deductible does not apply to the calendar year deductible. It will be subtracted from covered charges each time you visit the emergency room, regardless of whether you have otherwise met your calendar year deductible.

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 twenty-four (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 35 and the Benefit Limitations, Exceptions and Exclusions section beginning on page 68 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 pages 22-26 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 104), 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 out of pocket 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 57 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 16 for information on filing a medical claim.

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 18-20 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.

You must submit requests for payment within fifteen (15) months from the date services were provided, 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 fifty (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 three (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 23 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 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 18-20.

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 anytime.

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 the local Blue Cross and/or Blue Shield Plan.

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 29.

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 permanently 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 16 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.

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

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. 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.

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 58 and Outpatient Prescription Drug Exclusions section on pages 66-67.

Prescription medication covered by the Plan will be reimbursed at one hundred percent (100%), minus a fifty dollar ($50) copayment for a 1-month supply, based on the foreign exchange rate on the date of service. 50% coinsurance for discretionary medications such as those to treat erectile dysfunction applies. **Claims must be submitted within twelve (12) months from the date of purchase.**

MEDICAL NECESSITY

The benefits of this Plan are provided only for those services that are determined to be medically necessary. Medically necessary services and supplies are covered services.

Medical necessity means services and supplies as determined through the Plan's review process to be necessary, appropriate, and established as safe and effective for treatment of the patient's illness or injury. The Plan's review processes are consistent with acceptable treatment patterns found in established managed care environments and consistent with Anthem Blue Cross Medical Policy. **The fact that a provider may prescribe, order, recommend or approve a service, supply, or hospitalization does not in itself make it medically necessary, even though it is not specifically listed as an exclusion or limitation.** A service may be determined not to be medically necessary even though it may be considered beneficial to the patient. Established medical criteria for medical necessity must be met before that service, procedure, equipment or supply is determined to be medically necessary.

Services, procedures, equipment and supplies that are medically necessary must:

1. be appropriate and necessary for the diagnosis or treatment of the medical condition;
2. be consistent with the symptoms or diagnosis in treatment of the illness, injury, or condition;
3. be within standards of good medical practice within the organized medical community;
4. not be furnished primarily for the convenience of the patient, the treating physician, or other provider;
5. be consistent with Anthem Blue Cross Medical Policy (see definition on page 96);
6. not be for custodial care (see definition on page 97); and
7. be the most appropriate procedure, supply, equipment or service which can be safely provided. The most appropriate procedure, supply, equipment or service must satisfy the following requirements;
    a. There must be valid scientific evidence demonstrating that the expected health benefits from the procedure, supply, equipment or service are clinically significant and produce a greater likelihood of benefit, without a disproportionately greater risk of harm or complications, for you with the particular medical condition being treated than other possible alternatives; and
    b. Generally accepted forms of treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable; and
    c. For hospital stays, acute care as an inpatient is necessary due to the kind of services you are receiving or the severity of your condition, and safe and adequate care cannot be received in an outpatient setting or in a less intensified medical setting.

Inpatient hospital services or supplies which are generally not considered medically necessary include, but are not limited to, hospitalization:

1. for diagnostic studies that could have been provided on an outpatient basis;
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;
4. for preoperative work-up the night before surgery;
5. for inpatient rehabilitation or rehabilitative care that can be provided on an outpatient basis.

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.

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 out-of-pocket costs. 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 34) 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 out-of-pocket costs.
- 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 three (3) business days or thirty (30) business days (see Services Requiring Precertification on the following page) before the procedure, service or surgery is provided or before the purchase of durable medical equipment priced at $1,000 or higher. Note: Precertification is required for certain 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) and Nuclear Cardiac Imaging, but are not restricted to the specified three (3) or thirty (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 34) 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 certain imaging procedures precertification is required, but not within specific time frames. Such procedures include, but are 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) 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 three (3) business days prior to the start of the following procedures, services and surgeries or purchase of durable medical equipment: • Home infusion therapy services • Inpatient hospitalization • Acute inpatient rehabilitation • Skilled nursing facility (see page 51) • Home health care (see page 43) • All inpatient mental health or substance abuse treatment (see pages 46 and 52) • All outpatient facility-based care for mental health or substance abuse treatment (see pages 46-47 and 52-53) • Temporomandibular disorder (TMD) treatment and diagnostic services, including MRIs and surgeries • Maxillomandibular musculoskeletal surgeries • Septoplasty and sinus-related surgeries • Penile implant surgeries • Durable medical equipment priced at $1,000 or higher (see pages 40-41) • Bariatric surgeries • Any plastic or reconstructive procedures/ surgeries • Kidney and skin transplants • General anesthesia 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	Precertification is required no later than thirty (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

UTILIZATION REVIEW

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 34) 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. Certain 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) 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 twenty-four (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.

UTILIZATION REVIEW

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.

Non-Emergency Admission

The Review Center must be contacted for precertification at least three (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 86-88 for more information on utilization review appeal procedures.

Financial sanctions may be applied if the proposed hospital admission, outpatient surgery or other service is scheduled less than three (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.

UTILIZATION REVIEW

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 out-of-pocket 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.

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 five hundred dollars **($500)** for each Plan Member, not to exceed one thousand dollars **($1,000)** per family.

Charges will be applied to the deductible beginning on January 1, 2012, and will extend through December 31, 2012. Some services, however, are not subject to the deductible.

Covered charges for the following services will NOT be applied to the calendar year deductible:

- Physician office, outpatient hospital and urgent care visits and consultations provided by Preferred Providers.
- 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.

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 the emergency room deductible **($50)**. 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. It will be subtracted from covered charges each time you visit the emergency room, regardless of whether you have otherwise met your calendar year deductible.

MAXIMUM CALENDAR YEAR COPAYMENT AND COINSURANCE RESPONSIBILITY

When covered services are received from a Preferred Provider, the maximum copayment or coinsurance responsibility per calendar year is three thousand dollars ($3,000) per Plan Member, not to exceed six thousand dollars ($6,000) per family. For inpatient and outpatient hospital admissions provided at a Tier 2 Preferred Provider hospital, the maximum copayment or coinsurance responsibility per calendar year is six thousand dollars ($6,000) per Plan Member, not to exceed twelve thousand dollars ($12,000) per family. 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, but you remain responsible for costs in excess of any specified Plan maximums and for services or supplies which are not covered under this Plan.

Covered services received from Non-Preferred Providers, whether referred by a Preferred Provider or not, do not apply toward the maximum copayment or coinsurance.* In addition, you will be required to continue to pay your copayment or coinsurance for such treatment even after you have reached that amount. Remember, your copayment or coinsurance will be higher if you use Non-Preferred Providers, and you will be responsible for any charges that exceed the Allowable Amount.

*Exceptions:

- Covered services received from Non-Preferred Providers will apply toward the maximum copayment or coinsurance 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 copayment or coinsurance responsibility is met, you will no longer be required to pay a 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 copayment or coinsurance amount. Once the maximum copayment or coinsurance responsibility is met, you will no longer be required to pay a 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 copayment and coinsurance. You will continue to be responsible for these charges even after you have reached the maximum calendar year copayment/coinsurance amount:

- Copayments to Preferred Providers for physician office, outpatient hospital and urgent care visits, consultations, and diabetes self-management education program services.
- Copayments to Telemedicine Network Specialty Centers for consultations or second opinions.
- Coinsurance to Non-Preferred Providers if you live within a Preferred Provider area.
- Coinsurance for natural childbirth classes.
- Coinsurance made for any donor searches for transplants.
- All charges not paid by the Plan for outpatient prescription drugs.
- Sanctions for non-compliance with utilization review.
- Amounts applied toward the calendar year deductible or the emergency room deductible.
- 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.

PAYMENT AND MEMBER COPAYMENT AND COINSURANCE RESPONSIBILITY

Disclosure of Legality

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 allow for certain planned procedures to be performed by a Non-Preferred Provider. After receiving your request, a letter requesting the dates, specific procedure code numbers, and projected dollar amounts for the proposed services will be sent to your Physician. Upon receipt of the completed form from your Physician, the Allowable Amounts will be determined, and a copy of this information will be sent to you and your Physician.

Disclosure of Legality 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 Physician may require for the completion of this form are not a covered benefit of this Plan. **Disclosure of Legality estimates are provided for informational purposes and are not a guarantee of payment.**

The following example illustrates the Member's reduced out-of-pocket amount when receiving services from a Preferred Provider. The figures below are illustrative in nature only. The figures do not represent actual claimant information.

Payment Example

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	$200,000	$200,000
Allowable Amount – the allowance or negotiated amount under the Plan for service provided (see definition on page 95). Note: This is only an example. Allowable amount varies according to procedure and provider of service.	$75,000	$75,000
Calendar Year Deductible – the amount of Allowable Amount the Member is responsible to pay each calendar year before Plan benefits are payable	$500	$500
Coinsurance – the percentage of Allowable Amount the Member pays after any applicable deductible is satisfied	$3,000 (20% of Allowable Amount until maximum coinsurance met)	$29,800 (40% of Allowable Amount; maximum coinsurance is not applicable)
Plan Payment – the percentage of Allowable Amount the Plan pays after any applicable deductible and copayment or coinsurance are subtracted	$71,500 (80% of Allowable Amount until maximum copayment or coinsurance met, then 100%)	$44,700 (60% of Allowable Amount; maximum copayment or coinsurance is not applicable)
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)	$125,000 (Non-Preferred Provider can bill the Member for the difference between Allowable Amount and Billed Charges)
Total Amount the Member Is Responsible To Pay	**$3,500**	**$155,300**

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 27 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 28 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. **When Accessing Preferred Providers:**

   Physician office visits, 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 twenty dollar ($20) copayment. The twenty dollar ($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 eighty percent (80%) of the Allowable Amount, except for services with a twenty dollar ($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 twenty percent (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 one hundred percent (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 (b).

   b. **When Accessing Non-Preferred Providers:**

   Covered services provided by a Non-Preferred Provider are paid at sixty percent (60%) of the Allowable Amount. Plan Members are responsible for the remaining forty percent (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.

c. 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 sixty percent (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 eighty percent (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 sixty percent (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 eighty percent (80%) level. You are responsible for the remaining twenty percent (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 eighty percent (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 three (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 23), 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.

2. Emergency Care

Physician services for emergency care are paid at eighty percent (80%) of the Allowable Amount. Members are responsible for the remaining twenty percent (20%) and all charges in excess of the Allowable Amount.

