PERSCare

Supplement to Original Medicare Plan

Preferred Provider Organization

CalPERS

Evidence of Coverage

Effective January 1, 2012 – December 31, 2012

PERSCare

PERSCARE SUPPLEMENT TO ORIGINAL MEDICARE PLAN ADDENDUM #1 FOR 2012

This addendum contains information regarding benefit corrections to the PERSCare Supplement To Original Medicare Plan effective January 1, 2012. Please keep this important information with your Evidence of Coverage booklet for future reference. The following change is made to the section as described below.

The table which shows the copayment structure for the retail pharmacy and mail service programs (see page 22) is deleted and replaced by the following:

Participating Retail Pharmacy/ CVS Caremark Specialty Pharmacy (short-term use)	**Maintenance Medications*: Participating Retail Pharmacy filled at non-Maintenance Choice® Retail after 2nd fill** (a maintenance medication* taken longer than 60 days for a long-term or chronic condition)	**Maintenance Medications*: CVS Caremark Mail Service/ Maintenance Choice®** (a maintenance medication* taken longer than 60 days for a long-term or chronic condition)
Generic **$5.00**	Generic **$10.00**	Generic **$10.00**
Preferred Brand **$20.00**	Preferred Brand **$40.00**	Preferred Brand **$40.00**
Non-Preferred Brand **$50.00**	Non-Preferred Brand **$100.00**	Non-Preferred Brand **$100.00**
Partial Waiver of Non-Preferred Brand copayment** **$40.00**	Partial Waiver of Non-Preferred Brand copayment** **$70.00**	Partial Waiver of Non-Preferred Brand copayment** **$70.00**
Discretionary Drugs 50%	Discretionary Drugs 50%	Discretionary Drugs 50%
Up to a 34-day supply	**Up to a 34-day supply**	**Up to a 90-day supply**
Out-of-Pocket Maximum, per person each calendar year: not applicable	**Out-of-Pocket Maximum, per person each calendar year: not applicable**	**Out-of-Pocket Maximum, per person each calendar year: $1,000** (excluding Non-Preferred Brand-Name Medication copayments, Discretionary Drug coinsurance, and "Member Pays the Difference" differential)

* A maintenance medication should not require frequent dosage adjustments, and is prescribed for a long-term or chronic condition, such as arthritis, diabetes, and high blood pressure or is otherwise prescribed for long-term use (as an example, birth control). Ask your physician if you will be taking a prescribed medication longer than 60 days. If you continue to refill a maintenance prescription at a non-Maintenance Choice® retail pharmacy after the second fill, you will be charged a higher copayment, which is the applicable Mail Service copayment described above. Please note that while medications can be filled at a retail pharmacy, long-term medications (medications taken for 60 days or more) will cost more if refilled at a retail pharmacy after the second fill. Members can refill the same medications by Mail Service or at a Maintenance Choice® retail pharmacy at a cost savings. Certain Specialty medications are available only through the CVS Caremark Specialty Pharmacy.

Examples of common long-term or chronic conditions:

Birth control
High blood pressure
High cholesterol
Diabetes

Examples of common short-term acute illnesses, injuries or conditions:

Influenza (the "Flu")
Pneumonia
Urinary tract infection

** To obtain a partial waiver to purchase a Non-Preferred brand-name drug at a reduced copayment, please refer to the Partial Waiver of Non-Preferred Brand Copayment process as outlined in the Prescription Drug Appeal Procedure on pages 50-51. To obtain a partial copayment waiver, your physician must document the necessity for the non-preferred product vs. the preferred product(s) and the available generic alternative(s).

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, benefit information, identification cards, booklets, or claim forms, call or visit on-line:

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

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

PRESCRIPTION DRUG PROGRAM

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

Caremark PCS Health, L.L.C. ("CVS Caremark")
1-877-542-0284 (worldwide)
Web site: www.caremark.com/calpers

For information regarding Protected Health Information:

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

ELIGIBILITY AND ENROLLMENT

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

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

Or call:

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

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

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

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. 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, Vision Care Benefit and Outpatient Prescription Drug Programs.

