Supplement to Original Medicare Plan

Preferred Provider Organization

Evidence of Coverage

Effective January 1, 2015 – December 31, 2015

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

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.

MEDICARE

For information regarding your Medicare benefits, Medicare & You handbook, claims or correspondence, call or visit online:

Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

1-800-MEDICARE
1-800-633-4227
www.medicare.gov

CUSTOMER SERVICE

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

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

MEDICAL CLAIMS AND CORRESPONDENCE

Please mail your medical claims and correspondence to:

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

MEDICARE PART D - PRESCRIPTION DRUG PROGRAM

For information regarding your prescription drug coverage, refer to your PERSCare Medicare Part D Prescription Drug Plan EOC, call or visit on-line:

CVS Caremark
1-855-479-3660 (worldwide available 9/7/12)
1-800-863-5488 (TDD)
Web site: www.caremark.com/calpers

For information regarding Protected Health Information:

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

ELIGIBILITY AND ENROLLMENT

For information concerning eligibility and enrollment, contact the Health Benefits Officer at your agency (active) or the California Public Employees' Retirement System (CalPERS) 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)

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 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.

ADDRESS CHANGE

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

Retirees: To report an address change, retirees may contact CalPERS by phone at **888 CalPERS** (or **888**-225-7377), or on-line at www.calpers.ca.gov, select **Forms & Publications Center** and print and submit Change of Address Form to:

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

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.

PERSCare SUPPLEMENTAL PLAN
MEMBERSHIP DEPARTMENT

For direct payment of premiums, contact:

PERSCare Supplemental Plan
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.)

PERSCare SUPPLEMENTAL PLAN WEB SITE

Visit our Web site at:

www.calpers.ca.gov

PERSCare Supplemental Plan

This PERSCare Supplement to Original Medicare Plan (PERSCare Supplemental Plan) is designed for Members enrolled in the California Public Employees' Retirement System's (CalPERS) health benefits program who are also enrolled in both Parts A (hospital insurance) and B (medical insurance) of Medicare. The Plan is in addition to a Medicare Part D Prescription Drug Plan offered by CVS Caremark and described in a separate EOC. Benefits under the PERSCare Supplemental Plan are provided **ONLY** for services and supplies that Medicare determines to be allowable and Medically Necessary, except as specifically stated under the sections Benefits Beyond Medicare and Vision Care Benefit.

If you choose to get care from a provider who does not participate in the Medicare program, Medicare and this Plan will not pay for the services and supplies provided by that provider. You will have to pay whatever the provider charges you for his or her services. (For information on Medicare benefits, please refer to the *Medicare & You* handbook or call your nearest Social Security office.)

As a PERSCare Supplemental Plan Member, you are responsible for meeting the requirements of the PERSCare Supplemental Plan. Lack of knowledge of, or lack of familiarity with, the information contained in this Evidence of Coverage booklet does not serve as an excuse for noncompliance. Please take the time to familiarize yourself with this booklet and *Medicare & You*.

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 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 the Plan are subject to change and an Addendum or a new Booklet will be issued for viewing and/or distributed to each Member affected by the change. The latest Addenda and Booklet can be obtained through the website at www.anthem.com/ca/calpers, or you can call Customer Service at 1-877-737-7776.

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

Claim information can be used by Anthem Blue Cross 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 who can address your health care questions by calling 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. Be prepared to provide your name, the patient's name (if you are 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.
- 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. They are not a substitute for your physician's care.

LANGUAGE ASSISTANCE PROGRAM

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

The Language Assistance Program makes it possible for you to access oral interpretation services and certain written materials vital to understanding your health coverage at no additional cost to you.

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

- Spanish
- Chinese
- Vietnamese
- Korean
- Tagalog

Oral interpretation services are available in additional languages.

To request a written or oral translation, please contact Anthem Blue Cross Customer Service Department at 1-877-737-7776 to update your language preference to receive future translated documents or to request interpretation assistance.

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

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BENEFIT AND ADMINISTRATIVE CHANGES

The following is a brief summary of administrative changes that will take effect January 1, 2015.

- **Individual Conversion Plan** – This provision has been deleted in its entirety. Due to the creation of health insurance marketplaces ("Exchanges") under the Patient Protection and Affordable Care Act where individuals can purchase health insurance coverage, this benefit is no longer available.

- **Mental Health services and supplies** – This provision has been modified to remove limitations for these benefits and to clarify that both inpatient and outpatient services will be covered beyond what Medicare provides if authorized by Anthem Blue Cross' Review Center as Medically Necessary.

PERSCare SUPPLEMENT TO ORIGINAL MEDICARE PLAN - SUMMARY OF BENEFITS

ONLY services and supplies that Medicare determines to be allowable and Medically Necessary are covered under this PERSCare Supplement Plan. The following chart is only a summary of benefits under your PERSCare Supplemental Plan. Please refer to pages 8-9 for a detailed description of how Supplement to Original Medicare Benefits are paid. Payments applicable to Benefits Beyond Medicare are described on pages 10-16. Please review this Evidence of Coverage and *Medicare & You* (the handbook describing Medicare benefits at www.medicare.gov/Publications) for specific information on benefits, limitations and exclusions.

Benefit Category	Medicare Pays	Member Pays
Acupuncture	See Medicare Handbook	20%† (20 visits per Calendar Year.)
Ambulance	See Medicare Handbook	No charge — If Medicare-approved.*
Biofeedback	See Medicare Handbook	No charge — If Medicare-approved.*
Blood Replacement	See Medicare Handbook	20%†
Chiropractic	See Medicare Handbook	No charge — If Medicare-approved.*
Christian Science Treatment	See Medicare Handbook	No charge — If Medicare-approved.*
Diabetes Services** Glucose monitors, test strips, lancets, etc.	See Medicare Handbook	No charge — If Medicare-approved.*†
Diabetes Self-Management Training	See Medicare Handbook	No charge — If Medicare-approved.*
Diagnostic X-Ray/Laboratory	See Medicare Handbook	No charge — If Medicare-approved.*
Durable Medical Equipment**	See Medicare Handbook	No charge — If Medicare-approved.*
Emergency Care/Services Under certain conditions, Medicare helps pay for emergency outpatient care provided by non-participating hospitals.	See Medicare Handbook	No charge — If Medicare-approved.*

* **Important Note:** The term "No charge" above applies when benefits are payable by Medicare and you use a provider who accepts Medicare assignment (i.e., covered services will be paid in full). However, if you use a provider who does *not* accept Medicare assignment, you may be responsible for balances remaining after payment has been made by the PERSCare Supplemental Plan. See pages 8-9 for important information regarding Plan payments.

† For this service, a Benefit Beyond Medicare is also available. Please see the "Benefits Beyond Medicare" section of this booklet for details. In brief, in the specified situation, when benefits are not covered by Medicare, the Plan will pay 80% of allowed charges if you use an Anthem Blue Cross Preferred Provider. However, if you use a Non-Preferred Provider, the Plan will pay 80% of the Allowable Amount as determined by Anthem Blue Cross, and your responsibility will be 20% of the Allowable Amount plus any charges in excess of the Allowable Amount. See page 13 for important information regarding Plan payments.

** For Members who are eligible, services and certain drugs may be covered as described in your CVS Caremark Medicare Part D Prescription Drug Plan as described in that Plan's Evidence of Coverage booklet or as described elsewhere in this Evidence of Coverage booklet.

PERSCare SUPPLEMENT TO ORIGINAL MEDICARE PLAN - SUMMARY OF BENEFITS

Benefit Category	Medicare Pays	Member Pays
Hearing Aid Services The hearing aid (monaural or binaural), including ear mold(s), the hearing aid instrument, initial battery cords, and other ancillary equipment, is subject to a maximum payment of two thousand dollars ($2,000) per Member once every twenty-four (24) months.	See Medicare Handbook	20% of Anthem Blue Cross' Allowable Amount.†
Heart Transplants	See Medicare Handbook	No charge — If Medicare-approved.*
Home Health Services Medically necessary services obtained through a licensed home health agency.	See Medicare Handbook	No charge — If Medicare-approved.*
Hospice Care	See Medicare Handbook	No charge — If Medicare-approved.*
Hospital		
Inpatient	See Medicare Handbook	No charge — If Medicare-approved.*†
Outpatient**	See Medicare Handbook	No charge — If Medicare-approved.*†
Kidney Dialysis and Transplants	See Medicare Handbook	No charge — If Medicare-approved.*
Mental Health (may include treatment of substance abuse if Medicare-approved)		
Inpatient	See Medicare Handbook	No charge — If Medicare-approved.*†
Outpatient	See Medicare Handbook	Excess charges.*† (Medicare pays 50% of the approved amount for most services.)
Occupational Therapy	See Medicare Handbook	No charge — If Medicare-approved.†
Physical Therapy	See Medicare Handbook	No charge — If Medicare-approved.†

* **Important Note:** The term "No charge" above applies when benefits are payable by Medicare and you use a provider who accepts Medicare assignment (i.e., covered services will be paid in full). However, if you use a provider who does *not* accept Medicare assignment, you may be responsible for balances remaining after payment has been made by the PERSCare Supplemental Plan. See pages 8-9 for important information regarding Plan payments.