Hospital Services

1. Non-Emergency Services

a. When Accessing Preferred Hospitals:

Covered services provided by a Preferred Hospital or Ambulatory Surgery Center are paid at eighty percent (80%) of the Negotiated Amount for covered services. Plan Members are responsible for the remaining twenty percent (20%) 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 (b).

b. When Accessing Non-Preferred Hospitals:

Covered services provided by a Non-Preferred Hospital or Ambulatory Surgery Center are paid at sixty percent (60%) of Reasonable Charges. Plan Members are responsible for the remaining forty percent (40%), any charges in excess of the maximum plan payment of $350 per surgical session for covered services billed by an Ambulatory Surgery Center that is a Non-Preferred Provider, and all charges for non-covered services.

c. **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 Ambulatory Surgery Center staff are paid at eighty percent (80%) of the Allowable Amount.* **Plan Members are responsible for the remaining twenty percent (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 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 Ambulatory Surgery Center's facility charges, are paid at sixty percent (60%) of the Allowable Amount. Plan Members are responsible for the remaining forty percent (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 Ambulatory Surgery Center.

2. **Emergency Care**

Covered services provided by a Preferred Hospital that are incident to emergency care are paid at eighty percent (80%) of Billed Charges or eighty percent (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 eighty percent (80%) of Reasonable Charges (defined on page 102). For both Preferred Hospitals and Non-Preferred Hospitals, Plan Members are responsible for the remaining twenty percent (20%) and all charges for non-covered services.

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 Appeal Procedure section on page 85.

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 sixty percent (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:

- eighty percent (80%) of the Allowable Amount for the first ten (10) days each calendar year. Members are responsible for the remaining twenty percent (20%) of the Allowable Amount for covered services and ALL charges for non-covered services.
- seventy percent (70%) of the Allowable Amount for the next ninety (90) days in the same calendar year. Members are responsible for the remaining thirty percent (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:

- sixty percent (60%) of the Allowable Amount for each day during a covered stay. Members are responsible for the remaining forty percent (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 eighty percent (80%) of Anthem Blue Cross' Allowable Amount or eighty percent (80%) of the local Blue Cross and/or Blue Shield Plan's Allowable Amount. Members are responsible for the remaining twenty percent (20%).

Non-Preferred Provider home health care agencies, home infusion therapy providers, and durable medical equipment providers will be reimbursed at sixty percent (60%) of Anthem Blue Cross' Allowable Amount or sixty percent (60%) of the local Blue Cross and/or Blue Shield Plan's Allowable Amount. Members are responsible for the remaining forty percent (40%), any charges in excess of the Allowable Amount, and all charges for non-covered services and supplies.

Services provided by home health care agencies and home infusion therapy providers require a precertified treatment plan. The purchase of durable medical equipment priced at $1,000 or more requires precertification.

Cancer Clinical Trials

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

For Non-Preferred Providers
Covered services related to cancer clinical trials for Members with cancer who have been accepted into phase I, II, III, or IV cancer clinical trials upon their physician's referral will be reimbursed at sixty percent (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 forty percent (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 eighty percent (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 twenty percent (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 Utilization Review Appeal Procedure described on pages 86-88.

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 ten percent (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 ten percent (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 23 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 maximum calendar year copayment or coinsurance responsibility required under the payment design of the Plan.

*Note: This additional coinsurance will not apply to certain 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) 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 five hundred dollars ($500) will be assessed on inpatient charges or two hundred and fifty dollars ($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 maximum calendar year copayment or coinsurance 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 care services, benefits are provided (subject to satisfaction of applicable deductibles) for medically necessary services and supplies that are delivered with optimum efficiency. Services and supplies that are not covered under the Plan are listed under Benefit Limitations, Exceptions and Exclusions beginning on page 68.

Services or a treatment plan precertified 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

Subject to the calendar year deductible and applies toward the maximum calendar year copayment and coinsurance responsibility if services are received from Preferred Providers; however, the maximum calendar year coinsurance responsibility is unlimited if services are received from Non-Preferred Providers.

Supplies, except for prescription drugs, related to allergy testing and treatment are covered. Charges incurred for office visits in conjunction with allergy treatment may not be payable.

Alternative Birthing Center

80% All Providers

Not subject to the calendar year deductible and applies toward the maximum calendar year copayment and coinsurance responsibility. 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% All Providers

Subject to the calendar year deductible and applies toward the maximum calendar year copayment and coinsurance responsibility.

Emergency transportation by professional ambulance services (ground or air) required for emergency care services (as defined in this EOC). Medically necessary professional ambulance services (ground or air) required to transfer the patient from one facility to another, including services provided as a result of a “911” emergency response system* request for assistance.

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

Ambulatory Surgery Centers

80% Preferred Provider
60% Non-Preferred Provider

Subject to the calendar year deductible and applies toward the maximum calendar year copayment and coinsurance responsibility if services are received from Preferred Providers; however, the maximum calendar year coinsurance responsibility is unlimited if services are received from Non-Preferred Providers.

All covered services and supplies provided and billed by an Ambulatory Surgery Center that is a Non-Preferred Provider are subject to **a maximum payment of three hundred fifty dollars ($350)** each time you have outpatient surgery. This maximum payment does not apply to covered services provided by Preferred Providers and to physician charges that are billed separate from the facility charges.

Please see guidelines for Precertification of non-emergency procedures on page 25. 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 34) and/or denial of benefits.

Bariatric Surgery

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

Covered charges are subject to the calendar year deductible, and Member copayments or coinsurance will apply towards the maximum calendar year copayment and coinsurance responsibility.

Precertification for all bariatric surgical procedures must be obtained from the Review Center as soon as possible, but no later than three (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 34) and/ or denial of benefits.

Hospital and professional services and supplies provided in connection with bariatric surgery for treatment of morbid obesity are a benefit only when the procedure is in accordance with Anthem Blue Cross Medical Policy, and 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 twenty percent (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.

The calendar year deductible will not apply, and no copayments or coinsurance will be required for eligible travel expenses. Reimbursement is limited to the specified amounts below.

Covered travel expenses include:

- Transportation to and from the designated CME for the Member, up to three (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 two (2) trips (the initial surgery and one follow-up visit), not to exceed $130 per trip.
- One room double occupancy hotel accommodations for the Member and one companion for the pre-surgical and follow-up visits, up to two (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 four (4) days, not to exceed $100 per day.
- Other reasonable and necessary expenses, such as meals, are limited to a combined total of $25 per day, up to four (4) days per trip. Tobacco, alcohol and drug expenses are not covered.

To find out if you are eligible for reimbursement for travel expense or to request a claim form, call Anthem Blue Cross Customer Service at 1-877-737-7776. A legible copy of dated receipts for all expenses must be submitted along with a claim form to Anthem Blue Cross to obtain reimbursement.

Cancer Clinical Trials

80% Preferred Provider
60% Non-Preferred Provider

Subject to the calendar year deductible and applies toward the maximum calendar year copayment and coinsurance responsibility if services are received from Preferred Providers; however, the maximum calendar year coinsurance responsibility is unlimited if services are received from Non-Preferred Providers.

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

1. The treatment provided in the cancer clinical trial must either:
   a. Involve a drug that is exempt under federal regulations from a new drug application, or
   b. Be approved by (i) one of the National Institutes of Health, (ii) the federal Food and Drug Administration in the form of an investigational new drug application, (iii) the United States Department of Defense, or (iv) the United States Veteran's Administration.
2. The participant must have been diagnosed with cancer.
3. Participation in the cancer clinical trial must be recommended by your physician based upon his or her medical determination that participation would have a meaningful potential to benefit you.
4. For the purpose of this provision, a cancer clinical trial must have a therapeutic intent. Clinical trials solely for the purpose of testing toxicity are not covered.

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

- Typically provided absent a clinical trial.
- Required solely for the provision of the investigational drug, item, device or service.
- Clinically appropriate monitoring of the investigational item or service.

- Prevention of complications arising from the provision the investigational drug, item, device, or service.
- Reasonable and necessary care arising from the provision of the investigational drug, item, device, or service, including the diagnosis or treatment of the complications.

Routine patient care costs do not include any of the items listed below. In addition to the costs of non-covered services, the participant will be responsible for the costs associated with any of the following:

- Drugs or devices not approved by the federal Food and Drug Administration that are associated with the clinical trial.
- Services other than health care services, such as travel, housing, companion expenses and other non-clinical expenses that you may require as a result of the treatment provided for the purposes of the clinical trial.
- Any item or service provided solely to satisfy data collection and analysis needs for information that is not used in your clinical management.
- Health care services that, except for the fact they are provided in a clinical trial, are otherwise specifically excluded from the Plan.
- Health care services customarily provided by the research sponsors free of charge to persons enrolled in the trial.

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

Subject to the calendar year deductible and applies toward the maximum calendar year copayment and coinsurance responsibility if services are received from Centers of Medical Excellence (CME) or Anthem Blue Cross Preferred Providers; however, the maximum calendar year coinsurance responsibility is unlimited if services are received from Non-Preferred Providers.

All non-emergency hospitalizations require precertification by the Review Center as soon as possible, but no later than three (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 34) 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 page 41.

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 54-56) nor services for outpatient cardiac rehabilitation (see Outpatient or Out-of-Hospital Therapies on page 48).

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.

Chiropractic and Acupuncture

80% Preferred Provider
60% Non-Preferred Provider

Subject to the calendar year deductible and applies toward the maximum calendar year copayment and coinsurance responsibility if services are received from Preferred Providers; however, the maximum calendar year coinsurance responsibility is unlimited if services are received from Non-Preferred Providers.

Payment for any covered services, when medically necessary in accordance with Anthem Blue Cross Medical Policy, provided by a licensed chiropractor or any health professional qualified to perform acupuncture or acupressure is subject to a combined maximum of fifteen (15) visits per calendar year. Please consult with your Physician before receiving services to ensure the services are medically necessary and in accordance with Anthem Blue Cross Medical Policy.

Christian Science Treatment

80% All Providers

Subject to the calendar year deductible and applies toward the maximum calendar year copayment responsibility.

Treatment for a covered illness or injury is payable when services are provided by a Christian Science practitioner, Christian Science nurse, or Christian Science hospital. No payment, however, will be made for confinement in a Christian Science hospital for the purpose of rest or spiritual refreshment. This benefit includes treatment in absentia (Christian Science practitioners or nurses providing services, such as consultation or prayer, via the telephone).

Diabetes Self-Management Education Program

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

The twenty dollar ($20) copayment to a Preferred Provider is not subject to the calendar year deductible and does not apply toward the maximum calendar year copayment and coinsurance responsibility. In addition, you will be required to continue to pay the $20 copayment for such visits even after you have reached the maximum calendar year copayment and coinsurance responsibility amount.

Visits to a Non-Preferred Provider are subject to the calendar year deductible and the maximum calendar year coinsurance responsibility is unlimited for visits to Non-Preferred Providers.