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

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

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

Patient Protection and Affordable Care Act

Health Care Reform

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

24/7 NurseLine

Your Plan includes a 24-hour nurse assessment service to help you make decisions about your medical care. You can reach a specially trained registered nurse 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.

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BENEFIT AND ADMINISTRATIVE CHANGES

The following is a brief summary of administrative changes that will take effect January 1, 2012. Be sure to refer to the PERSCare Supplemental To Original Medicare Plan - Summary Of Benefits beginning on page 2, Outpatient Prescription Drug Program beginning on page 22, Prescription Drug Coverage Management Programs beginning on page 29, Outpatient Prescription Drug Exclusions beginning on page 30, Prescription Drug Appeal Procedure beginning on page 50, and Definitions beginning on page 55, for more information.

- **CVS Caremark.** Your pharmacy benefits manager will now be CVS Caremark. See the website www.caremark.com/calpers to locate a participating pharmacy near you.
- **Member Pays the Difference.** For brand name medications, where a U.S. Food and Drug Administration (FDA) approved generic equivalent, the Member will pay the difference in cost between the brand medication and its generic equivalent, plus the applicable generic copayment.
- **Prescription Drug Co-Payments for Preferred Brand Name Drugs.** Your prescription drug co-payments have been changed as follows:
    - For Participating Retail Pharmacy/CVS Caremark Specialty Pharmacy..... $20
    - For Participating Retail Pharmacy and Maintenance Medications filled at non-Maintenance Choice® after 2nd fill..... $40
    - For CVS Caremark Mail Service or Mail Service/Maintenance Choice®..... $40
- **Prescription Drug Co-Payments for Non-Preferred Brand Name Drugs.** Your prescription drug co-payments have been changed as follows:
    - For Participating Retail Pharmacy/CVS Caremark Specialty Pharmacy..... $50
    - For Participating Retail Pharmacy and Maintenance Medications filled at non-Maintenance Choice® after 2nd fill..... $100
    - For CVS Caremark Mail Service or Mail Service/Maintenance Choice®..... $100

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 9-11 for a detailed description of how Supplement to Original Medicare Benefits are paid and the Outpatient Prescription Drug Program section beginning on page 22. Payments applicable to Benefits Beyond Medicare are described on pages 12-18. 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 10-11 for important information regarding Plan payments.

† This is a Benefits Beyond Medicare. 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 15 for important information regarding Plan payments.

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.†
Physician Visits Office/Home/Hospital Visits Allergy Testing/Treatment	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 10-11 for important information regarding Plan payments.

† This is a Benefits Beyond Medicare. 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 15 for important information regarding Plan payments.

PERSCare SUPPLEMENT TO ORIGINAL MEDICARE PLAN - SUMMARY OF BENEFITS

Benefit Category	Medicare Pays	Member Pays
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 14-15.)
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 10-11 for important information regarding Plan payments.

† This is a Benefits Beyond Medicare. 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 15 for important information regarding Plan payments.

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

PERSCare SUPPLEMENT TO ORIGINAL MEDICARE PLAN - SUMMARY OF BENEFITS

Benefit Category	Medicare Pays	Member Pays
Prescription Drugs		
Retail Pharmacy Program for short-term use up to a 34-day supply	See Medicare Handbook The coverage under the PERSCare Supplement to Original Medicare Plan Outpatient Prescription Drug Program section takes the place of Medicare voluntary outpatient prescription drug benefits (Part D). You are not allowed to enroll in a Part D prescription drug plan and remain enrolled in the PERSCare Supplement to Original Medicare Plan.	$5 generic $20 Preferred (On CVS Caremark's Preferred Drug List) brand-name medications $50 Non-Preferred (Not on CVS Caremark's Preferred Drug List) brand-name medications*** $40 for Partial Waiver of Non-Preferred Brand copayment + 50% Discretionary Drugs
Maintenance medications** if refilled at a retail pharmacy* after 2nd fill		$10 generic $40 Preferred (On CVS Caremark's Preferred Drug List) brand-name medications $100 Non-Preferred (Not on CVS Caremark's Preferred Drug List) brand-name medications ***
Mail Service/Maintenance Choice® Program** for maintenance medications**, up to a 90-day supply.		$10 generic $40 Preferred (On CVS Caremark's Preferred Drug List) brand-name medications $100 Non-Preferred (Not on CVS Caremark's Preferred Drug List) brand-name medications ***
Pocket Maximum, per person each calendar year: $1,000 (excluding Non-Preferred Brand-Name Medication copayments, Discretionary Drug coinsurance, and "Member Pays the Difference" differential)		$70 for Partial Waiver of Non-Preferred Brand copayment + 50% Discretionary Drugs