† For this service, a Benefit Beyond Medicare is also available. Please see the "Benefits Beyond Medicare" section of this booklet for details. In brief, in the specified situation, when benefits are not covered by Medicare, the Plan will pay 80% of allowed charges if you use an Anthem Blue Cross Preferred Provider. However, if you use a Non-Preferred Provider, the Plan will pay 80% of the Allowable Amount as determined by Anthem Blue Cross, and your responsibility will be 20% of the Allowable Amount plus any charges in excess of the Allowable Amount. See page 13 for important information regarding Plan payments.

** For Members who are eligible, services and certain drugs may be covered as described in your CVS Caremark Medicare Part D Prescription Drug Plan as described in that Plan's Evidence of Coverage booklet or as described elsewhere in this Evidence of Coverage booklet.

PERSCare SUPPLEMENT TO ORIGINAL MEDICARE PLAN - SUMMARY OF BENEFITS

Benefit Category	Medicare Pays	Member Pays
Physician Visits**		
Office/Home/Hospital Visits	See Medicare Handbook	No charge — If Medicare-approved.*
Allergy Testing/Treatment		
Podiatrists' Services**	See Medicare Handbook	No charge — If Medicare-approved.*
Preventive Care		
Gynecological Exam (Pap test)	See Medicare Handbook	No charge — If Medicare-approved.*
Immunization/Inoculation	See Medicare Handbook	No charge — If Medicare-approved.*†
Skilled Nursing Care**		
Up to 100 days each benefit period in a Medicare-approved facility.	See Medicare Handbook	No charge — If Medicare-approved.*
From 101 to 365 days.		20% of Anthem Blue Cross' Allowable Amount.† (Must be precertified by Anthem Blue Cross – see pages 12-13.)
Speech Therapy	See Medicare Handbook	No charge — If Medicare-approved.† ($5,000 lifetime maximum per Member)
Smoking Cessation Program		
Up to $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.	See Medicare Handbook	20% of Anthem Blue Cross' Allowable Amount.†

* **Important Note:** The term "No charge" above applies when benefits are payable by Medicare and you use a provider who accepts Medicare assignment (i.e., covered services will be paid in full). However, if you use a provider who does *not* accept Medicare assignment, you may be responsible for balances remaining after payment has been made by the PERSCare Supplemental Plan. See pages 8-9 for important information regarding Plan payments.

† For this service, a Benefit Beyond Medicare is also available. Please see the "Benefits Beyond Medicare" section of this booklet for details. In brief, in the specified situation, when benefits are not covered by Medicare, the Plan will pay 80% of allowed charges if you use an Anthem Blue Cross Preferred Provider. However, if you use a Non-Preferred Provider, the Plan will pay 80% of the Allowable Amount as determined by Anthem Blue Cross and your responsibility will be 20% of the Allowable Amount and any charges in excess of the Allowable Amount. See page 13 for important information regarding Plan payments.

** For Members who are eligible, services and certain drugs may be covered as described in your CVS Caremark Medicare Part D Prescription Drug Plan as described in that Plan's Evidence of Coverage booklet or as described elsewhere in this Evidence of Coverage booklet.

PERSCare SUPPLEMENT TO ORIGINAL MEDICARE PLAN - SUMMARY OF BENEFITS

Benefit Category	Medicare Pays	Member Pays
Vision Care One exam and two lenses per Calendar Year. One set of frames during a 24-month period. Maximum Allowance Exam.....$35 Frames.....$30 Each lens: Single Vision .....$20 Bifocal .....$35 Trifocal .....$45 Lenticular .....$50 Contact Lenses.....$100	Not Covered by Medicare	Any amount in excess of the Maximum Allowance

INTRODUCTION

Welcome to the PERSCare Supplemental Plan!

This PERSCare Supplement to Original Medicare Plan (PERSCare Supplemental Plan) is designed for Members enrolled in the California Public Employees' Retirement System's (CalPERS) health benefits program who are also enrolled in both Parts A (hospital insurance) and B (medical insurance) of Medicare. This Plan is in addition to a Medicare Part D Plan offered by CVS Caremark and described in a separate EOC. Medicare Part A is hospital insurance that helps cover inpatient care in hospitals, skilled nursing facilities, and hospices, in addition to home health care. Medicare Part B helps cover preventive care services and Medically Necessary services like doctors' visits, outpatient care, home health services, and other medical services. Check your Medicare card to find out if you have Part B. Medicare Part D covers prescription drugs and is administered by CVS Caremark. **You are not allowed to enroll in a Part D prescription drug plan that is not part of a CalPERS approved health benefit plan and remain enrolled in the PERSCare Supplement to Original Medicare Plan. If you choose to opt out of the CVS Caremark Medicare Part D Prescription Drug Plan, you will lose your Medicare Part D prescription drug coverage, and you will be responsible for all of your prescription drug costs.**

After you or your eligible family members are enrolled in this Plan, you may not change enrollment to a Basic Plan unless (1) there is an involuntary termination of your Medicare benefits or (2) you move, other than temporarily, outside the United States as defined in the Federal Social Security Act. If you voluntarily cancel Part B of Medicare, you will not be eligible for a Basic Plan, nor will you be allowed to remain in this Plan.

A family group member, including a person enrolled in this PERSCare Supplemental Plan, who is not eligible for Medicare and continues in the PERSCare Basic Plan must enroll in this Plan when he or she is eligible to enroll in Medicare.

A Notice of Creditable Coverage documents your coverage under the PERSCare Supplemental Plan. However, you should be aware that, if you have a subsequent break in this coverage of 63 days or more before enrolling in Part D, you could be subject to payment of higher Part D premiums. You may request a copy of a Notice of Creditable Coverage by calling the CVS Caremark Customer Service Department at 1-855-479-3660.

Please note that this Plan does not cover custodial care in any facility or situation, including a skilled nursing facility.

As a PERSCare Supplemental Plan Member, you are responsible for meeting the requirements of the PERSCare Supplemental Plan. Lack of knowledge of, or lack of familiarity with, the information contained in this Evidence of Coverage booklet does not serve as an excuse for noncompliance. Please take the time to familiarize yourself with this booklet and *Medicare & You*.

Thank you for joining PERSCare Supplemental Plan.

PERSCare Supplemental Plan Identification Card

Following enrollment as a PERSCare Supplemental Plan Member, you will receive a PERSCare Supplemental Plan ID card. To receive medical services as described in the Plan, please present your ID Card to each provider of service. If you need a replacement card, call the Anthem Blue Cross Customer Service Department at 1-877-737-7776.

Possession of a PERSCare Supplemental Plan ID card confers no right to services or 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.

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.

MEDICARE & YOU

Each year the U.S. Department of Health and Human Services publishes a Medicare handbook entitled *Medicare & You*. This handbook outlines the benefits Medicare provides and includes any changes in deductibles, coinsurance, or benefits that may occur from year to year. To obtain a copy, contact your nearest Social Security office, visit the Web site **www.medicare.gov**, call 1-800-MEDICARE or write to:

Medicare Publications
Department of Health and Human Services
Centers for Medicare & Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244-1850

A directory of physicians who accept Medicare assignment (Medicare Provider Directory) can also be obtained from the Department of Health and Human Services at the above address.

Please refer to page 9 of this Evidence of Coverage booklet for a description of the difference in benefit payments using a provider who accepts Medicare assignment and a provider who does not accept Medicare assignment. It is your responsibility to confirm with your provider whether or not he or she accepts Medicare assignment prior to receiving services.

Some providers do not participate in Medicare. If you choose to get care from a provider who has decided not to participate in, or has been excluded from, the Medicare program, Medicare and this Plan will not pay for services provided by that provider. You will have to pay whatever the provider charges you for his or her services.

Claim-Free Service

As a PERSCare Supplemental Plan Member, you may enroll in a claims filing program called the *Claim-Free* program. Your enrollment in the *Claim-Free* program means that you need not file a paper claim yourself for Supplement to Original Medicare professional and hospital benefits as long as your provider billed Medicare directly.

NOTE: The *Claim-Free* program does not apply to the "Benefits Beyond Medicare" listed on pages 11-13. See page 13 for more information on how to obtain reimbursement for those benefits.

Once enrolled in the *Claim-Free* program, your Supplement to Original Medicare benefits will automatically be paid through Anthem Blue Cross' *Claim-Free* process, which makes it possible for Anthem Blue Cross plans to electronically obtain Medicare claims data directly from Medicare claims processors.