Benefits are provided for patients enrolled in a diabetes instruction 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 instruction program" (1) is designed to educate patients 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

Subject to the calendar year deductible and applies toward the maximum calendar year copayment and coinsurance responsibility if services are received from Preferred Providers; however, the maximum calendar year coinsurance responsibility is unlimited if services are received from Non-Preferred Providers.

Outpatient services from all providers, including diagnostic X-rays, diagnostic examinations, clinical laboratory services, and Pap tests or mammograms for treatment of illness.

Precertification is required for certain 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) 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 34) 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

Subject to the calendar year deductible and applies toward the maximum calendar year copayment and coinsurance responsibility if services are received from Preferred Providers; however, the maximum calendar year coinsurance responsibility is unlimited if services are received from Non-Preferred Providers.

The purchase of durable medical equipment priced at $1,000 or more must be precertified by the Review Center no later than three (3) business days **prior** to 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 34) and/or denial of benefits.

Rental or purchase, including repair and maintenance, of standard outpatient prosthetic appliances (defined on page 102) and standard durable medical equipment (defined on page 98). 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 three hundred and fifty dollars ($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.

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 70 for Benefit Limitations, Exceptions and Exclusions related to this benefit.

Emergency Care Services

80% All Providers

Subject to the calendar year deductible and applies toward the maximum calendar year copayment and coinsurance responsibility.

A fifty dollar ($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.

For inpatient hospital services, the Review Center must be notified within twenty-four (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 34) 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 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. This benefit includes emergency room physician visits.

Benefits are also provided for emergency maternity admissions if due to unexpected "premature" delivery. A premature delivery is one that occurs prior to the eighth (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 pages 49-50.

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

Subject to the calendar year deductible and applies toward the maximum calendar year copayment and coinsurance responsibility if services are received from Preferred Providers; however, the maximum calendar year coinsurance responsibility is unlimited if services are received from Non-Preferred Providers.

Services for voluntary sterilization, including tubal ligation and vasectomy, and medically necessary 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 and diaphragms are covered under the Outpatient Prescription Drug Program. Infertility services, including drugs for treating infertility, are not covered.

Refer to pages 70, 72 and 73 for Benefit Limitations, Exceptions and Exclusions of this benefit.

Hearing Aid Services

80% Preferred Provider
60% Non-Preferred Provider

Subject to the calendar year deductible and applies toward the maximum calendar year copayment and coinsurance responsibility if services are received from Preferred Providers; however, the maximum calendar year coinsurance responsibility is unlimited if services are received from Non-Preferred Providers.

Hearing aid services include a hearing evaluation to measure the extent of hearing loss and a hearing aid evaluation to determine the most appropriate make and model of hearing aid. 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 40-41.

The Hearing Aid

The hearing aid itself (monaural or binaural), including ear mold(s), the hearing aid instrument, initial battery cords, and other ancillary equipment, is subject to **a maximum of one hearing aid, every thirty-six (36) months**. This benefit also includes visits for fitting, counseling, adjustment, and repairs at no charge for a one-year period following the provision of a covered hearing aid. Refer to page 70 for Benefit Limitations, Exceptions and Exclusions of this benefit.

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

Subject to the calendar year deductible and applies toward the maximum calendar year copayment and coinsurance responsibility if services are received from Preferred Providers; however, the calendar year coinsurance responsibility is unlimited if services are received from Non-Preferred Providers. Inpatient services provided for hip and knee joint replacement are limited to a maximum of $30,000 per procedure. Anthem Blue Cross has developed a list of Value Based Purchasing Design 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 three (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 34) and/or denial of benefits.

Home Health Care

80% Preferred Provider
60% Non-Preferred Provider

Subject to the calendar year deductible and applies toward the maximum calendar year copayment and coinsurance responsibility if services are received from Preferred Providers; however, the maximum calendar year coinsurance responsibility is unlimited if services are received from Non-Preferred Providers.

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 **forty-five (45) visits per calendar year**.

A treatment plan must be submitted in writing to the Review Center for precertification within three (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 34) and/or denial of benefits.

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 four (4) hours or less of covered services 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 48-49.
- 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 forty-five (45) per calendar year maximum.

Home Infusion Therapy

80% Preferred Provider
60% Non-Preferred Provider

Subject to the calendar year deductible and applies toward the maximum calendar year copayment and coinsurance responsibility if services are received from Preferred Providers; however, the maximum calendar year coinsurance responsibility is unlimited if services are received from Non-Preferred Providers.

Services and medications must be precertified by the Review Center as soon as possible, but no later than three (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 34) and/or denial of benefits.

In-home services by a home infusion therapy provider will be authorized only if the following criteria are met:

a. The services are medically necessary and appropriate; and
b. The attending physician has submitted both a prescription and a plan of treatment prior to services being provided.

Skilled nursing visits, including skilled nursing visits in association with home infusion therapy services, must be precertified by the Review Center. These visits are included under the Home Health Care benefit. For precertification requirements, see the Home Health Care benefit description as shown above.

Hospice Care

80% All Providers

Subject to the calendar year deductible and applies toward the maximum calendar year copayment and coinsurance responsibility.

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 ninety (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 ninety (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:

- 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;
- Counseling for the patient and family. Family counseling includes no more than two (2) visits of bereavement counseling, up to ninety (90) days following the patient's death;
- Up to five (5) days of inpatient hospital care for the patient (respite care).

Hospital Benefits

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

Subject to the calendar year deductible and applies toward the maximum calendar year copayment and coinsurance responsibility if services are received from Preferred Providers; however, the maximum calendar year coinsurance responsibility is unlimited if services are received from Non-Preferred Providers.

All non-emergency hospitalizations and acute inpatient rehabilitation require precertification by the Review Center as soon as possible, but no later than three (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 three (3) business days or thirty (30) business days prior to the start of services listed under Services Requiring Precertification on page 23. 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 34) and/or denial of benefits. For information on benefits for hospital services related to Emergency Care Services, refer to page 41.

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 three (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

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. Also see Ambulatory Surgery Centers on page 36.

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. If these routine services are provided in an outpatient hospital setting, the following maximums will apply:

- Colonoscopy services are limited to **a maximum payment of one thousand five hundred dollars ($1,500)** per procedure.
- Cataract surgery services are limited to **a maximum payment of two thousand dollars ($2,000)** per procedure.
- Arthroscopy services are limited to **a maximum payment of six thousand dollars ($6,000)** per procedure.

An exception will be provided to allow routine colonoscopy, cataract surgery or arthroscopy services to be performed in an outpatient hospital for patient safety reasons or if there are no Preferred Ambulatory Surgical Center Providers within a thirty (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

Subject to the calendar year deductible and applies toward the maximum calendar year copayment and coinsurance responsibility if services are received from Preferred Providers; however, the maximum calendar year coinsurance responsibility is unlimited if services are received from Non-Preferred Providers.

Medically necessary physician and hospital services relating to prenatal and postnatal care and complications of pregnancy. Medical hospital benefits for routine nursery care for the first 30 days of the newborn child, if the child's natural mother is an enrolled employee, or an enrolled annuitant or family member. Examination, nursery care and circumcision of the newborn are provided if the newborn is enrolled as a family member.

An alternative birthing center may be used instead of hospitalization. Covered services provided by alternative birthing centers, both Preferred Providers and Non-Preferred Providers, are not subject to the calendar year deductible, payable at 80% of the Allowable Amount, and apply toward the maximum calendar year copayment and coinsurance responsibility. 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 forty-eight (48) hours for normal vaginal delivery or ninety-six (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 41 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

Subject to the calendar year deductible and applies toward the maximum calendar year copayment and coinsurance responsibility if services are received from Preferred Providers; however, the maximum calendar year coinsurance responsibility is unlimited if services are received from Non-Preferred Providers.

Precertification from the Review Center must be obtained three (3) business days before admission, or within twenty-four (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 34) and/or denial of benefits.

Benefits are provided for hospital and physician services medically necessary to stabilize an acute psychiatric condition. Inpatient programs and inpatient stays at residential treatment facilities are not covered.

Refer to pages 70-73 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

Subject to the calendar year deductible and applies toward the maximum calendar year copayment and coinsurance responsibility if services are received from Preferred Providers; however, the maximum calendar year coinsurance responsibility is unlimited if services are received from Non-Preferred Providers.

All covered outpatient facility-based care provided by a residential treatment facility must be precertified by the Review Center at least three (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 34) and/or denial of benefits. For information on precertification, refer to page 24.

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 70-73 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

The twenty dollar ($20) copayment applies only to the office visit. The $20 copayment to a Preferred Provider is not subject to the calendar year deductible and does not apply toward the maximum calendar year copayment and coinsurance responsibility. You will be required to continue to pay the $20 copayment for office visits even after you have reached the maximum calendar year copayment responsibility amount. Other physician services rendered during an office visit, outpatient hospital visit, or urgent care visit are paid at eighty percent (80%) of the Allowable Amount.

Visits to a Non-Preferred Provider are subject to the calendar year deductible; however, the maximum calendar year copayment and coinsurance responsibility is unlimited for visits to Non-Preferred Providers.

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 70-73 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)

Not subject to the calendar year deductible and does not apply toward the maximum calendar year copayment and coinsurance responsibility.

To prepare new and expectant parents for a natural birthing experience, the Plan will pay up to fifty dollars ($50) or fifty percent (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 twenty-five dollars ($25) or fifty percent (50%) of class fees (whichever is less).

Outpatient or Out-of-Hospital Therapies

Cardiac Rehabilitation

80% Preferred Provider
60% Non-Preferred Provider

Subject to the calendar year deductible and applies toward the maximum calendar year copayment and coinsurance responsibility if services are received from Preferred Providers; however, the maximum calendar year coinsurance responsibility is unlimited if services are received from Non-Preferred Providers.

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 forty (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 pages 38-39) or any services in connection with a heart transplant (see Transplant Benefits on pages 54-56).

Physical Therapy and Occupational Therapy

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

Subject to the calendar year deductible and applies toward the maximum calendar year copayment and coinsurance responsibility if services are received from Preferred Providers; however, the maximum calendar year coinsurance responsibility is unlimited if services are received from Non-Preferred Providers.

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. **Benefits are limited to a combined 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 three (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 34) and/or denial of benefits.

Pulmonary Rehabilitation

80% Preferred Provider
60% Non-Preferred Provider

Subject to the calendar year deductible and applies toward the maximum calendar year copayment and coinsurance responsibility if services are received from Preferred Providers; however, the maximum calendar year coinsurance responsibility is unlimited if services are received from Non-Preferred Providers.