* Maintenance medications may be filled or refilled at CVS/pharmacy or Longs Drugs locations even after the 2nd refill through the Maintenance Choice® program. See page 22 for details regarding Maintenance Choice®.

** Maintenance medications are drugs that do not require frequent dosage adjustments, which are usually prescribed for long-term use, such as birth control, or for a chronic condition, such as arthritis, diabetes, or high blood pressure. These drugs are usually taken longer than sixty (60) days. Refer to the Outpatient Prescription Drug Program beginning on page 22 for more information.

*** Member Pays the Difference. For brand name medications, where a U.S. Food and Drug Administration (FDA) approved generic equivalent is available, the Member will pay the difference in cost between the brand medication and its generic equivalent, plus the applicable generic copayment.

+ In order to obtain a Partial Waiver of the Non-Preferred Brand copayment, your physician must document the necessity for the Non-Preferred product vs. the Preferred product(s) and the available generic alternative(s) through CVS Caremark's formal appeals process outlined on pages 50-51.

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. Medicare Part A is hospital insurance that helps cover inpatient care in hospitals, skilled nursing facility, hospice, and home health care. Medicare Part B helps cover preventive services and medically-necessary services like doctors' services, outpatient care, home health services, and other medical services. Check your Medicare card to find out if you have Part B.

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.

The coverage under PERSCare Supplemental Plan Outpatient Prescription Drug Program takes the place of the Medicare voluntary outpatient prescription drug benefits (Part D). The Plan's outpatient prescription drug coverage is on average as good as or better than the standard benefit set by the federal government for Medicare Part D (also called creditable coverage). Because the Plan's prescription drug coverage is creditable, you are not allowed to enroll in a Part D prescription drug plan and remain enrolled in this Plan. Enrollment in Part D will result in the loss of your PERSCare Supplemental Plan medical and prescription drug coverage.

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 Anthem Blue Cross Customer Service Department at 1-877-737-7776.

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 and prescription drug benefits as described in the Plan, please present your ID Card to each provider of service. If you need a replacement card, 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 11 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 12-18. See page 15 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. In some cases, you may receive your PERSCare Supplemental Plan benefit claim payment faster than your Medicare payment.

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 below.

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

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 58).

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 57), 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 benefits provided under "Benefits Beyond Medicare" must be submitted within fifteen (15) months after the date services were provided.

To receive reimbursement for **Vision Care Benefits,** refer to page 17 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.** Services provided by a Christian Science nurse or practitioner including treatment in absentia (Christian Science practitioners or nurses providing services, such as consultation or prayer, via the telephone).

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 if Medicare has determined the stay to be medically necessary.

      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 Utilization Review Appeal Procedure described on pages 47-49.

b. Outpatient hospital services and supplies. Medically necessary diagnostic, therapeutic and/or surgical services performed at a hospital 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 for the treatment of mental disorders only. Covered services are as follows:

a. Inpatient Services

Covered charges for services and supplies furnished by a hospital and a physician for treatment of mental or psychoneurotic disorders while confined in a hospital as a registered bed patient. Hospital charges for room and board in excess of the semi-private (two-bed) room rate and charges of a physician for psychiatric care in excess of a maximum payment of thirty-two dollars ($32.00) per day will be excluded.

b. Outpatient Services

The Plan will pay up to a maximum payment of thirty-two dollars ($32.00) for covered charges per day for psychiatric care as defined on page 59 for treatment of mental or psychoneurotic disorders while not confined in a hospital as a registered bed patient.