To enroll in the *Claim-Free* program, return the postcard that will be sent to you automatically once you are enrolled in the PERSCare Supplemental Plan. You may also call Anthem Blue Cross at 1-877-737-7776 to enroll. Please make sure you have your Medicare card available when you place the call.

You may disenroll from the *Claim-Free* program for any reason by calling Anthem Blue Cross at 1-877-737-7776. Make sure you have your Medicare card available when you place the call. If you choose to disenroll in the Claim-Free program, you will need to submit your claims to Medicare as discussed on the next page.

Supplement to Original Medicare Benefits

Subject to benefits being covered by Medicare while you are enrolled under the PERSCare Supplemental Plan, the PERSCare Supplemental Plan will pay the amounts shown below under *Plan Payments* for Medically Necessary services and supplies furnished for the diagnosis or treatment of illness, pregnancy, or accidental injury. The date on which a service or supply is furnished will be deemed the date on which the expense was incurred or the charge made.

If you choose to get care from a provider who does not participate in the Medicare program, Medicare and this Plan will not pay for the services and supplies provided by that provider. You will have to pay whatever the provider charges you for his or her services. (For information on Medicare benefits, please refer to the *Medicare & You* handbook or call your nearest Social Security office.)

Hospital Benefits (Part A)

If you are not enrolled in the *Claim-Free* program, you should present your PERSCare Supplemental Plan ID card along with your Social Security Medicare ID card at the hospital admissions desk. The hospital may bill Anthem Blue Cross for benefits under your PERSCare Supplemental Plan after they have received payment from Medicare. You should discuss billing procedures with the hospital's billing office.

If you do not have your PERSCare Supplemental Plan ID card when you enter the hospital or if the status of your contract is questioned, ask the hospital to contact Anthem Blue Cross at 1-877-737-7776.

Medical Benefits (Part B)

If you are not enrolled in the *Claim-Free* program, you must first submit all medical claims to Medicare.

After Medicare has processed your claim, you will receive a Medicare Summary Notice statement. Write your member number and group number (from your PERSCare Supplemental Plan ID card) on the Medicare Summary Notice statement, then mail it and a copy of the itemized bill for the services received to:

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

Prescription Drug Benefits (Part D)

If you are enrolled in the CVS Caremark Medicare Part D Prescription Drug Plan refer to your Medicare Part D Prescription Drug Coverage EOC or contact:

CVS Caremark
445 Great Circle Road
Nashville, TN 37228

The PERSCare Supplemental Plan will make supplemental payments as described below.

Payments for services covered by this Plan may be paid to you or directly to the provider, if he or she is a Physician Member (see definition on page 43).

Payment of Supplement to Original Medicare Benefits

Deductibles

When a Member is receiving concurrent benefits from Medicare, the PERSCare Supplemental Plan pays one hundred percent (100%) of the Medicare Part A and B deductibles.

Plan Payments

When a Member is receiving concurrent benefits from Medicare, the PERSCare Supplemental Plan payments for covered charges are provided according to whether the provider participates in the Medicare program and accepts Medicare assignment or not. The following illustrates how PERSCare Supplemental Plan payments will be determined.

*If the provider participates in Medicare and **accepts Medicare** assignment:*	*If the provider participates in Medicare and **DOES NOT accept Medicare** assignment:*	*If the provider **DOES NOT participate** in Medicare:*
The PERSCare Supplemental Plan payment is limited to one hundred percent (100%) of the difference between the amount paid by Medicare and Medicare's approved amount. See notes 1 and 2 below.	The PERSCare Supplemental Plan payment is limited to one hundred percent (100%) of the Medicare Limiting Amount (defined on page 43), less the amount paid by Medicare for covered charges. See notes 1 and 3 below.	Medicare and this Plan do not pay. The total provider charges are the Member's responsibility to pay. See note 4 below.

For information on Medicare assignment, please refer to the *Medicare & You* handbook.

NOTES:

1. With regard to professional services and supplies, the PERSCare Supplemental Plan payment plus the Medicare payment will be accepted as payment in full by Anthem Blue Cross Physician Members. Whether they accept Medicare assignment or not, Anthem Blue Cross Physician Members will not bill Members for amounts exceeding Medicare's approved amount. Members remain responsible for charges for services and supplies that are not covered by Medicare or the PERSCare Supplemental Plan.

2. With regard to professional services and supplies, The PERSCare Supplemental Plan plus the Medicare payment will be accepted as payment in full by providers who are not Anthem Blue Cross Physician Members but who **DO** accept Medicare assignment. Such providers may not bill Members for charges in excess of Medicare's approved amount. Members remain responsible for charges for services and supplies that are not covered by Medicare or the PERSCare Supplemental Plan.

3. With regard to professional services and supplies, Plan Members are responsible for any difference between the combined amount paid by the PERSCare Supplemental Plan and Medicare and the charges billed by providers who are not Anthem Blue Cross Physician Members and who do not accept Medicare assignment, within the limits of applicable law. Such providers may bill Members for the balance of any unpaid charges and for services and supplies that are not covered by Medicare or the PERSCare Supplemental Plan.

4. Some providers do not participate in Medicare. Plan Members will be responsible for the total charges billed by providers who do not participate in the Medicare program.

BENEFITS BEYOND MEDICARE

Benefits Beyond Medicare Summary

Benefits for “Benefits Beyond Medicare” will be determined at the same time your Supplement to Original Medicare benefits are determined for services and supplies covered under both parts of the Plan.

To obtain reimbursement for those services and supplies that are a benefit only of your “Benefits Beyond Medicare” coverage, submit copies of your bills, properly identified, to:

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

No claim forms are necessary.

Bills submitted should include:

The statement “Benefits Beyond Medicare”	The Medicare ID number & the Medicare effective date
Subscriber’s name	Date(s) of service
Subscriber ID / Member number	Diagnosis
Group number	Type(s) of service
Patient’s name	Provider’s name & tax ID number
Patient’s date of birth	Amount charged for each service
Patient’s date of injury/illness	Patient’s other insurance information

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.

To receive reimbursement for **Vision Care Benefits,** refer to pages 15-16 for the mailing address and other information.

Claims Review for Benefits Beyond Medicare

The PERSCare Supplemental Plan reserves the right to review all claims and medical records to determine whether any exclusions or limitations apply.

BENEFITS BEYOND MEDICARE

Benefits Beyond Medicare Detail

The PERSCare Supplemental Plan will provide the following coverage for Medically Necessary services and supplies when a Plan Member's benefits under Medicare are exhausted, or when charges for the services and supplies outlined in this section exceed amounts covered by Medicare:

1. **Acupuncture or acupressure services** provided by any health professional qualified to perform acupuncture or acupressure, subject to a maximum payment of twenty (20) visits per Calendar Year.

2. **Blood replacement.** The first three (3) pints of blood when disallowed by Medicare and unreplaced.

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

   No payment will be made for overnight stays in a Christian Science nursing facility.

4. **Hearing aid services as follows:**

   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.

   The hearing aid (monaural or binaural), including ear mold(s), the hearing aid instrument, initial battery cords, and other ancillary equipment, is subject to a maximum payment of two thousand dollars ($2,000) per Member once every twenty-four (24) months. The Plan provides payment of up to two thousand dollars ($2,000) regardless of the number of hearing aids purchased. 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.

   The following are excluded under the Plan:

   1. Purchase of hearing aid batteries or other ancillary equipment, except those covered under the terms of the initial hearing aid purchase.
   2. Charges for a hearing aid which exceeds specifications prescribed for correction of hearing loss.
   3. Replacement parts for hearing aids or repair of hearing aids after the covered one-year warranty period.
   4. Replacement of a hearing aid more than once in any period of twenty-four (24) months.
   5. Surgically implanted hearing devices.

5. **Hospital services and supplies – Inpatient and Outpatient.** (Mental health benefits are described separately below).

   a. **Inpatient hospital services and supplies beyond the benefit period as specified by Medicare in the Medicare handbook *Medicare & You*.** After the Member has exhausted the benefit period specified by Medicare, additional inpatient hospital days may be authorized.

      Admission and services for inpatient hospital must be reviewed by Anthem Blue Cross' Review Center and precertified as Medically Necessary. To initiate this review, call the Review Center at 1-800-451-6780 no later than one month **before** the benefit period specified by Medicare has ended. If the Review Center determines that the inpatient hospital stay is not Medically Necessary, the Review Center will advise the treating physician and the patient, or a person designated by the patient, that coverage will not be guaranteed. 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. Failure to obtain the required precertification may result in increased Member payment responsibility and/or denial of benefits.

If you have any questions concerning the Review Center's decisions regarding your treatment plan, call the Review Center's coordinator who managed your care at 1-800-451-6780. If you do not agree with any portion of the Review Center's final determination, you or your physician may appeal this decision by following the Medical Claims Review And Appeals Process described on pages 31-33.

b. **Outpatient hospital services and supplies.** Medically Necessary diagnostic, therapeutic and/or surgical services performed at a hospital's outpatient department or outpatient facility.