Upon referral of a physician, medically necessary services are covered **to a maximum payment of one thousand five hundred dollars ($1,500) per Member each calendar year** when provided by licensed personnel in a formal pulmonary rehabilitation program.

Speech Therapy

80% Preferred Provider
60% Non-Preferred Provider

Subject to the calendar year deductible and applies toward the maximum calendar year copayment and coinsurance responsibility if services are received from Preferred Providers; however, the maximum calendar year coinsurance responsibility is unlimited if services are received from Non-Preferred Providers.

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 three (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 34) 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 72 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
60% Non-Preferred Provider

The twenty dollar ($20) copayment applies only to the visit portion of the physician's bill. The $20 copayment to a Preferred Provider is not subject to the calendar year deductible and does not apply toward the maximum calendar year copayment and coinsurance responsibility. You will be required to continue to pay the $20 copayment for such visits even after you have reached the maximum calendar year copayment and coinsurance responsibility amount. Other physician services rendered during an office visit, outpatient hospital visit, or urgent care visit are paid at eighty percent (80%) of the Allowable Amount (see Other Physician Services below).

Visits to a Non-Preferred Provider are subject to the calendar year deductible; however, the maximum calendar year coinsurance responsibility is unlimited for visits to Non-Preferred Providers.

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 calendar year deductible and apply toward the maximum calendar year copayment and coinsurance responsibility if services are received from Preferred Providers. 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 are subject to the calendar year deductible; however, the maximum calendar year coinsurance responsibility is unlimited if services are received from Non-Preferred Providers.

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 page 41). 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 103) may be covered under the Telemedicine Program benefit (as described on page 53).

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. Services received from Non-Preferred Providers are subject to the calendar year deductible, and the maximum calendar year coinsurance responsibility is unlimited for services received from Non-Preferred Providers.

Benefits include health care services designed for the prevention and early detection of illness in Members who have not experienced any symptoms. Preventive care generally includes routine physical examinations, tests and immunizations (e.g., Zostavak).

For purposes of this benefit, "preventive" means physician visits and medical services related to vaccinations, indicated screening tests and procedures. This benefit does not apply to treatment or follow-up testing. For example:

- An indicated screening colonoscopy for colon cancer is covered under this benefit.
- Follow-up colonoscopies after abnormal results or cancer treatment would not be covered under this benefit.

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

Anesthesia during colonoscopies: Intravenous conscious sedation provided by the gastroenterologist during a colonoscopy is a covered benefit. General anesthesia (deep sedation administered by an anesthesiologist or nurse anesthetist) during a colonoscopy is not a covered benefit unless you obtain prior authorization for it. 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. Before receiving anesthesia during a colonoscopy, 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 and will not be covered under the Preventive Care benefit.

Refer to page 10 for specific preventive care guidelines for children, adolescents, adults, and seniors.

Reconstructive Surgery

80% Preferred Provider
60% Non-Preferred Provider

Subject to the calendar year deductible and applies toward the maximum calendar year copayment and coinsurance responsibility if services are received from Preferred Providers; however, the maximum calendar year coinsurance responsibility is unlimited if services are received from Non-Preferred Providers.

Precertification from the Review Center must be obtained as soon as possible, but no later than three (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 34) and/or denial of benefits.

Hospital and physician services provided in connection with reconstructive surgery are a benefit only to the extent that surgery is coincident with and necessary to the repair or alleviation of bodily damage caused by illness, congenital anomaly, or accidental injury. 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. Services must commence within ninety (90) days from the date on which the injury was sustained or within ninety (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.

Skilled Nursing and Rehabilitation Care

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

Subject to the calendar year deductible and applies toward the maximum calendar year copayment and coinsurance responsibility if services are received from Preferred Providers; however, the maximum calendar year coinsurance responsibility is unlimited if services are received from Non-Preferred Providers.

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 three (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 34) 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 one hundred (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

100% of covered program charge, up to $100 per calendar year

Not subject to the calendar year deductible and does not apply toward the maximum calendar year copayment and coinsurance responsibility.

The plan will reimburse the Plan Member **up to a maximum of one hundred dollars ($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.

Substance Abuse

Inpatient Care

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

Subject to the calendar year deductible and applies toward the maximum calendar year copayment and coinsurance responsibility if services are received from Preferred Providers; however, the maximum calendar year coinsurance responsibility is unlimited if services are received from Non-Preferred Providers.

Precertification from the Review Center must be obtained three (3) business days before admission, or within twenty-four (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 34) 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.

Refer to page 70-73 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

Subject to the calendar year deductible and applies toward the maximum calendar year copayment and coinsurance responsibility if services are received from Preferred Providers; however, the maximum calendar year coinsurance responsibility is unlimited if services are received from Non-Preferred Providers.

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 three (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 34) and/or denial of benefits. For information on precertification, refer to page 24.

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
60% Non-Preferred Provider

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

The twenty dollar ($20) copayment applies only to the office visit. The $20 copayment to a Preferred Provider is not subject to the calendar year deductible and does not apply toward the maximum calendar year copayment and coinsurance responsibility. You will be required to continue to pay the $20 copayment for office visits even after you have reached the maximum calendar year copayment responsibility amount. Other physician services rendered during an office visit, outpatient hospital visit, or urgent care visit are paid at eighty percent (80%) of the Allowable Amount.

Visits to a Non-Preferred Provider are subject to the calendar year deductible; however, the maximum calendar year copayment and coinsurance responsibility is unlimited for visits to Non-Preferred Providers.

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 70-73 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

The twenty dollar ($20) copayment to a Telemedicine Network provider applies only to the consultation or second opinion portion of the Specialty Center's bill. The $20 copayment is not subject to the calendar year deductible and does not apply toward the maximum calendar year copayment and coinsurance responsibility. You will be required to continue to pay the $20 copayment for such encounters even after you have reached the maximum calendar year copayment and coinsurance responsibility amount.

Other services provided by a Telemedicine Network Presentation Site or Specialty Center are subject to the calendar year deductible and apply toward the maximum calendar year copayment and coinsurance.

Coverage will be provided for telemedicine, as defined on page 103, 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.

Kidney, Cornea, and Skin Transplants

Hospital Services	80% Preferred Provider 60% Non-Preferred Provider
Evaluations and Diagnostic Tests	80% Preferred Provider 60% Non-Preferred Provider

Subject to the calendar year deductible and applies toward the maximum calendar year copayment and coinsurance responsibility if services are received from Preferred Providers; however, the maximum calendar year coinsurance responsibility is unlimited if services are received from Non-Preferred Providers.

Precertification for kidney and skin transplants must be obtained from the Review Center as soon as possible, but no later than three (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 34) 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 kidney, 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. Copayments or coinsurance made for donor searches for transplants will not apply to the maximum calendar year copayment and coinsurance responsibility. Reasonable charges for 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 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.

Special Transplant Benefit

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

Subject to the calendar year deductible and applies toward the maximum calendar year copayment and coinsurance responsibility.

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 34) 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 twenty percent (20%) of the lesser of Billed Charges or the negotiated rate for covered services and all charges for non-covered services.

Covered expenses for the donor, including donor testing and donor search, are limited to those incurred for medically necessary medical services only. Copayments or coinsurance made for donor searches for transplants will not apply to the maximum calendar year copayment and coinsurance responsibility. Reasonable charges for 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.

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. Any copayments or coinsurance made for these donor searches will not apply to the maximum calendar year copayment and coinsurance responsibility.

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 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 one (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 reasonable expenses, such as meals.

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

The twenty dollar ($20) copayment applies to the charge for the physician visit to a Preferred Provider for urgent care only. The charge for the physician visit is not subject to the calendar year deductible, and the $20 copayment does not apply toward the maximum calendar year copayment and coinsurance responsibility. You will be required to continue to pay the $20 copayment for such visits even after you have reached the maximum calendar year copayment and coinsurance responsibility amount. Other physician services rendered by a Preferred Provider during an urgent care visit are subject to the calendar year deductible and paid at eighty percent (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 forty percent (40%) and all charges in excess of the Allowable Amount. The maximum calendar year coinsurance responsibility is unlimited for visits to Non-Preferred Providers.

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 eighty percent (80%) of the Allowable Amount. You are responsible for the remaining twenty percent (20%) up to the maximum calendar year copayment and coinsurance responsibility.

Services received from a Non-Preferred Provider are subject to the calendar year deductible, and you are responsible for the remaining forty percent (40%) and all charges in excess of the Allowable Amount. The maximum calendar year coinsurance responsibility is unlimited for services received from Non-Preferred Providers.

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 104). 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 use of a hospital or emergency room. Charges for facility and hospital services are not covered under this Urgent Care benefit. Choosing to visit a hospital for urgent care may result in increased copayment or coinsurance responsibility and/or denial of benefits.

OUTPATIENT PRESCRIPTION DRUG PROGRAM

Outpatient Prescription Drug Benefits

The Outpatient Prescription Drug Program is administered by CVS Caremark. This program will pay for prescription medications which are: (a) prescribed by a licensed prescriber (defined on page 102) in connection with a covered illness, condition, or accidental injury; (b) dispensed by a registered pharmacist, subject to the exclusions listed in the Outpatient Prescription Drug Exclusions on pages 66-67; and (c) approved through the Coverage Management Programs described in the Prescription Drug Coverage Management Programs section on page 65. All prescription medications are subject to clinical drug utilization review when dispensed.

Covered outpatient prescription drugs prescribed by a licensed prescriber in connection with a covered illness 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.

Maintenance Choice®

Maintenance medications for long-term or chronic conditions may be obtained at CVS/pharmacy and Longs Drugs retail pharmacy locations, for up to a ninety (90) day supply, through the Maintenance Choice® Program. Maintenance Choice® offers the face-to-face experience and quick service of retail, with the lower Mail Service copayment structure. Prescriptions for eighty-four (84) to ninety (90) day supplies of maintenance medications can be filled under the Maintenance Choice® Program and your copayment will be the same as it would be for a Mail Service order. To utilize Maintenance Choice®, visit a CVS/pharmacy or Longs Drug retail pharmacy location and follow the procedure described above under “Participating Pharmacy.”

The Plan’s Outpatient Prescription Drug Program is designed to save you and the Plan money without compromising safety and effectiveness standards by encouraging you to ask your physician to prescribe generic drugs whenever possible and to also prescribe medications on CVS Caremark’s Preferred Drug List. Members can still receive any covered medication, and your physician still maintains the choice of medication prescribed.

Coordination of Benefits provisions do not apply to the Outpatient Prescription Drug Program.