This benefit does not cover treatment of substance abuse. Refer to pages 32-35 for Benefit Limitations, Exceptions and Exclusions applicable to this benefit.

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 Utilization Review Appeal Procedure described on pages 47-49.

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.
    - expenses for outpatient prescription drugs.
    - expenses for mental health services and supplies.
    - 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, outpatient prescription drugs, and mental health services and supplies, 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 55, except for hospital providers. Covered charges with respect to hospital providers are the actual cost to the Plan Member for hospital services and supplies that are benefits of the Plan.

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	$100,000	$100,000
Allowable Amount – the allowance or negotiated amount under the Plan for service provided (see definition on page 55). Note: This is only an example. Allowable amount varies according to procedure and provider of service.	$35,000	$35,000
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	$32,000 (80% of Allowable Amount until maximum copayment or coinsurance met, then 100%)	$32,000 (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)	$65,000 (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**	**$68,000**

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 Utilization Review Appeal Procedure described on pages 47-49.

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.

OUTSIDE THE UNITED STATES

Foreign Prescription Drug Claims: There are no Participating Pharmacies outside of the United States. To receive reimbursement for outpatient prescription medications purchased outside the United States, complete a CVS Caremark Prescription Reimbursement Claim Form and mail the form along with your pharmacy receipt to CVS Caremark. To obtain a claim form visit the CVS Caremark web site at www.caremark.com/calpers, or contact CVS Caremark Customer Care at 1-877-542-0284.

Reimbursement for drugs will be limited to those obtained while living or traveling outside of the United States and will be subject to the same restrictions and coverage limitations as set forth in this Evidence of Coverage document. Excluded from coverage are foreign drugs for which there is no approved U.S. equivalent, experimental or investigational drugs, or drugs not covered by the Plan (e.g., drugs used for cosmetic purposes, drugs for weight loss, etc.). Please refer to the list of covered and excluded drugs outlined in the Outpatient Prescription Drug Program section starting on page 22 and Outpatient Prescription Drug Exclusions section on pages 30-31.

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

OUTPATIENT PRESCRIPTION DRUG PROGRAM

Outpatient Prescription Drug Benefits

The Outpatient Prescription Drug Program is administered by CVS Caremark. This program will pay for prescription medications which are: (a) prescribed by a licensed prescriber (defined on page 59) in connection with a covered illness, condition, or accidental injury; (b) dispensed by a registered pharmacist, subject to the exclusions listed in the Outpatient Prescription Drug Exclusions on pages 30-31; and (c) approved through the Coverage Management Programs described in the Prescription Drug Coverage Management Programs section on page 29. All prescription medications are subject to clinical drug utilization review when dispensed.

Covered outpatient prescription drugs prescribed by a licensed prescriber in connection with a covered illness or accidental injury and dispensed by a registered pharmacist may be obtained either through the CVS Caremark Retail Pharmacy Program or the CVS Caremark Mail Service Program.

Maintenance Choice®

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

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

Note: PERSCare Supplemental Plan coverage under this section takes the place of Medicare voluntary outpatient prescription drug benefits (Part D). You are not allowed to enroll in a Part D prescription drug plan and remain enrolled in the PERSCare Supplemental Plan.

Coinsurance and "Member Pays the Difference"

- Discretionary Drugs (as defined on page 56) are subject to a 50% coinsurance.
- "Member Pays the Difference" program: If a brand name drug is selected when a generic alternative is available, Members will pay the difference in cost between the brand name drug and the generic equivalent, plus the generic copayment.
- In order to obtain a Partial Waiver of the Non-Preferred Brand copayment, your physician must document the necessity for the Non-Preferred product vs. the Preferred product(s) and the available generic alternative(s) through CVS Caremark's formal appeals process outlined on pages 49-50.