6. **Immunizations.** Age-appropriate routine immunizations recommended by the Advisory Committee on Immunization Practices. Discuss your immunization needs with your physician.

7. **Lancets** and lancing devices for the self-administration of blood tests to monitor a covered condition (e.g., checking blood glucose level for self-management of diabetes).

8. **Mental health services and supplies.**

   a. **Inpatient hospital services and supplies beyond the benefit period as specified by Medicare in the Medicare handbook *Medicare & You*.** After the Member has exhausted the benefit period specified by Medicare, additional inpatient hospital days may be authorized.

      Admission and services for inpatient hospital must be reviewed by Anthem Blue Cross' Review Center and precertified as Medically Necessary. To initiate this review, call the Review Center at 1-800-451-6780 no later than one month **before** the benefit period specified by Medicare has ended. If the Review Center determines that the inpatient hospital stay is not Medically Necessary, the Review Center will advise the treating physician and the patient, or a person designated by the patient, that coverage will not be guaranteed. 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. Failure to obtain the required precertification may result in increased Member payment responsibility and/or denial of benefits.

   b. **Outpatient Services**

      Outpatient services and supplies beyond the benefits as specified by Medicare in the Medicare handbook *Medicare & You*. After the Member has exhausted the benefits specified by Medicare, additional outpatient services and supplies may be authorized.

      Outpatient services and supplies for mental health care must be reviewed by Anthem Blue Cross' Review Center and precertified as Medically Necessary. To initiate this review, call the Review Center at 1-800-451-6780 no later than one month **before** the authorization period for services and supplies specified by Medicare has ended. If the Review Center determines that the outpatient services and supplies are not Medically Necessary, the Review Center will advise the treating physician and the patient, or a person designated by the patient, that coverage will not be guaranteed. 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. Failure to obtain the required precertification may result in increased Member payment responsibility and/or denial of benefits.

9. **Physical or Occupational Therapy.** Services provided by a licensed provider for treatment of an acute condition upon referral by a physician.

10. **Skilled Nursing.**

    Semi-private room charges for skilled nursing facility stays, from the 101st through the 365th day during each benefit period. After exhaustion of benefits under this Plan during a benefit period, the Member must again qualify under Medicare and receive benefits from Original Medicare before the Plan's coverage will commence. An additional 265 days will not be approved unless a new benefit period has been established by Medicare and Medicare has determined the stay to be Medically Necessary.

Admission and services in connection with confinement in a skilled nursing facility must be reviewed by Anthem Blue Cross' Review Center and precertified as Medically Necessary after the first 100 days. To initiate this review, call the Review Center at 1-800-451-6780 no later than one month **before** the first 100 days in the benefit period have ended. If the Review Center determines that the skilled nursing facility stay is not Medically Necessary, the Review Center will advise the treating physician and the patient, or a person designated by the patient, that coverage will not be guaranteed. 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. Failure to obtain the required precertification may result in increased Member payment responsibility and/or denial of benefits.

If you have any questions concerning the Review Center's decisions regarding your treatment plan, call the Review Center's coordinator who managed your care at 1-800-451-6780. If you do not agree with any portion of the Review Center's final determination, you or your physician may appeal this decision by following the Medical Claims Review And Appeals Process described on pages 31-33.

NOTE: Benefits are not payable for custodial care whether alone or in conjunction with other Medically Necessary services.

11. **Speech Therapy.** Services provided by a licensed provider limited to a lifetime maximum payment of five thousand dollars ($5,000) per Plan Member.

12. **Smoking Cessation Programs** 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. A legible copy of dated receipts for expenses must be submitted along with a claim form to Anthem Blue Cross to obtain reimbursement.

Payment of Benefits Beyond Medicare

Covered charges applicable to Benefits Beyond Medicare will be payable as follows:

1. PERSCare Supplemental Plan pays eighty percent (80%) of covered charges. Plan Members are responsible to pay the remaining twenty percent (20%) copayment, any charges in excess of the Allowable Amount for covered services received from Non-Preferred Providers, plus all charges for non-covered services. Please see Payment Example (Benefits Beyond Medicare) on the next page.

2. Your maximum copayment responsibility is three thousand dollars ($3,000) each Calendar Year. However, the following Plan Member out-of-pocket expenses will not be included in calculating your three thousand dollars ($3,000) maximum copayment responsibility:

   - expenses for vision care benefits.
   - copayments for services from Non-Preferred Providers.

   After you have paid your three thousand dollars ($3,000) copayment, PERSCare Supplemental Plan will pay one hundred percent (100%) for any additional covered charges, excluding charges for vision care incurred by you during the same Calendar Year. **Important Note: You remain responsible for costs in excess of the Allowable Amount for covered services received from Non-Preferred Providers, costs in excess of any specified Plan maximums, and for services or supplies which are not covered under this Plan.** Please see Payment Example (Benefits Beyond Medicare) on the next page.

NOTE: Payments for all covered services are based on the Allowable Amount for such services, as defined on page 41.

BENEFITS BEYOND MEDICARE

Payment Example (Benefits Beyond Medicare)

	Preferred Provider	**Non-Preferred Provider**
Billed Charge – the amount the provider actually charges for a covered service provided to a Member	$180,000	$180,000
Allowable Amount – the allowance or negotiated amount under the Plan for service provided (see definition on page 41). Note: This is only an example. Allowable amount varies according to procedure and geographic area.	$90,000	$90,000
Coinsurance – the percentage of Allowable Amount the Member pays	$3,000 (20% of Allowable Amount until maximum coinsurance met)	$3,000 (20% of Allowable Amount until maximum coinsurance met)
Plan Payment – the percentage of Allowable Amount the Plan pays	$87,000 (80% of Allowable Amount until maximum copayment or coinsurance met, then 100%)	$87,000 (80% of Allowable Amount until maximum copayment or coinsurance met, then 100%)
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)	$90,000 (Non-Preferred Provider can bill the Member for the difference between Allowable Amount and Billed Charges)
Total Amount the Member Is Responsible To Pay	**$3,000**	**$93,000**

VISION CARE BENEFITS

Vision Care

For California Residents

If you are a California resident, your routine vision care benefits are administered by Vision Service Plan (VSP). To receive maximum benefits under this Plan, make sure your vision care provider is a VSP participating provider. VSP participating providers have agreed to discounted fee arrangements which should reduce your out-of-pocket expenses. VSP participating providers will obtain an authorization number on your behalf and will submit claims to VSP after you have received services.

To locate a VSP participating provider near you, call VSP at 1-800-877-7195 or visit the Web site at www.vsp.com.

You are not restricted to using VSP participating providers. If you choose to receive services from a non-participating provider, you must pay the bill at the time you receive the services and then request reimbursement from VSP.

To obtain reimbursement directly from VSP, submit a copy of an itemized bill, listing the covered services and supplies you received, to:

VSP
Non-Member Doctor Claims
P.O. Box 997100
Sacramento, CA 95899-7100

For Members Residing Outside California

If you reside outside the state of California, vision care benefits will be provided as shown on the next page for covered services and supplies provided by any qualified vision care provider.

To obtain reimbursement for those services and supplies, submit a copy of your itemized bill, properly identified, to:

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

Routine Vision Care Benefits - What Is Covered

The Vision Care Benefits described on the next page are provided for *routine* vision care ONLY. Examples of covered services include *routine* eye examinations, refractions, pupil dilation, glasses and contact lenses. Examples of vision care services that are **not** considered *routine* include examinations for diagnosed medical conditions of the eye such as cataracts or glaucoma, and eyeglasses or contact lenses prescribed following cataract surgery.

To obtain reimbursement for the treatment of such non-routine, medical conditions of the eye, you must first submit copies of your bills to Medicare for processing. After Medicare has paid its portion of the bill, submit a copy of the bill along with a copy of your Medicare Summary Notice to:

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

VISION CARE BENEFITS

Vision Care Benefits

The PERSCare Supplemental Plan provides benefits for routine vision care services and supplies up to the maximum allowance shown below:

	Allowance
Complete eye examination	$35.00
Lens (each):	
Single vision	$20.00
Bifocal	$35.00
Trifocal	$45.00
Lenticular	$50.00
Contact lenses (see below)	$100.00
Frames	$30.00

Examinations are limited to one (1) per Plan Member and lenses are limited to two (2) per Plan Member during a Calendar Year. Frames are limited to one (1) set per Plan Member over a two-year period.

Once each Calendar Year, you may have an eye examination for refractive error, including refraction, examination of the inner eye, measurement of eye tension, routine testing for visual field, and muscle balance. If normal examination reveals the need, a complete visual field examination, including pupil dilation or muscle balance, will be allowed. A follow-up visit for muscle balance will also be covered if Medically Necessary.