Coinsurance and “Member Pays the Difference”

- Discretionary Drugs (as defined on page 97) are subject to a 50% coinsurance.
- “Member Pays the Difference” program: If a brand name drug is selected when a generic alternative is available, Members will pay the difference between the brand name drug and the generic equivalent, plus the generic copayment.
- In order to obtain a Partial Waiver of the Non-Preferred Brand copayment, your physician must document the necessity for the Non-Preferred product vs. the Preferred product(s) and the available generic alternative(s) through CVS Caremark’s formal appeals process outlined on pages 89-90.

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 Maintenance Choice® retail pharmacies for maintenance medications. Your copayment will vary depending on whether you use retail or Mail Service/ Maintenance Choice®, and whether you select generic, Preferred or Non-Preferred brand-name medications, or whether you refill maintenance medications at a non-Maintenance Choice® retail pharmacy after the second fill.

OUTPATIENT PRESCRIPTION DRUG PROGRAM

The following table shows the copayment structure for the retail pharmacy and mail service programs:

Participating Retail Pharmacy/ CVS Caremark Specialty Pharmacy (short-term use)	**Maintenance Medications*: Participating Retail Pharmacy filled at non-Maintenance Choice® Retail after 2nd fill** (a maintenance medication* taken longer than 60 days for a long-term or chronic condition)	**Maintenance Medications*: CVS Caremark Mail Service/ Maintenance Choice®** (a maintenance medication* taken longer than 60 days for a long-term or chronic condition)
Generic **$5.00**	Generic **$10.00**	Generic **$10.00**
Preferred Brand **$20.00**	Preferred Brand **$40.00**	Preferred Brand **$40.00**
Non-Preferred Brand **$50.00**	Non-Preferred Brand **$100.00**	Non-Preferred Brand **$100.00**
Partial Waiver of Non-Preferred Brand copayment** **$40.00**	Partial Waiver of Non-Preferred Brand copayment** **$70.00**	Partial Waiver of Non-Preferred Brand copayment** **$70.00**
Discretionary Drugs 50%	Discretionary Drugs 50%	Discretionary Drugs 50%
Up to a 30-day supply	**Up to a 30-day supply**	**Up to a 90-day supply**
Out-of-Pocket Maximum, per person each calendar year: not applicable	**Out-of-Pocket Maximum, per person each calendar year: not applicable**	**Out-of-Pocket Maximum, per person each calendar year: $1,000** (excluding Non-Preferred Brand-Name Medication copayments, Discretionary Drug coinsurance and "Member Pays the Difference" differential)

* A maintenance medication should not require frequent dosage adjustments and is prescribed for a long-term or chronic condition, such as arthritis, 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 prescription 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. 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 Maintenance Choice® retail pharmacy at a cost savings. Certain Specialty medications are available only through the CVS Caremark Specialty Pharmacy.

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 Mail Service 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 1-877-542-0284.

Examples of common long-term or chronic conditions:

Birth control
High blood pressure
High cholesterol
Diabetes

Examples of common short-term acute illnesses or conditions:

Influenza (the "Flu")
Pneumonia
Urinary tract infection

** To obtain a partial waiver to purchase a Non-Preferred brand-name medication at a reduced copayment amount, please refer to the Partial Waiver of Non-Preferred Brand Copayment process as outlined in the Prescription Drug Appeal Procedure section on pages 89-90. To obtain a partial copayment waiver, your physician must document the necessity for the non-preferred product vs. the preferred product(s) and the available generic alternative(s).

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 filled by Mail Service will be filled with a FDA-approved bioequivalent generic, if one exists, unless your physician specifies otherwise. A one thousand-dollar ($1,000) maximum (excluding copayments for Non-Preferred Brand-Name Medications, Discretionary Drugs, and Member Pays the Difference differential) calendar year copayment (per person) applies to Mail Service/ Maintenance Choice® prescriptions.

Although Generic Medications (defined on page 98) are not mandatory, the Plan encourages you to purchase generics 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 96). Prescriptions filled with Generic equivalent medications have lower copayments and also help to manage the increasing cost of health care without compromising the quality of your pharmaceutical care.

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.

While this program was designed primarily for use in California, 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 five dollar ($5.00) copayment for generic medications, a twenty dollar ($20.00) copayment for Preferred brand-name medications, or a fifty dollar ($50.00)copayment for Non-Preferred brand-name medications. Non-Preferred brand-name medications can be purchased for a forty dollar ($40.00) copayment with an approved partial copayment waiver (pages 89-90). If the pharmacy does not accept your ID card and is a Non-Participating Pharmacy (defined on page 100), there is additional cost to you.

If you refill a maintenance medication at a 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. If you want to utilize a Non-Participating Pharmacy, please follow the procedure for using a Non-Participating Pharmacy described below. For covered medications you take on a long-term basis (60 days or more), use CVS Caremark Mail Service, or a Maintenance Choice® retail pharmacy for a lower copayment. For more information on CVS Caremark Mail Service, see How To Use CVS Caremark Mail Service on pages 62-64, visit the CVS Caremark Web site at www.caremark.com/calpers, or call CVS Caremark Customer Care at 1-877-542-0284.

How To Use The Retail Pharmacy Program Nationwide

Participating Pharmacy

1. Take your prescription to any Participating Pharmacy. To locate a Participating Pharmacy near you, visit the CVS Caremark Web site at www.caremark.com/calpers or contact CVS Caremark Customer Care at 1-877-542-0284.
2. 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.
3. You will be required to pay the pharmacist your appropriate copayment for each prescription order or refill. You may be required to sign a receipt for your prescription at the pharmacy.

4. In the event you do not have your ID card prior to going to the pharmacy, contact CVS Caremark Customer Care at 1-877-542-0284 for assistance with processing your prescription at a Participating Pharmacy. In order to obtain an ID card, you may contact the Anthem Blue Cross Customer Service Department at 1-877-737-7776. If you pay the Participating Pharmacy the full cost of your medication at the time of purchase without presenting your ID card, your reimbursement will be the same as if you had used a Non-Participating Pharmacy. (See example below.)

Non-Participating Pharmacy

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 twelve (12) months from the date of purchase to be covered. Any claim submitted outside the twelve (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 out-of-pocket 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 out-of-pocket 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.

Note: Covered medications purchased from your physician will be reimbursed under the Non-Participating Pharmacy benefit through CVS Caremark.

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. 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 requires: (a) a prescription; (b) is FDA-approved; and (c) is covered by CalPERS. Only products that are FDA-approved and commercially available will be considered Preferred for purposes of determining copay. The copay for a compounded medication is determined by the most expensive ingredient used for your compounded medication. 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. At a Non-Participating Pharmacy, 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. An example showing how reimbursement will be determined can be found on page 61.

Mail Service Program

Maintenance medications for long-term or chronic conditions may be obtained by mail, for up to a ninety (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 **ninety (90) day supply** of medication for only ten dollars ($10.00) for each generic medication, forty dollars ($40.00) for each Preferred brand-name medication, one hundred dollars ($100.00) for each Non-Preferred brand-name medication, or seventy dollars ($70.00) for each Partial Waiver of Non-Preferred Brand Copayment. In addition to out-of-pocket 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.
- **Out-of-pocket maximum:** Your maximum calendar year copayment (per person) through the Mail Service Program is one thousand dollars ($1,000). Copayments for Non-Preferred Brand-Name Medications, Discretionary Drugs, and Member Pays the Difference Drugs do not apply to your out-of-pocket maximum.

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 ninety (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 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 Waiver of Non-Preferred brand-name. 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. 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.

3. You may also have your physician fax your prescriptions or send them electronically (often called e-prescribing) to CVS Caremark.

   a. To fax prescriptions, your physician may call 1-800-378-5697 for faxing instructions. (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 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.

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.

OUTPATIENT PRESCRIPTION DRUG PROGRAM

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. 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 a Prior Authorization Program/Point of Sale Utilization Review Program. Additional programs may be added at the discretion of the Plan.

The Plan may implement additional new programs designed to ensure that medications dispensed to its Members are covered under this Plan. **As new drugs are developed, including generic versions of brand-name drugs, or when drugs receive FDA approval for new or alternative uses, the Plan reserves the right to review the coverage of those drugs or class of drugs under the Plan. The Plan reserves the right to exclude, discontinue or limit coverage of those drugs or class of drugs following such review. Any benefit payments made for a prescription medication shall 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.

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 initiate a coverage review and 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 forty-eight (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. For example, coverage for erectile dysfunction therapy is allowed for up to eight (8) treatments, doses or units per 30 days.

Please visit the CVS Caremark Web site at www.caremark.com/calpers, or contact CVS Caremark Customer Care at 1-877-542-0284 to determine if your drug 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.

To obtain specialty medications, you or your physician should call 1-800-237-2767. CVS Caremark's Specialty Pharmacy hours of operation are 4:30 AM to 6 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 thirty (30) day supply.

OUTPATIENT PRESCRIPTION DRUG EXCLUSIONS

The following are excluded under the Outpatient Prescription Drug Program:

1. Drugs not approved by the U.S. Food and Drug Administration (FDA).**
2. Drugs or medicines obtainable without a licensed prescriber's prescription, often called over-the-counter (OTC) drugs or behind-the counter (BTC) drugs, except insulin, diabetic test strips and lancets, and Plan B.
3. Contraceptives, such as, diaphragms, injectable drugs, Intrauterine devices, time-released subdermal implants (e.g., Implanon), are not covered under the Prescription Drug Program, however, they may be considered for coverage through the medical benefit.
4. 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.
5. A prescription drug that has an over-the-counter alternative.
6. Anorexiants and appetite suppressants or any other anti-obesity drugs.
7. Supplemental fluorides (e.g., infant drops, chewable tablets, gels and rinses).
8. Charges for the purchase of blood or blood plasma.
9. Hypodermic needles and syringes, except as required for the administration of a covered drug.
10. Non-medical therapeutic devices, durable medical equipment, appliances and supplies, including support garments, even if prescribed by a physician, regardless of their intended use. *
11. Drugs which are primarily used for cosmetic purposes rather than for physical function or control of organic disease.
12. Drugs labeled "Caution – Limited By Federal Law to Investigational Use" or non-FDA approved Investigational Drugs. Any drug or medication prescribed for experimental indications.
13. Any drugs prescribed solely for the treatment of an illness, injury or condition that is excluded under the Plan.
14. Any drugs or medications which are not legally available for sale within the United States.
15. Any charges for injectable immunization agents, desensitization products or allergy serum, or biological sera, including the administration thereof. *
16. Professional charges for the administration of prescription drugs or injectable insulin. *
17. 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. *
18. 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. *
19. 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.
20. Any quantity of dispensed drugs or medicines which exceeds a thirty (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 ninety (90) day supply of covered drugs or medicines as prescribed by a licensed prescriber.
21. Refills of any prescription in excess of the number of refills specified by a licensed prescriber.