Copayment Structure

The Plan's incentive copayment structure includes generic, Preferred and Non-Preferred brand-name medications. The Member has an incentive to use generic and Preferred brand-name drugs, and Mail Service or Maintenance Choice® retail pharmacies for maintenance medications. Your copayment will vary depending on whether you use retail or Mail Service/ Maintenance Choice®, and whether you select generic, Preferred or Non-Preferred brand-name medications, or whether you refill maintenance medications at a non-Maintenance Choice® retail pharmacy after the second fill.

OUTPATIENT PRESCRIPTION DRUG PROGRAM

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

Participating Retail Pharmacy/ CVS Caremark Specialty Pharmacy (short-term use)	**Maintenance Medications*: Participating Retail Pharmacy filled at non-Maintenance Choice® Retail after 2nd fill** (a maintenance medication* taken longer than 60 days for a long-term or chronic condition)	**Maintenance Medications*: CVS Caremark Mail Service/ Maintenance Choice®** (a maintenance medication* taken longer than 60 days for a long-term or chronic condition)
Generic **$5.00**	Generic **$10.00**	Generic **$10.00**
Preferred Brand **$20.00**	Preferred Brand **$40.00**	Preferred Brand **$25.00**
Non-Preferred Brand **$50.00**	Non-Preferred Brand **$100.00**	Non-Preferred Brand **$75.00**
Partial Waiver of Non-Preferred Brand copayment** **$40.00**	Partial Waiver of Non-Preferred Brand copayment** **$70.00**	Partial Waiver of Non-Preferred Brand copayment** **$70.00**
Discretionary Drugs 50%	Discretionary Drugs 50%	Discretionary Drugs 50%
Up to a 34-day supply	**Up to a 34-day supply**	**Up to a 90-day supply**
Out-of-Pocket Maximum, per person each calendar year: not applicable	**Out-of-Pocket Maximum, per person each calendar year: not applicable**	**Out-of-Pocket Maximum, per person each calendar year: $1,000** (excluding Non-Preferred Brand-Name Medication copayments, Discretionary Drug coinsurance, and "Member Pays the Difference" differential)

* A maintenance medication should not require frequent dosage adjustments, and is prescribed for a long-term or chronic condition, such as arthritis, diabetes, and high blood pressure or is otherwise prescribed for long-term use (as an example, birth control). Ask your physician if you will be taking a prescribed medication longer than 60 days. If you continue to refill a maintenance prescription at a non-Maintenance Choice® retail pharmacy after the second fill, you will be charged a higher copayment, which is the applicable Mail Service copayment described above. Please note that while medications can be filled at a retail pharmacy, long-term medications (medications taken for 60 days or more) will cost more if refilled at a retail pharmacy after the second fill. Members can refill the same medications by Mail Service or at a Maintenance Choice® retail pharmacy at a cost savings. Certain Specialty medications are available only through the CVS Caremark Specialty Pharmacy.

Examples of common long-term or chronic conditions:

Birth control
High blood pressure
High cholesterol
Diabetes

Examples of common short-term acute illnesses, injuries or conditions:

Influenza (the "Flu")
Pneumonia
Urinary tract infection

** To obtain a partial waiver to purchase a Non-Preferred brand-name drug at a reduced copayment, please refer to the Partial Waiver of Non-Preferred Brand Copayment process as outlined in the Prescription Drug Appeal Procedure on pages 50-51. To obtain a partial copayment waiver, your physician must document the necessity for the non-preferred product vs. the preferred product(s) and the available generic alternative(s).

OUTPATIENT PRESCRIPTION DRUG PROGRAM

The copayment applies to each prescription order and to each refill. The copayment is not reimbursable and cannot be used to satisfy any deductible requirement. (Under some circumstances your prescription may cost less than the actual copayment, and you will be charged the lesser amount.)

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

Although Generic Medications (defined on page 56) are not mandatory, the Plan encourages you to purchase generics whenever possible. Generic equivalent medications may differ in color, size, or shape, but the U.S. Food and Drug Administration (FDA) requires that they have the same quality, strength, purity and stability as the Brand-Name Medications (defined on page 55). Prescriptions filled with Generic equivalent medications have lower copayments and also help to manage the increasing cost of health care without compromising the quality of your pharmaceutical care.