When an eye examination indicates that correction is necessary for proper visual health and welfare, the PERSCare Supplemental Plan will pay up to the maximums stated for covered supplies.

Contact Lenses

When the Plan Member chooses contact lenses instead of other eyewear, the PERSCare Supplemental Plan provides payment only up to the combined allowance for frames and lenses specified above, **but not to exceed one hundred dollars ($100.00)**.

The PERSCare Supplemental Plan will also pay a maximum of one hundred dollars ($100.00) toward the purchase of contact lenses when Medically Necessary following cataract surgery, or if they are the only means by which vision in the better eye can be corrected to at least 20/70.

Vision Care Benefit Exclusions

The following are excluded under the Plan:

1. Lenses that do not require a prescription or sunglasses, plain or prescription. Glasses with a tint other than No. 1 or No. 2 will be considered sunglasses for the purpose of this exclusion.
2. Services and materials (a) in connection with non-surgical treatment or procedures, such as orthoptics and visual training; (b) received in a United States government hospital, furnished elsewhere by or for the United States government, or provided by any government plan or law under which the individual is or could be covered; or (c) provided under workers' compensation benefits.
3. Replacement of lenses or frames which were furnished under the PERSCare Supplemental Plan and which have been lost, stolen or broken.
4. Any procedure done to correct a refractive error, including surgeries such as LASIK and PRK.

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: (a) an inpatient hospital stay for Medical Necessity after the first one hundred and fifty days (150) in a benefit period; and (b) all skilled nursing facility stays for Medical Necessity after the first one hundred (100) days in a benefit period. To initiate this review, call the Review Center at 1-800-451-6780 no later than one month **before** the first 150 days of an inpatient hospital stay have ended or 100 days of a skilled nursing facility stay have ended. The Plan may also request the Review Center to review other kinds of care for Medical Necessity.

Staff in the Review Center will work with you and your physician to assist you in receiving maximum benefit coverage and to minimize your out-of-pocket costs. The Review Center will continue to monitor care throughout the stay to help assure that quality medical care is efficiently delivered.

Payment will be denied if the Review Center determines that an inpatient hospital stay or a skilled nursing facility stay is not Medically Necessary or that a lower level of care is more appropriate. You and your physician will be advised if the Review Center determines that the stay is not Medically Necessary. 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.

If you have any questions concerning the Review Center's decision regarding continuing care, you or your physician may call the Review Center's coordinator who managed your care at 1-800-451-6780. If you do not agree with the Review Center's determination, you or your physician may appeal this decision by following the Medical Claims Review And Appeals Process described on pages 31-33.

Case Management

The purpose of Case Management services is to assist you in obtaining high quality, cost-effective and Medically Necessary care. Currently, case management nurses in the Review Center review all inpatient hospital stays after the first 150 days and all skilled nursing facility stays after the first one hundred (100) days. The Member, the Member's physician or the Plan may also request that the Review Center perform Case Management services for a Member who 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.

If Case Management services are requested for and accepted by a PERSCare Supplemental Plan 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 PERSCare Supplemental Plan Evidence of Coverage as requiring review.

OUTSIDE THE UNITED STATES

Medicare does not provide benefits when you are outside the United States or its territories and need medical attention or hospitalization for illness or injury. Therefore, you should pay the bill yourself and submit to Anthem Blue Cross a copy of the itemized bill along with a report from the attending physician (written in English). You will then be reimbursed directly by the PERSCare Supplemental Plan for covered services.

All requests for reimbursement must be submitted within fifteen (15) months from the date services were provided to:

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

Temporary Absence Outside the United States

When a Member incurs covered charges during the first six (6) months of a temporary absence outside the United States and its territories (unless provided in Canada or Mexico*), the PERSCare Supplemental Plan will provide the benefits as described in the PERSCare Basic Plan Evidence of Coverage (EOC) booklet as though the Member incurring such charges were insured under that plan. These benefits will include the PERSCare Basic Plan co-payments and deductibles. You may obtain a copy of the PERSCare Basic Plan Evidence of Coverage booklet by the calling the Anthem Blue Cross Customer Service telephone at 1-877-737-7776.

If a Member is in the hospital on the last day of the six (6) months' temporary absence outside the United States, benefits will be provided under the PERSCare Basic Plan for the duration of the hospital confinement or until the PERSCare Basic Plan has paid benefits that reach the benefit maximum.

*Exception for Canadian and Mexican Hospitals. Medicare generally cannot pay for hospital or medical services outside the United States. But it can help pay for care in qualified Canadian or Mexican hospitals in three situations: (1) if you are in the U.S. when an emergency occurs and a Canadian or Mexican hospital is closer than the nearest U.S. hospital that can provide the care you need; (2) if you live in the U.S. and a Canadian or Mexican hospital is closer to your home than the nearest U.S. hospital which can provide the care you need, regardless of whether or not an emergency exists; or (3) if you are in Canada traveling by the most direct route to or from Alaska and another state and an emergency occurs which requires that you be admitted to a Canadian hospital (this provision does not apply if you are vacationing in Canada).

When Medicare hospital insurance (Part A) covers your inpatient stay in a Canadian or Mexican hospital, your PERSCare Supplemental Plan medical insurance can cover necessary physician services and any required use of an ambulance.

Members Who Move Outside the United States

If you move, other than temporarily, outside the United States as defined in the Federal Social Security Act, you are no longer eligible for this Plan. You must change enrollment to a Basic Plan as Medicare does not provide benefits when you are permanently outside the United States. Please contact the Health Benefits Officer at your agency (actives) or the CalPERS Health Account Services Section (retirees) as soon as possible to enroll in a Basic Plan and to get a copy of the Basic Plan Evidence of Coverage document. Once you are enrolled under the Basic Plan, all applicable deductibles, copayments, benefit maximums, and exclusions described under the Basic Plan will apply. Any benefits provided under this PERSCare Supplemental Plan will no longer apply. You will need a copy of the Basic Plan Evidence of Coverage in order to determine what your medical benefits are. You may also visit Anthem Blue Cross' website www.anthem.com/ca/calpers to access benefit information.

BENEFIT LIMITATIONS, EXCEPTIONS AND EXCLUSIONS

This Plan supplements your Medicare benefits and provides benefits beyond Medicare. Benefits provided by this Plan beyond those covered by Medicare are subject to review for Medical Necessity before, during and/or after services have been rendered.

The following exclusions apply only to those services not covered by Medicare. 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 that a particular condition may be affected by more than one exclusion.

Under no circumstances will this 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, stair lifts, swimming pools, spas, hot tubs, air filtering systems or car hand controls, whether or not their use or installation is for purposes of providing therapy or easy access.

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

2. **Benefit Substitution/Flex Benefit/In Lieu Of.** Any program, treatment, service, or benefit cannot be substituted for another benefit or non-existing benefit. For example, a Member may not receive home health care benefits in lieu of an admission to a skilled nursing facility.

3. **Chiropractic X-rays.** X-rays taken in a chiropractor's office are not covered; however, if X-rays are taken at a Medicare-approved facility, they will be covered.

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

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

6. **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.

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

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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).

8. **Equipment and Supplies.** Orthopedic shoes (except when joined to braces) or shoe inserts, air purifiers, air conditioners, humidifiers, dehumidifiers, exercise equipment or any other equipment not primarily medical in nature; and supplies for comfort, hygiene or beautification, including wigs.

9. **Excess Charges.** Any expense incurred for services of a physician or other health care provider in excess of Plan benefits.

10. **Experimental or Investigational Practices or Procedures.** Experimental or investigational practices or procedures, and services in connection with such practices or procedures.

    Costs incurred for any treatment or procedure deemed by the Plan to be experimental or investigational, as defined on page 42, are not covered.

11. **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.

12. **Home Infusion Therapy.** The cost and administration of medications or fluids by the intravenous route in the home setting. (Note: Infusion therapy is a benefit that is available in other settings that are approved by Medicare, such as outpatient infusion centers and skilled nursing facilities.)

13. **Marriage and Family Counseling.** Counseling by any physician for the sole purpose of resolving conflicts between a subscriber and his or her spouse or children unless authorized as Medically Necessary Mental Health services and supplies under Benefits Beyond Medicare.

14. **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.

15. **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 or approved by Medicare.

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

17. **Rehabilitation or Rehabilitative Care.**

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

    b. Any testing, training or rehabilitation for educational, developmental or vocational purposes.

18. **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.

19. **Substance Abuse.** Charges incurred for treatment relating to substance abuse, including addiction to or dependency on tobacco or nicotine unless authorized as Medically Necessary Mental Health services and supplies under Benefits Beyond Medicare.

20. **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 Member or Member's family, or involving only physicians or other health care providers.

21. **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.

22. **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.

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

24. **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.