OUTPATIENT PRESCRIPTION DRUG EXCLUSIONS

22. Any drugs or medicines dispensed more than one (1) year following the date of the licensed prescriber's prescription order.

23. Any charges for special handling and/or shipping costs incurred through a Participating Pharmacy, a non-Participating Pharmacy, or the Mail Service pharmacy.

24. Any quantity of dispensed medications that is deemed inappropriate as determined through CVS Caremark's coverage management programs.

25. 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 102, are not covered.

26. Replacement of lost, stolen or destroyed prescription drugs.

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 theses 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.

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 22-26 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. **Behavioral Therapies For The Treatment Of Delays in Development.** Therapies for the treatment of delays in development, unless resulting from acute illness or injury, or congenital defects amenable to surgical repair (such as cleft lip/palate), are not covered.

   a. Examples of excluded therapies include but not limited to Applied Behavioral Analysis and the LEAP, TEACCH, Denver and Rutgers programs.

   b. Examples of non-covered diagnoses include Pervasive Developmental Disorders (including Autism), Down Syndrome, and Cerebral Palsy, as they are considered both developmental and/or chronic in nature.

3. **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 25-26, 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.

4. **Blood and Blood Products**. Charges incurred for the purchase of blood or blood products when the blood has been replaced.

5. **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.

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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. **Clinical Trials.** Services and supplies in connection with clinical trials are not covered except as specifically provided in the Cancer Clinical Trials benefit description on pages 37-38.

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

8. **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.

9. **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.

10. **Custodial Care**

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

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

11. **Dental Implants**. Dental implants and any related services.

12. **Dental Services, General**. 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.

13. **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).

14. **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 40-41; dental braces and other orthodontic appliances; 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 40-41. Prosthetic and durable medical equipment replacement and repair resulting from loss, misuse, abuse and/or accidental damage are not covered.

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

16. **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 98, are not covered.

17. **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.

18. **Feet, Procedures Affecting**. Callus or corn paring or excision, or toenail trimming, except as specifically provided in the Physician Services benefit description on pages 49-50. Any manipulative procedure for weak or fallen arches, flat or pronated foot, or foot strain.

19. **Government-Provided Services**. Any services provided by a local, state, or federal government agency unless reimbursement by this Plan for such services is required by state or federal law.

20. **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.

21. **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 thirty-six (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 40-41.

22. **Hospital Admission**. Inpatient charges in connection with a hospital stay primarily for diagnostic tests which could have been performed safely on an outpatient basis.

23. **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.

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

25. **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 page 83, or qualifies under the provisions described under Consolidated Omnibus Budget Reconciliation Act (COBRA) beginning on pages 80-81, or CalCOBRA Continuation of Group Coverage beginning on page 81-82. See Emergency Care Services on page 41 for benefit coverage of emergency maternity admissions.

26. **Medical Trainee Services**. Services performed in any inpatient or outpatient setting by house officers, residents, interns and others in training.

27. **Natural Childbirth Classes**. Natural childbirth classes will be reimbursed only when given by certified ASPO/Lamaze childbirth educators, see page 47. Classes devoted solely to individual perinatal specialties, other than Lamaze, are not covered.

28. **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 52.

29. **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.

30. **Nutrition**. Vitamins, minerals, medical foods and nutritional supplements (except enteral feeding) whether or not prescribed by a licensed prescriber; nutritional counseling, except as specifically provided under the Diabetes Self-Management Education Program benefit on pages 39-40 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.

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

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

33. **Private-Duty Nursing**

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

b. Private-duty unskilled nursing.

34. **Psychiatric or Psychological Care**

a. Psychiatric or psychological care for the treatment of the following conditions is excluded under this Plan:

1. personality disorders;
2. sexual deviations and disorders;
3. abuse of drugs, except as provided in the Substance Abuse benefit description on pages 52-53;
4. conduct disorders;
5. mental retardation and developmental delays;
6. conditions of abnormal behavior which are not directly attributed to a mental disorder which is the focus of attention or treatment;
7. attention deficit disorders.

b. Telephone consultations.

c. Psychological testing or testing for intelligence or learning disabilities unless medically necessary to assess brain function suspected to be impaired due to trauma, or organic dysfunction.

d. Inpatient treatment for eating disorders is excluded under this Plan, unless the inpatient stay is necessary for the treatment of anorexia nervosa or bulimia nervosa.

e. Services on court order or as a condition of parole or probation unless the services are determined to be medically necessary and appropriate for the condition being treated and otherwise covered by the Plan.

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

g. Non-therapeutic treatment, custodial care and educational programs.

NOTE: Any dispute regarding a psychiatric condition will be resolved with reference to the American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), Fourth Edition. Washington, DC, American Psychiatric Association, 1994. Use of DSM-IV to resolve disputes is subject to change as new editions are published.

35. 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.

36. 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.

37. Residential Treatment Facility. Charges associated with an inpatient stay at a Residential Treatment Facility (defined on page 102), transitional living center, or board and care facility. This exclusion does not apply to precertified outpatient day or evening services as provided in the Mental Health Benefits description on pages 46-47 and Substance Abuse benefit description on pages 52-53. A Plan Member is not covered for any overnight stay(s) at a Residential Treatment Facility when obtaining precertified outpatient day or evening services for covered Mental Health Benefits or Substance Abuse benefits.

38. Self-injectable drugs. Injectable drugs which are self-administered by the subcutaneous route (under the skin) by the patient or family member. Drugs with Food and Drug Administration (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.

39. Sexual Transformations. Charges for or incident to gender reassignment surgery (transsexual operations) or any resulting medical complications.

40. 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 page 49.

41. 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.

42. **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 53.

43. **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.

44. **Transportation and Travel Expense.** Expense incurred for transportation, except as specifically provided in the Ambulance benefit on page 35, the Travel Benefits for Bariatric Surgery on pages 36-37, and the Travel Benefits for Special Transplant Services on page 56. Mileage reimbursement except as specifically provided in the Travel Benefits for Bariatric Surgery on pages 36-37, and the Travel Benefits for Special Transplant Services on page 56 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.

45. **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.

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

47. **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.

48. **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 ten percent (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.

49. **War**. Conditions caused by war, whether declared or undeclared.

50. **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 adolescents,

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 36-37.

51. 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.

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.

GENERAL PROVISIONS

Eligibility

If you encounter any problems with eligibility, you should contact your employing agency's Health Benefits Officer (active) or the CalPERS Health Account Services Section (retirees) at 888 CalPERS (or 888-225-7377) to resolve the problem. Once the problem has been corrected, CalPERS will notify Anthem Blue Cross.

Possible problems that require HBO intervention include:

- No record of enrollment;
- Dispute with regard to the effective date of coverage and cancellation dates;
- Changes in family status (e.g., marriage, divorce, and newborn and adopted children).

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 Amount.

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 Amount. 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 77-79.

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.

Continuation of Group Coverage

Eligibility for Continuation of Group Coverage under PERS Select is dependant 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 will have the option to convert to an individual plan (see Individual Conversion Plan on pages 82-83) or 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. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage entirely.

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 eighteen (18), twenty-nine (29), or thirty-six (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 sixty (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 one hundred and two percent (102%) of the applicable group premiums rate, except for the employee or enrolled family member who is eligible to continue group coverage to twenty-nine (29) months because of entitlement to Social Security disability benefits. In this case, the cost of coverage for months nineteen (19) through twenty-nine (29) shall not exceed one hundred and fifty percent (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 eighteen (18) months: (This coverage may be continued for up to twenty-nine (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 thirty-six (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 that does not include a pre-existing condition exclusion or limitation; or

4. the enrollee, after electing COBRA, becomes entitled to Medicare benefits; or
5. the continuation of coverage was extended to twenty-nine (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 thirty-six (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. one hundred and ten percent (110%) of the applicable group premiums rate if coverage under federal COBRA ended after 18 months; or
2. one hundred and fifty percent (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 that does not include an exclusion or limitation relating to a pre-existing condition that the enrollee has; 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 three (3) years from the date the qualifying event has occurred which originally entitled the Plan Member to continue group coverage under this Plan. A Plan Member whose continuation of group coverage is terminated or expires under the group continuation plan may be eligible to enroll in an individual conversion plan described below.

Individual Conversion Plan

The Individual Conversion Plan will be available to a Plan Member whose continuation of group coverage is terminated or expires under the group continuation plan. The group continuation plan under COBRA or CalCOBRA must have been elected and exhausted in order for the Plan Member to continue coverage under the Individual Conversion Plan.

Continued Protection

Regardless of age, physical condition or employment status, you and your enrolled dependents may transfer to the Individual Conversion Plan being issued by Anthem Blue Cross at the time enrollment is terminated, other than by voluntary cancellation or failure to continue enrollment or make contributions while in a non-pay status.

However, if this Plan is replaced by your employer with another plan, transfer to the Anthem Blue Cross conversion plan will not be permitted.

An application for a conversion plan and the first premium payment must be received by Anthem Blue Cross within sixty-three (63) days from the date coverage under PERS Select is terminated.

To request an application, write to:

Anthem Blue Cross
P.O. Box 9153
Oxnard, CA 93031-9153

Benefits and rates of individual conversion plans will be different from those of this Plan.

An individual conversion plan is also available to:

- Family members, if the employee or annuitant dies;
- Children who marry or attain the age of twenty-six (26) while enrolled under PERS Select;
- Family members of an employee who enters military service;
- The spouse of a subscriber whose marriage has been terminated; and
- The domestic partner of a subscriber whose domestic partnership has been terminated.

When a child reaches age twenty-six (26), or if a family member becomes ineligible for any other reason given above**, it is your responsibility to inform Anthem Blue Cross**. Upon receiving notification, Anthem Blue Cross will offer such family member an individual conversion 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 thirty (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 sixty (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 twelve (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 ninety-one (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

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.

MEDICAL CLAIMS APPEAL PROCEDURE

The procedures outlined below are designed to ensure the Plan Member full and fair consideration of complaints submitted to the Plan. The procedures should be followed carefully and in the order listed.

Claims for payment must be submitted to Anthem Blue Cross within ninety (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 fifteen (15) months from the date of service or payment will be denied.

The following procedures shall be used to resolve any dispute which results from any act, error, or omission with respect to any medical claim filed by or on behalf of a Plan Member. (See Utilization Review Appeal Procedure on pages 86-88 for procedures used to resolve any dispute which results from a medical necessity determination by Anthem Blue Cross' Review Center.)

The cost of copying and mailing medical records required for Anthem Blue Cross to review its determination is the responsibility of the person or entity requesting the review.