Medical Necessity Exclusion

The fact that a physician or other provider may prescribe, order, recommend, or approve a service, supply or hospitalization does not, in itself, make it Medically Necessary or make the charge an allowable expense, even though it is not specifically listed as an exclusion or limitation. The Plan reserves the right to review all claims to determine if a service, supply, or hospitalization is Medically Necessary. The Plan may limit the benefits for those services, supplies or hospitalizations that are not Medically Necessary.

Limitations Due to Major Disaster or Epidemic

In the event of any major disaster or epidemic, Physician Members 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 Physician Members 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.

CONTINUATION OF COVERAGE

Continuation of Group Coverage

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

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

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.

CONTINUATION OF COVERAGE

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 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.

Benefits After Termination

1. In the event the Plan is terminated by the CalPERS Board of Administration or by the PERSCare Supplemental Plan, the PERSCare Supplemental Plan 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 (1) when confined in a hospital or skilled nursing facility or confined pursuant to an alternative care arrangement; (2) when, as a result of accidental injury or disease, prevented from engaging in any occupation for compensation or profit or prevented from performing substantially all regular and customary activities usual for a person of the Plan Member's age and family status; or (3) when diagnosed as totally disabled by the Plan Member's physician and such diagnosis is accepted by the PERSCare Supplemental Plan.

    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 Plan Member's physician not less frequently than at sixty (60) day intervals during the period that the termination services and benefits are available.

CONTINUATION OF COVERAGE

Extension of coverage shall be provided for the shortest of the following periods:

- Until the total disability ceases;
- For a maximum period of twelve (12) months after the date of termination, subject to the PERSCare Supplemental Plan 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 CalPERS Board, by the PERSCare Supplemental Plan, or by voluntary cancellation, and the date of such termination of coverage occurs during the Plan Member's certified confinement in a hospital or 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 the PERSCare Supplemental Plan; or
   - Until the Plan's maximum benefits are paid.

GENERAL INFORMATION

Eligibility and Enrollment

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

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

CalPERS
Health Account Services Section
P.O. Box 942714
Sacramento, CA 94229-2714
or call:
888 CalPERS (or 888-225-7377)
(916) 795-3240 9TDD)

Live/Work

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

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

Request for Additional Information

A questionnaire will be sent to you annually regarding other health care coverage or Medicare coverage. A questionnaire regarding third-party liability will be sent to you following Anthem Blue Cross' receipt of any claim which appears to be the liability or legal responsibility of a third party. Your cooperation in returning the form promptly will provide Anthem Blue Cross with information necessary to process your claim. If another carrier has the primary responsibility for claims payment, submit a copy of the other carrier's Explanation of Benefits with the itemized bill from the provider of service. **Anthem Blue Cross cannot process your claim without this information.**

Payment to Providers—Assignment of Benefits

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

LIABILITIES

Third-Party Liability

If a Plan Member receives medical services covered by the PERSCare Supplemental Plan 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 the PERSCare Supplemental Plan, 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 the PERSCare Supplemental Plan with a lien, to the extent of benefits provided by the PERSCare Supplemental Plan, upon the Plan 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 claims 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 the PERSCare Supplemental Plan 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 the PERSCare Supplemental Plan to recovery.

Pursuant to Government Code section 22947, a PERSCare Supplemental Plan 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:

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

The PERSCare Supplemental Plan 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. The PERSCare Supplemental Plan 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 the PERSCare Supplemental Plan

When covered services have been rendered by a Preferred Provider or Participating Pharmacy and payment has been made by the PERSCare Supplemental Plan, the Plan Member is responsible only for any applicable deductible and/or copayment. However, if covered services are rendered by a Non-Preferred Provider or non-Participating Pharmacy, the Plan Member is responsible for any amount the PERSCare Supplemental Plan 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 of the PERSCare Supplemental Plan

If the PERSCare Supplemental Plan 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 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 the Plan or Anthem Blue Cross 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 for Preferred Provider services, the PERSCare Supplemental Plan may, based upon Medical Necessity, approve continuation of care at the Preferred Provider level of reimbursement. Upon the PERSCare Supplemental Plan'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 Plan Member to choose an alternative provider and to determine the Preferred Provider status of that provider.

COORDINATION OF BENEFITS

Coordination of Benefits provides maximum coverage for medical and hospital bills at the lowest cost by avoiding excessive payments. A Plan Member who is covered under more than one group plan will not be permitted to make a "profit" by collecting benefits on any claim in excess of the billed amount. Benefits will be coordinated between the plans to provide appropriate payment, not to exceed 100% of the Allowable Expense.

This Coordination of Benefits section will apply only to Benefits Beyond Medicare and Vision Care Benefits.

Anthem Blue Cross will send you a questionnaire annually regarding other health care coverage or Medicare coverage. ***You must provide this information to Anthem Blue Cross within 30 calendar days.*** If you do not respond to the questionnaire, claims will be denied or delayed until Anthem Blue Cross receives the information. You may provide the information to Anthem Blue Cross in writing or by telephoning Customer Service.

(The meanings of key terms used in these Coordination of Benefits provisions are shown on the next page under Definitions.)

Effect on Benefits

If this Plan is determined to be the primary carrier, this Plan will provide its benefits in accordance with the plan design and without reductions due to payments anticipated by a secondary carrier. Physician Members and other Preferred Providers may request payment from the secondary carrier for any difference between their Billed Charges and this Plan's payment.

If the other carrier has the primary responsibility for claims payment, your claim submission under this Plan must include a copy of the primary carrier's Explanation of Benefits together with the itemized bill from the provider of service. Your claim cannot be processed without this information. HMO plans often provide benefits in the form of health care services within specific provider networks and may not issue an Explanation of Benefits for covered services. If the primary carrier does not provide an Explanation of Benefits, you must submit that plan's official written statement of the reason for denial with your claim.

When this Plan is the secondary carrier, its benefits may be reduced so the combined benefit payments and services of all the plans do not exceed 100% of the Allowable Expense. The benefit payment by this Plan will never be more than the sum of the benefits that would have been paid if you were covered under this Plan only.

If this Plan is a secondary carrier with respect to a Plan Member and Anthem Blue Cross is notified that there is a dispute as to which plan is primary, or that the primary carrier has not paid within a reasonable period of time, this Plan will provide the benefits that would have been paid if it were the primary carrier, **only** when the Plan Member:

1. Assigns to this Plan the right to receive benefits from the other plan to the extent that this Plan would have been obligated to pay as secondary carrier, **and**
2. Agrees to cooperate fully in obtaining payment of benefits from the other plan, **and**
3. Allows Anthem Blue Cross to obtain confirmation from the other plan that the benefits claimed have not previously been paid.

Order of Benefits Determination

When the other plan does not have a Coordination of Benefits provision, it will always be the primary carrier. Otherwise, the following rules determine the order of benefit payments:

1. A plan which covers the Plan Member as other than a dependent shall be the primary carrier.

2. When a plan covers a dependent child whose parents are not separated or divorced, and each parent has a group plan which covers the dependent child, the plan of the parent whose birth date (excluding year of birth) occurs earlier in the Calendar Year shall be primary carrier. If either plan does not have the birthday rule provision of this paragraph regarding dependent children, primary carrier shall be determined by the plan that does not include this provision.
3. When a claim involves expenses for a dependent child whose parents are separated or divorced, plans covering the child as a dependent will determine their respective benefits in the following order:
   a. the plan of the parent with custody of the child;
   b. if the custodial parent has remarried, the plan of the stepparent married to the parent with custody of the child;
   c. the plan of the noncustodial parent without custody 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 an insured 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.

MEDICAL CLAIMS REVIEW AND APPEALS PROCESS

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

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

Please refer to your PDP EOC for the Pharmacy Appeal Process.

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

Medicare Denied Claims

1. **Notice of Claim Denial**

   This Plan supplements the benefits paid by Medicare. If a medical claim has been denied by Medicare, the supplemental payment through this Plan will also be denied, as secondary payment by this Plan is dependent upon Medicare's primary payment. Anthem Blue Cross will notify you of such denial in writing. The Anthem Blue Cross notice shall contain the reason for the denial.

2. **Claim Denial due to Medicare Denial**

   You must appeal the Medicare determination with Medicare if the Medicare claim is denied. Your appeal rights are detailed on the back of the Medicare Summary Notice form that is mailed to you. If, after the appeal process is completed, you receive notification from Medicare that the claim has been paid, this Plan will pay any covered supplemental benefits.

Claim Denials for Benefits Beyond Medicare

1. **Objection to Claim Processing**

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

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

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

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

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

In the event any claim for Benefits Beyond Medicare (see pages 10-14) is denied, in whole or in part, Anthem Blue Cross will notify you and/or your Authorized Representative of such denial in writing within 30 days. Any denial of a claim for benefits is considered an "adverse benefit determination" (ABD) and can be based on the fact that it is not a covered benefit, the treatment is not Medically Necessary, or the treatment is Experimental/Investigational. The denial can be the result of Utilization Review for a prospective service, a service that is currently being pursued, or a service that has already been provided. (See Utilization Review on pages 17.) The ABD shall contain specific reasons for the denial and an explanation of the Plan's review and appeal procedure. Any ABD is subject to Internal Review upon request.

3. Internal Review

You and/or your Authorized Representative may request a review of an ABD by writing or calling Anthem Blue Cross' Customer Service Department within one hundred and eighty (180) days of receipt of an ABD. Your appeal or grievance must clearly state your issue, such as the reasons you disagree with the ABD or why you are dissatisfied with the Services you received. If you would like Anthem Blue Cross to consider your grievance on an urgent basis, please write "urgent" on the request and provide the rationale. (See definition of "Urgent Review" on page 39.) Requests for review should be sent to:

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

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

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

If Anthem Blue Cross upholds the ABD within the timeframes described above, that decision becomes a "Final Adverse Benefit Determination" (FABD), and you may pursue the independent External Review process described in section 5. below.

4. Urgent Review

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

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

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

5. Request for Independent External Review

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

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

For more information about the Plan's standard for Medical Necessity, please see pages 42-43.

You and/or your Authorized Representative may request an independent External Review no later than four (4) months from the date of receipt of the FABD. The type of services in dispute must be a covered benefit. For cases involving Medical Judgment, you and/or your Authorized Representative must exhaust the independent External Review prior to requesting a CalPERS Administrative Review. (See CalPERS Administrative Review and Administrative Hearing on pages 34-35.)

You and/or your Authorized Representative may also request an independent External Review if Anthem Blue Cross fails to render a decision within the timelines specified above in 3. for Internal Review. For a more complete description of independent External Review rights, please see 45 Code of Federal Regulations section 147.136.

6. Request for CalPERS Administrative Review Process

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

CalPERS ADMINISTRATIVE REVIEW AND ADMINISTRATIVE HEARING

1. Administrative Review

If you remain dissatisfied after exhausting the Internal Review process for benefit decisions and the independent External Review in cases involving Medical Judgment, you or your Authorized Representative may submit a request for CalPERS Administrative Review. You must exhaust Anthem Blue Cross' internal grievance process, and the independent External Review process, when applicable, prior to submitting a request for CalPERS Administrative Review.

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

The request must be mailed to:

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

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

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

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

CalPERS will attempt to provide a written determination within 30 days from the date all pertinent information is received by CalPERS. For claims involving urgent care, CalPERS will make a decision as soon as possible, taking into account the medical exigencies, but no later than three (3) business days from the date all pertinent information is received by CalPERS.

2. Administrative Hearing

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

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

CalPERS ADMINISTRATIVE REVIEW AND ADMINISTRATIVE HEARING

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

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

3. Appeal Beyond Administrative Review and Administrative Hearing

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

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

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

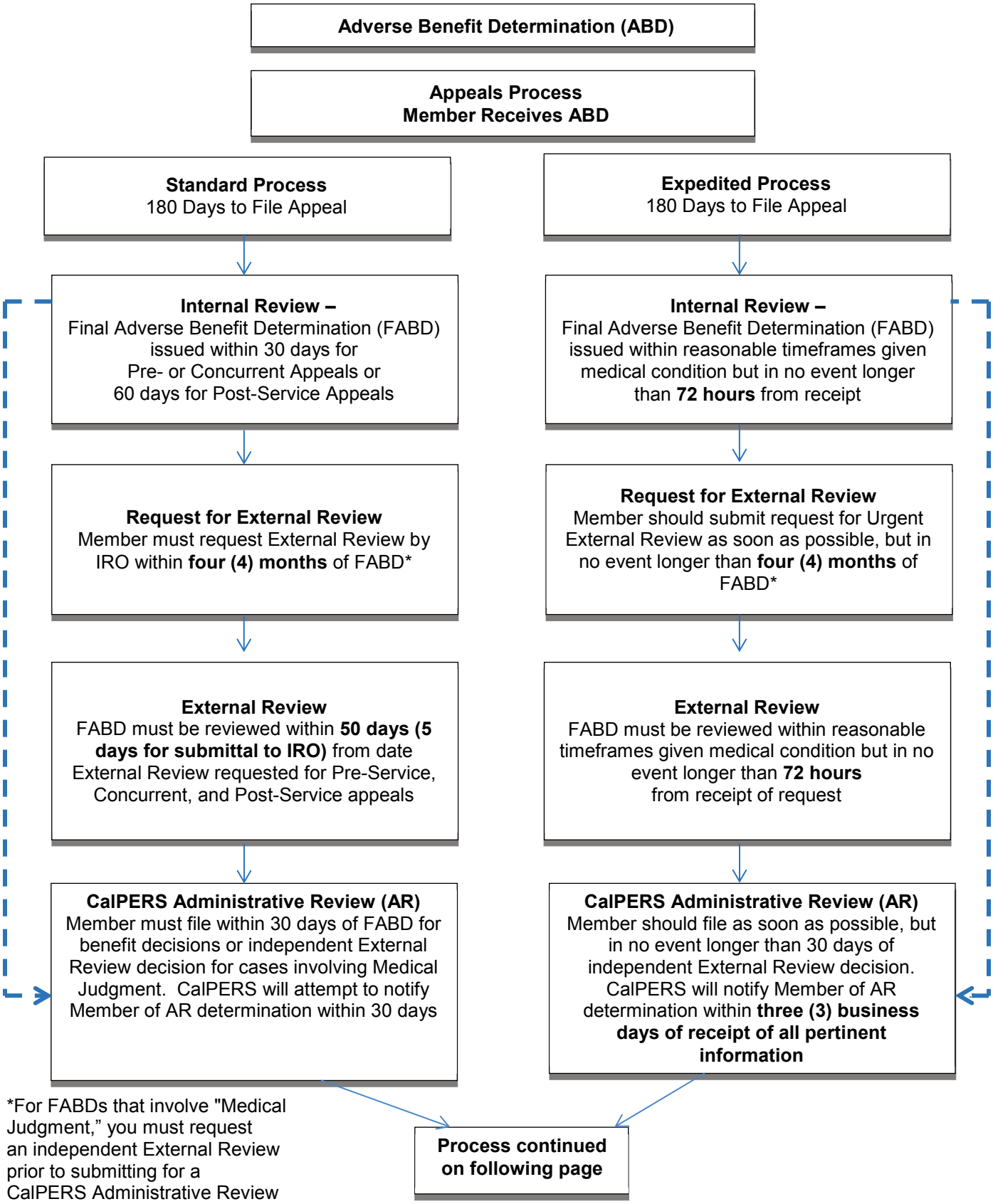
- **Right to records, generally.** You may, at your own expense, obtain copies of all non-medical and non-privileged medical records from the administrator and/or CalPERS, as applicable.
- **Records subject to attorney-client privilege.** Communication between an attorney and a client, whether oral or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

Service of Legal Process

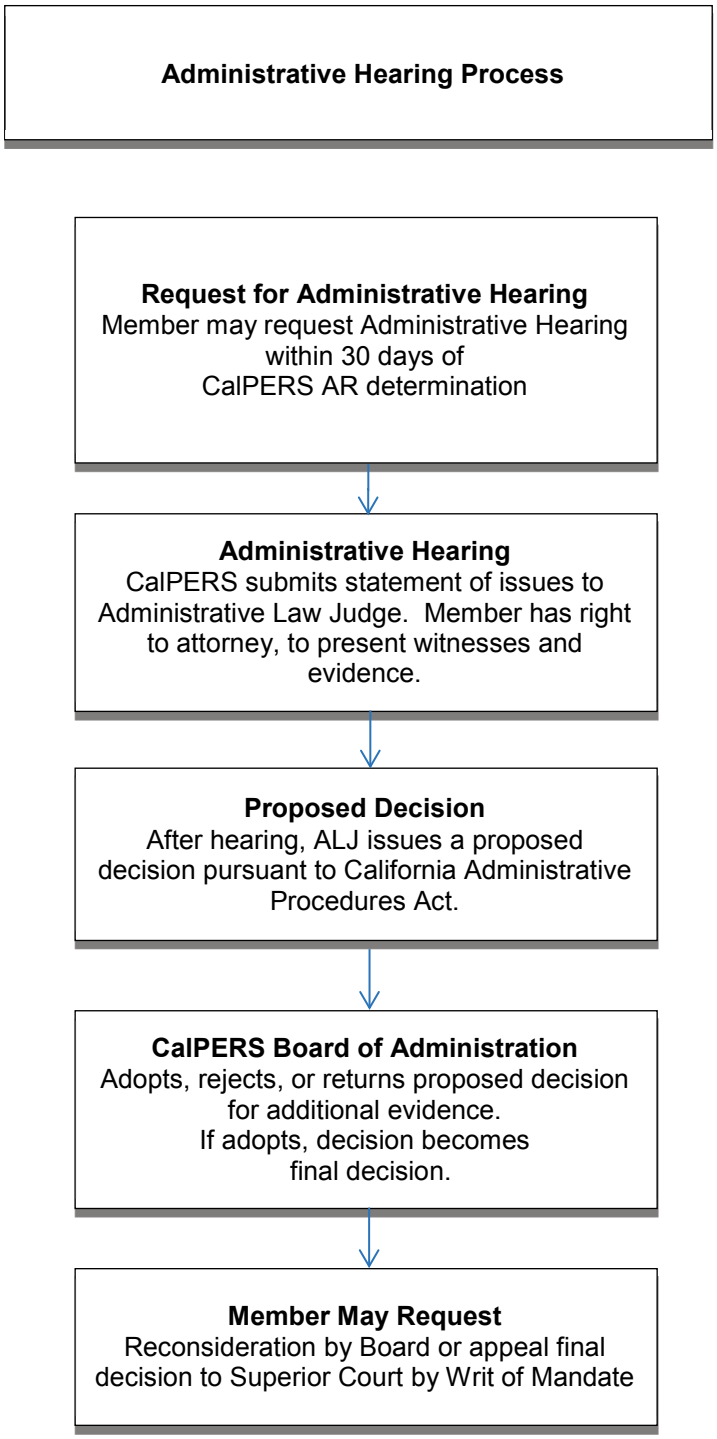
Legal process or service upon the Plan must be served in person at:

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

ADVERSE BENEFIT DETERMINATION (ABD) CHART



ADVERSE BENEFIT DETERMINATION (ABD) CHART



ADVERSE BENEFIT DETERMINATION (ABD) CHART

Adverse Benefit Determination (ABD)
Appeals Process Definitions

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

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

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

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

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

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

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

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

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

Internal Review – The review conducted by Anthem Blue Cross for an ABD.

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

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

ADVERSE BENEFIT DETERMINATION (ABD) CHART

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

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

MONTHLY RATES

Type of Enrollment	Enrollment Code	Cost
Insured Only	2791	$368.76
Insured and One Dependent	2792	$737.52
Insured and Two or More Dependents	2793	$1,106.28

State Employees and Annuitants. The rates shown above are effective January 1, 2015, 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 the Health Benefits Officer at your employing agency or retirement system.

Public Agency Employees and Annuitants. The rates shown above are effective January 1, 2015, 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 the Health Benefits Officer at your agency or retirement system.

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

Administrator –

1. denotes CalPERS as the global administrator of the Plan through the Self-Funded Health Plans Unit of the Health Account Services Section 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 allowance as defined below for the service(s) rendered, or the provider's Billed Charge, whichever is less. The allowance is:

1. the amount Anthem Blue Cross has determined is an appropriate payment for the service(s) rendered in the provider's geographic area, based upon such factors as the PERSCare Supplemental 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 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 determines is appropriate considering the particular circumstances and the services rendered.

Annuitant – defined in accordance with the definition currently in effect in PEMHCA and Regulations.

Anthem Blue Cross – the claims administrator responsible for administering medical benefits and providing utilization review services under this Plan. As used in this Evidence of Coverage booklet, the term "Anthem Blue Cross" shall be used to refer to both Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company.

Balance Billing – a request for payment by a provider to a Member for the difference between Anthem Blue Cross' Allowable Amount and the Billed Charges.

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).

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.

Christian Science nurse – a Christian Science nurse approved as such by The First Church of Christ, Scientist, in Boston, Massachusetts, and listed in the Christian Science Journal.

Christian Science Nursing Facility – A Christian Science nursing facility accredited by The Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.

Christian Science Practitioner – A Christian Science practitioner approved as such by The First Church of Christ, Scientist, in Boston, Massachusetts, and listed in the Christian Science Journal.

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

Contract Period – the period of time from January 1, 2015, through December 31, 2015.

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, and 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.

DEFINITIONS

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.

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

Employer – is defined in accordance with the definition currently in effect in PEMHCA and Regulations.

Experimental or Investigational – any treatment, therapy, procedure, drug or drug usage for non-FDA approved indications, facility or facility usage, equipment or equipment usage, device or device usage, or supplies which are not recognized in accordance with generally accepted professional medical standards as being safe and effective for use in the treatment of an illness, injury, or condition at issue. Additionally, any services that require approval by the federal government or any agency thereof, or by any state governmental agency, prior to use, and where such approval has not been granted at the time the services were rendered, shall be considered experimental or investigational. Any services that are not approved or recognized in accordance 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 – is defined in accordance with the definition currently in effect in PEMHCA and Regulations.

FDA – U.S. Food and Drug Administration.

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 for the provision of diabetic medical nutrition therapy only; 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.

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.

Incurred Charge – a charge shall be deemed “incurred” on the date the particular service or supply is provided or obtained.

Inpatient – an individual who has been admitted to a hospital as a registered acute bed patient (overnight) and who is receiving services that could not be provided on an outpatient basis, under the direction of a physician.

Medically Necessary (Medical Necessity) – services, procedures, equipment or supplies the Plan determines to be:

1. Appropriate and necessary for the diagnosis or treatment of the medical condition;
2. Provided for the diagnosis or direct care and treatment of the medical condition;
3. Within standards of good medical practice within the organized medical community;
4. Not primarily for your convenience, or the convenience of your physician or another provider; and

5. The most appropriate supply or level of service which can safely be provided. For hospital stays, this means that acute care as an inpatient is needed due to the kind of services you are receiving or the severity of your condition, and that safe and adequate care cannot be received as an outpatient or in a less intensified medical setting.

   NOTE: The Plan will accept Medicare's determination of Medical Necessity for services covered by Medicare.

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

Medicare Limiting Amount – refers to a federally mandated maximum amount a provider can charge a Member for covered services if the provider does not accept Medicare assignment. This amount cannot exceed fifteen percent (15%) more than Medicare's approved amount.

Member – See definition under Plan Member on the next page.

Non-Preferred Provider (Non-PPO) – a group of physicians, hospitals or other health professionals that (1) do not have a Prudent Buyer Plan Participating Provider Agreement in effect with Anthem Blue Cross at the time services are rendered, or (2) do not participate in a Blue Cross and/or Blue Shield Plan network outside California at the time services are rendered. Any of the following types of providers may be Non-Preferred Providers: physicians, hospitals, ambulatory surgery centers, home health agencies, facilities providing diagnostic imaging services, durable medical equipment providers, skilled nursing facilities, clinical laboratories, urgent care providers and home infusion therapy providers. An individual Preferred Provider may be considered a Non-Preferred Provider if (1) services are rendered at a location other than specified in the "Prudent Buyer Plan Participating Provider Agreement" or (2) the tax identification number used for billing purposes is different than specified in the "Prudent Buyer Plan Participating Provider Agreement."

Open Enrollment Period – a period of time established by the CalPERS Board 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.

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, as payment in full for covered services.

Plan – means the PERSCare Supplement to Original Medicare Plan (PERSCare Supplemental Plan). PERSCare Supplemental Plan is a self-funded health plan established and administered by CalPERS.

Plan Member – any employee, annuitant, or family member enrolled in the PERSCare Supplement to Original Medicare Plan.

Precertification (precertified) – 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. This term does not include the determination of eligibility for coverage or the payment of benefits under the Plan.

Preferred Provider (PPO) – a group of physicians, hospitals or other health professionals that (1) have a Prudent Buyer Plan Participating Provider Agreement in effect with Anthem Blue Cross at the time services are rendered, provides a service at the location set forth in the "Prudent Buyer Participating Provider Agreement," and bills Anthem Blue Cross utilizing the tax identification number (TIN) under the terms of that Agreement for those services rendered, or (2) 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 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.

DEFINITIONS

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.

Public Employees' Medical and Hospital Care Act (PEMHCA) — Title 2, Division 5, Part 5 (sections 22750 thru 22948.3) of the Government Code of the State of California.

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.

Self-Administered Injectables – medications available in injectable drug form and considered suitable for patient self-administration.

Services – Medically Necessary health care services and Medically Necessary supplies furnished incident to those services.

Skilled Nursing Facility – a facility that 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.

Subscriber – the person enrolled who is responsible for payment of premiums to the PERSCare Supplemental Plan, and whose employment or other status, except family dependency, is the basis for eligibility for enrollment under this Plan.

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.

United States – all the states, District of Columbia, Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa.

FOR YOUR INFORMATION

Organ Donation

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

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

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

If you decide to become a donor, please discuss it with your family. Let your physician know your intentions as well. Obtain a donor card from the Department of Motor Vehicles. Be sure to sign the donor card and keep it with your driver's license or identification card.

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

Long-Term Care Program

Your PERSCare Supplemental 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 PERSCare 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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