1. **Notice of Claim Denial**

   In the event any claim for benefits is denied, in whole or in part, Anthem Blue Cross shall notify the Plan Member of such denial in writing. The notice shall contain specific reasons for such denial and an explanation of the Plan's review and appeal procedure.

2. **Objection to Claim Processing or Denial**

   An aggrieved Plan Member may object by writing to Anthem Blue Cross' Customer Service Department within sixty (60) days of the discovery of any act, error, or omission with regard to a properly submitted claim; or within sixty (60) days of receipt of a notice of claim denial. The objection must set forth all reasons in support of the proposition that an act, error, or omission occurred.

3. **Time Limits for Response to Objection**

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

   If Anthem Blue Cross affirms the denial or fails to respond within thirty (30) days after receiving the request for review and the Member still objects to an act, error, or omission as stated above, the Member may proceed to item 4 below.

4. **Request for Reconsideration**

   If the Plan Member is not satisfied with the response to the initial inquiry, he or she may request reconsideration within sixty (60) days of receiving notice of Anthem Blue Cross' response. The request should be submitted in writing to the Customer Service Department. Any additional information that would affect the decision should be included. Anthem Blue Cross will acknowledge receipt of a reconsideration request by written notice to the Member within twenty (20) days. Anthem Blue Cross will then either affirm or resolve the denial within thirty (30) days.

5. **Request for Administrative Review**

   If the Plan Member is not satisfied with the response to the Request for Reconsideration, he or she may request a final administrative determination from CalPERS within thirty (30) days using the procedure set forth on pages 91-92.

UTILIZATION REVIEW APPEAL PROCEDURE

Anthem Blue Cross' Review Center may render a utilization review determination on whether a particular medical service is medically necessary at any of the following three stages:

1. Before services are rendered (prospective utilization review — see pages 22-26 for Precertification and pages 25 for Non-Emergency Admissions); or
2. During the rendering of services (concurrent utilization review); or
3. After services are rendered (retrospective utilization review).

If a Plan Member, treating provider, or facility disagrees with the Review Center's determination at any of these stages, they have the right to state that disagreement and request a reconsideration by the Review Center. The Review Center may refer certain prospective review determinations directly to CalPERS for its final administrative determination.

The cost of copying and mailing medical records required for the Review Center to provide reconsideration of its initial determination is the responsibility of the person or entity requesting the review.

Prospective and Concurrent Utilization Review Determinations

The following procedures apply to reviews of determinations made prior to or during the time medical services are rendered:

Step 1: Reconsideration

If the Review Center does not certify a requested medical service, the Plan Member, treating provider, or facility may request a reconsideration by the Review Center physician advisor. This request must be made within thirty (30) days of receipt of the initial notification of the utilization review determination for a particular medical service. This request may be made orally by calling 1-800-451-6780 or by a written request sent to:

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

New information, if available, should be submitted with a request for reconsideration. This may include:

- Additional test results or other diagnostic or qualitative information not provided with the initial request;
- Information regarding additional health concerns or other special circumstances which can impact or affect treatment decisions;
- Information about how proposed treatment impacts or affects functional capabilities or medical stability; or
- Information about changes in health status.

Reconsideration will be handled in the following manner:

- After reviewing all medical information received, the Review Center physician will discuss the proposed or ongoing treatment with the treating physician by telephone.
- The physician advisor will inform the treating physician whether the non-certification will be overturned or upheld.
- Written confirmation of the Review Center's determination regarding the request for reconsideration (reconsideration determination) will be issued to the Member and provider(s) within one (1) business day following the date the decision is made.

Step 2: Appeals

If the Review Center's determination is upheld following reconsideration review, the Plan Member, treating provider, or facility may request a second level of review, or Appeal, by a different physician advisor.

The Appeal process will follow the same procedures as in Step 1 above.

The Member, treating provider, or facility must request an Appeal within thirty (30) days of receipt of the reconsideration determination. This request may be initiated orally but must be immediately followed by a written request sent to the above address.

New information, if available and not submitted at the time the reconsideration was requested, should be submitted with a request for Appeal.

All relevant new information, examples of which are provided in Step 1 above, must be received no later than sixty (60) days after the initiation of the Appeal to be considered by the Review Center.

The review will be handled in the following manner:

- A different Review Center physician advisor will review the medical records received, with any additional information that may have been submitted, and make a determination.
- Written confirmation of the determination will be issued to the Member and provider(s) within thirty (30) days of receipt of any additional medical records that may be required.

Retrospective Utilization Review Determinations

The following procedures apply to reviews of determinations made after services have been rendered:

Step 1: Reconsideration

If the Review Center has not approved a request for a medical service that has already been received, the Plan Member, treating provider, or facility may request a reconsideration review by a Review Center physician advisor. This request for review must be made within thirty (30) days of receipt of the initial notification of the utilization review determination for a particular medical service and submitted in writing to:

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

New information, if available, should be submitted with a request for reconsideration. This may include:

- Additional test results or other diagnostic or qualitative information not provided with the initial request;
- Information regarding additional health concerns or other special circumstances which can impact or affect treatment decisions;
- Information about how the treatment impacts or affects functional capabilities or medical stability; or
- Information about changes in health status.

The review will be handled in the following manner:

- After reviewing all medical records received, a Review Center physician advisor will review the case and make a determination.

- Written confirmation of the Review Center's determination regarding the request for reconsideration (reconsideration determination) will be issued to the Member and provider(s) within one (1) business day following the date the decision is made.

Step 2: Appeals

If the Review Center's determination is upheld following reconsideration review, the Plan Member, treating provider, or facility may request a second-level review, or Appeal, by a different physician advisor.

The Plan Member, treating provider, or facility may only request an Appeal within thirty (30) days of receipt of the reconsideration determination. This request must be submitted in writing to the same address as in Step 1 above.

New information, if available and not submitted at the time the reconsideration was requested, should be submitted with a request for Appeal.

All relevant new information, examples of which are provided in Step 1 above, must be received no later than sixty (60) days after the initiation of the Appeal to be considered by the Review Center.

The review will be handled in the following manner:

- A different Review Center physician advisor will review the medical records received, with any additional information that may have been submitted, and make a determination.
- Written confirmation of the determination will be issued to the Member and provider(s) within thirty (30) days of receipt of any additional medical records that may be required.

Request for Administrative Review

Following a prospective, concurrent, or retrospective utilization review determination, if the Plan Member contests the Review Center's reconsideration determination after pursuing the matter through the Review Center's Appeal procedure, the Plan Member may request a final administrative determination from CalPERS within thirty (30) days using the procedure found on pages 91-92 of this booklet.

Objection to Denial of Experimental or Investigative Treatment

If services are denied because the Anthem Blue Cross Review Center determines that they are experimental or Investigational, an independent external review may be requested. You may request an independent review of a coverage decision for services that have been denied as being experimental or investigational if:

- You have a terminal condition;
- Your physician certifies that standard therapies have been ineffective or would be inappropriate; and
- Either your physician certifies in writing that the denied therapy is likely to be more beneficial than standard therapies, or you or your physician have requested a therapy that, based on documented medical and scientific evidence, is likely to be more beneficial than standard therapies.

You will be notified of the opportunity to request this review when services are denied.

PRESCRIPTION DRUG APPEAL PROCEDURE

CVS Caremark manages both the administrative and clinical prescription drug appeals process for CalPERS. If you wish to request a coverage determination, you may contact CVS Caremark's Customer Care at 1-877-542-0284, and they will provide you with instructions and the necessary forms to begin the process. Your request for a coverage determination must be made in writing to CVS Caremark. The written response you will receive back is known as an **initial determination**. When you receive this information, it will tell you how to appeal the initial determination in writing to CVS Caremark if you are not satisfied with the response. That appeal is a **first level appeal**. If the first level appeal is denied, you may then appeal a second time in writing and provide additional information for consideration. That is called a **second level appeal**. If the second level appeal is also denied by CVS Caremark, then you may pursue a **final voluntary administrative review** directly with CalPERS. The detailed information for the process is described below.

1. Denial of a Drug Requiring Approval Through Coverage Management Programs

You may request a second level of appeal for each medication denied through Coverage Management Programs within one-hundred eighty (180) days from the postmark date of the notice of initial benefit denial sent by CVS Caremark. Appeals should be directed to:

CVS Caremark
P. O. Box 52084
Irving, TX 75063 Phoenix, AZ 85072-2084
Fax: 1-866-689-3092

If you are dissatisfied with the second level determination made by CVS Caremark, you may request a final administrative review from CalPERS within thirty (30) days of receipt of your appeal denial letter by following the procedure set forth in the CalPERS Final Administrative Determination Procedure section on pages 91-92.

2. Partial Waiver of Non-Preferred Brand Copayment

You may request a partial waiver of the Non-Preferred brand-name medication copayment through CVS Caremark's first level appeals process by obtaining a letter from your physician that clearly attests to the necessity for the non-preferred product vs. the preferred product or available generic alternative. The physician's letter should document the reason(s) for the waiver as one or more of the following:

- The Member has not tolerated a preferred alternative (e.g. adverse reaction, allergy or sensitivity).
- The Member has failed an adequate trial (duration of at least two weeks) with a preferred alternative.
- The Member is already stable on the non-preferred drug, and transitioning to a preferred alternative would pose a clinical risk to the Member.

Submit your request for a partial waiver to:

CVS Caremark
P. O. Box 52084
Irving, TX 75063 Phoenix, AZ 85072-2084
Fax: 1-866-689-3092

CVS Caremark's coverage management staff will carefully review your waiver request, and you will be notified in writing of the outcome of your first level appeal. If the partial waiver request is approved, the Non-Preferred brand-name medication copayment will be partially waived, and you will be charged the Partial Waiver of Non-Preferred brand-name medication copayment for that specific Non-Preferred product for one year from the date of approval (see chart on page 59). If you wish to continue to receive the partial waiver at the end of the one year approval period, you will need to make a new request using the process noted above. To avoid paying an increased copayment, it is suggested that you submit your new request 30 days prior to the expiration of the previous approval.

Failure to attest to a supportable medical need for a Non-Preferred brand-name medication will result in denial of the partial waiver request. You may submit a second level appeal and provide additional information from your physician documenting the medical necessity of the Non-Preferred brand-name medication.

If you are dissatisfied with the determination made by CVS Caremark after a second level appeal, you may request a final administrative review from CalPERS within thirty (30) days of receipt of your appeal denial letter using the procedure set forth in the CalPERS Final Administrative Determination Procedure section on pages 91-92.

The Plan reserves the right to periodically re-evaluate the medical necessity of the partial waiver of the Non-Preferred Brand copayment. As part of this review, you may be required to submit information from your physician to support the continued necessity for the Non-Preferred Brand drug. Failure to submit this documentation in a timely manner can result in repeal of the partial waiver of the Non-Preferred Brand copayment, and you will be charged the applicable Non-Preferred Brand copayment.

3. Member Pays the Difference

The Member may request an authorization to obtain the brand name product, when medically necessary. See the section Prior Authorization/Point of Sale Utilization Review Program on page 65 on how to get an authorization.

4. 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 the Plan Member 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, the Member 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 the Plan Member in writing of the reason(s) for denial of the claim.

If you are dissatisfied with the second level determination made by CVS Caremark, you may request a final administrative review from CalPERS within thirty (30) days of your receipt of the denial letter using the procedure set forth in the CalPERS Final Administrative Determination Procedure section on the next following pages.

CalPERS FINAL ADMINISTRATIVE DETERMINATION PROCEDURE

If the Plan Member remains dissatisfied after the appeal procedures of the appropriate third-party administrator have been exhausted, the Member may appeal to the Board. This appeal must be submitted in writing to CalPERS within thirty (30) days from the postmark date of the administrator's final adverse benefit determination.

The appeal must be mailed to:

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

The appeal must set forth the facts and the law upon which the appeal is based. If the Plan Member has medical records from Non-Preferred Providers supporting the appeal, the records should be included with the written appeal request. The Plan Member should send **copies** of documents, not originals, as CalPERS is unable to return any documents. Providing supporting information to CalPERS is voluntarily. However, failure to provide such information may delay or preclude CalPERS in providing a final adverse benefit determination regarding the appeal. The time limit may be extended an additional thirty (30) days if good cause is shown; however, in no event will an appeal be accepted more than sixty (60) days after the postmark date of the Plan's final administrative determination.

Examples of what may be appealed include, but are not limited to:

- Failure to properly pay incurred expenses.
- Denial of approval for covered services.

Examples of what may not be appealed includes, but is not limited to:

- Medical malpractice.
- General exclusions listed on pages 68-74.

If CalPERS accepts the appeal, the following procedures apply.

1. Administrative Review

The Plan Member may present information described above or arguments in writing to support his or her position. CalPERS staff will attempt to resolve or address the Member's concern(s) in writing within thirty (30) days from the date all pertinent information is received by CalPERS.

2. Administrative Hearing

If a dispute remains following the Administrative Review process, the matter may proceed through the administrative hearing process. The Plan Member must request an Administrative Hearing within 30 days from the date of the Administrative Review. These hearings are conducted in accordance with the Administrative Procedure Act (Government Code section 11500 *et seq*.). These hearings are formal legal proceedings presided over by an Administrative Law Judge (ALJ), and Plan Members unrepresented by an attorney should become familiar with this law and its requirements if they choose to appeal to this level. The ALJ's Proposed Decision is not the final decision. The CalPERS Board of Administration must vote whether or not to adopt the Proposed Decision as its own decision at an open meeting. The Board's final decision will be provided to the Member.

3. Appeal Beyond Administrative Determination Procedure

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

CalPERS FINAL ADMINISTRATIVE DETERMINATION PROCEDURE

A Plan Member may not begin civil legal remedies until after the Plan Member has complied with these administrative procedures.

Summary of Process and Rights of Plan Members

- **Right to records, generally.** The Plan Member may, at his or her 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, the Plan Member may be represented by an attorney. If the Member chooses to be represented by an attorney, the Member must do so at his or her own expense. Neither CalPERS nor the administrator will provide an attorney or reimburse the Member for the cost of an attorney even if the Member prevails on appeal.
- **Right to experts and consultants.** At any stage of the proceedings, the Plan Member may present information through the opinion of an expert, such as a physician. If the Member chooses to retain an expert to assist in presentation of a claim, it must be at the Member's own expense. Neither CalPERS nor the administrator will reimburse the Member for the costs of experts, consultants or evaluations.

Service of Legal Process

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

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

MONTHLY RATES

State Employees and Annuitants

Type of Enrollment	Enrollment Code	Cost
Insured Only	0451	$463.12
Insured and One Dependent	0452	$926.24
Insured and Two or More Dependents	0453	$1,204.11

The rates shown above are effective January 1, 2012, 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 sixty (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, Yolo, and Yuba.

Type of Enrollment	Enrollment Code	Cost
Insured Only	0721	$487.39
Insured and One Dependent	0722	$974.78
Insured and Two or More Dependents	0723	$1,267.21

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

Type of Enrollment	Enrollment Code	Cost
Insured Only	0801	$429.22
Insured and One Dependent	0802	$858.44
Insured and Two or More Dependents	0803	$1,115.97

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	$446.68
Insured and One Dependent	0822	$893.36
Insured and Two or More Dependents	0823	$1,161.37

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	$474.74
Insured and One Dependent	0532	$949.48
Insured and Two or More Dependents	0533	$1,234.32

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

Type of Enrollment	Enrollment Code	Cost
Insured Only	0531	$453.39
Insured and One Dependent	0532	$906.78
Insured and Two or More Dependents	0533	$1,178.81

Out-of-California. PERS Select is not available to out-of-state employees and annuitants.

The rates shown above are effective January 1, 2012, 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 sixty (60) days' written notice to Plan subscribers.

DEFINITIONS

Accidental Injury — definite trauma resulting from a sudden, unexpected and unplanned event, occurring by chance, caused by an independent external source.

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

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 19) 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 — any public or private establishment with an organized medical staff of physicians; permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures; continuous physician services whenever a patient is in the facility; and which does not provide services or accommodations for patients to stay overnight.

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

Appeal — refers to the Member's right to request review of decisions relating to the Member's rights under the Plan. The term includes all of the following: the internal review should be in accordance with the grievance procedure in the Plan, the Plan's final administrative review by CalPERS; the fair hearing accorded by statute; and any administrative and judicial review thereof.

Balance Billing — a request for payment by a provider to a Member for the difference between Anthem Blue Cross or Blue Cross and/or Blue Shield Plan Allowable Amounts and the Billed Charges.

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 (Brand-Name Drug) — 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.

Chiropractic Services — chiropractic services billed by any licensed physician will apply toward the chiropractic benefit calendar year maximum.

Christian Science Hospital — only nursing homes and sanitariums which are approved by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.

Christian Science Nurses — only those Christian Science nurses approved as such by The First Church of Christ Scientist, in Boston, Massachusetts.

Christian Science Practitioners — only those Christian Science practitioners approved as such by the Board of Directors, The First Church of Christ Scientist, in Boston, Massachusetts, and listed in the Christian Science Journal.

DEFINITIONS

Chronic Care — treatment for an illness, injury or condition which does not require hospitalization (although confinement in a lesser facility may be appropriate), which may be expected to be of long duration, has no reasonably predictable date of termination, and may be marked by recurrence requiring continuous or periodic care as necessary.

Close Relative — the spouse, domestic partner, child, brother, sister or parent of a subscriber or family member.

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 3-8 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 Copayment and Coinsurance. 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 Copayment and Coinsurance Responsibility.

Congenital Anomaly — an abnormality present at birth.

Contract Period — the period of time from January 1, 2012, through December 31, 2012.

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 3-8 for a list of the Member's applicable Copayments for certain covered services. When using a Preferred Provider, the office visit Copayment will not accumulate towards satisfaction of the Calendar Year Deductible, nor will it apply to the Maximum Calendar Year Copayment and Coinsurance Responsibility.

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.

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.

Discretionary Drugs – drug products used to treat non-life threatening conditions like erectile dysfunction.

Drug — see definition under Prescription Drugs on page 102.

DEFINITIONS

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.

Elective (Non-emergency) Services — services provided when the patient's condition permits adequate time to schedule the necessary diagnostic work-up and/or initiation of treatment.

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 the Act and Regulations.

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

Experimental or Investigational — any treatment, therapy, procedure, drug or drug usage, 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, or treatment is experimental or investigational will be resolved by Anthem Blue Cross, which will have full discretion to make such determination on behalf of the Plan and its participants.

Family Member — an employee's or annuitant's spouse or domestic partner and any child including an adopted child, a stepchild, or recognized natural child.

FDA — U.S. Food and Drug Administration.

Generic Medication (Generic Drug) — 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.

Incurred Charge — a charge shall be deemed "incurred" on the date the particular service or supply is provided or obtained.

Infusion Center — Any location, licensed according to state and local laws, in which medically necessary intravenous prescription drugs are administered.

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.

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 — see Prescription Drug.

Member — see definition under Plan Member.

DEFINITIONS

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 to locate a Participating Pharmacy.

Non-Preferred Brand-Name Medication — Medications not listed on your printed CVS Caremark 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. 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 (e.g. an individual physician) who bills Anthem Blue Cross using the code for a Non-Preferred Provider (e.g. medical group) for a service rendered on a specific date shall be considered a Non-Preferred Provider for that service on that date. An individual Preferred Provider may be considered a Non-Preferred Provider if services are rendered outside the geographic area 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.

Open Enrollment Period — a period of time established by the CalPERS Board of Administration during which eligible employees and annuitants may enroll in a health benefits plan, add family members, or change their enrollment from one health benefits plan to another without any additional requirements.

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 Facility — a licensed facility, other than a physician's office or hospital, that provides medical and/or surgical services on an outpatient basis.

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.

DEFINITIONS

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 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 (the plan administrator and insurer) through contracts with third-party administrators: Anthem Blue Cross and CVS Caremark.

Plan Member — any employee, annuitant or family member enrolled in PERS Select.

Plastic Surgery — surgery to correct congenital or developmental abnormalities or characteristics which are outside the broad range of normal.

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 — 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.

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 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.

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 in the geographic area set forth in the Participating Provider Agreement, and bills Anthem Blue Cross 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 (licensed prescriber) — a licensed health care provider with the authority to prescribe medication.

Prescription — 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 licensed prescriber; (3) insulin; (4) hypodermic needles and syringes if prescribed by a licensed 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 — the request for each separate drug or medication by a licensed prescriber and each authorized refill of such request.

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 Care — psychoanalysis, psychotherapy, counseling or other care most commonly provided by a psychiatrist, psychologist, licensed clinical social worker, or marriage, family and child counselor to treat a nervous or mental disorder, or to treat mental or emotional problems associated with illness or injury.

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.

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 22-26).

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.

Self-administered injectables — medications available in injectable drug form and considered suitable for patient self-administration.

Services — includes medically necessary health care services and medically necessary supplies furnished incident to those services.

DEFINITIONS

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 Drugs – 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.

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 in Absentia — Christian Science practitioners or nurses rendering services, such as consultation or prayer, via the telephone.

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 — is the services received for a sudden, serious, or unexpected 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.

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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PER-0112-SEL

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