Retail Pharmacy Program

Medication for a short duration, up to a 34-day supply, may be obtained from a Participating Pharmacy by using your PERSCare Supplemental Plan ID card.

While this program was designed primarily for use in California, there are many Participating Pharmacies outside California that will also accept your PERSCare Supplemental Plan ID card. At Participating Pharmacies, simply show your ID card and pay either a five dollar ($5.00) copayment for generic medications, a twenty dollar ($20.00) copayment for Preferred brand-name medications, or a fifty dollar ($50.00) copayment for Non-Preferred brand-name medications. Non-Preferred brand-name medications can be purchased for a forty dollar ($40.00) copayment with an approved partial copayment waiver (pages 50-51). If the pharmacy does not accept your ID card and is a Non-Participating Pharmacy (defined on page 57), there is additional cost to you.

If you refill a maintenance medication at a retail pharmacy after the second fill, you will be charged a higher copayment, which is the applicable Mail Service copayment described above under Copayment Structure.

To find a Participating Pharmacy close to you, simply visit the CVS Caremark Web site at www.caremark.com/calpers, or contact CVS Caremark Customer Care at 1-877-542-0284. If you want to utilize a Non-Participating Pharmacy, please follow the procedure for using a Non-Participating Pharmacy described below. For covered medications you take on a long-term basis (60 days or more), use CVS Caremark Mail Service, or a Maintenance Choice® retail pharmacy for a lower copayment. For more information on CVS Caremark Mail Service, see How To Use CVS Caremark Mail Service on pages 26-28, visit the CVS Caremark Web site at www.caremark.com/calpers, or call CVS Caremark Customer Care at 1-877-542-0284.

How To Use The Retail Pharmacy Program Nationwide

Participating Pharmacy

1. Take your prescription to any Participating Pharmacy. To locate a Participating Pharmacy near you, visit the CVS Caremark Web site at www.caremark.com/calpers or contact CVS Caremark Customer Care at 1-877-542-0284.

2. Present your PERSCare Supplemental Plan ID card to the pharmacist. The pharmacist will fill the prescription for up to a thirty-four (34) day supply of medication. Verify that the pharmacist has accurate information about you and your covered dependents, including date of birth and gender.

3. You will be required to pay the pharmacist your appropriate copayment for each prescription order or refill. You may be required to sign a receipt for your prescription at the pharmacy.

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

Non-Participating Pharmacy

If you fill medications at a Non-Participating Pharmacy, either inside or outside California, **you will be required to pay the full cost of the medication at the time of purchase.** To receive reimbursement, complete a CVS Caremark Prescription Reimbursement Claim Form and mail it to the address indicated on the form. **Claims must be submitted within twelve (12) months from the date of purchase to be covered. Any claim submitted outside the twelve (12) month time period will be denied.**

Payment will be made directly to you. It will be based on the amount that the Plan would reimburse a Participating Pharmacy minus the applicable copayment.

Example of Direct Reimbursement Claim for a Preferred Brand-Name Medication*

1.	Pharmacy charge to you (Retail Charge)	$ 48.00
2.	Minus CVS Caremark's Negotiated Network Amount on a Preferred Brand-Name Medication	($ 30.00)
3.	Amount you pay in excess of allowable amount due to using a Non-Participating Pharmacy or not using your ID Card at a Participating Pharmacy	$ 18.00
4.	Plus your copayment for a Preferred Brand-Name Medication	$ 20.00
5.	Your total out-of-pocket cost would be	$ 38.00

If you had used your ID Card at a Participating Pharmacy, the Pharmacy would only charge the Plan $30.00 for the drug, and your out-of-pocket cost would only have been the $20.00 copayment. Please note that if you paid a higher copayment after your second fill at retail for a maintenance medication, you will not be reimbursed for the higher amount.

As you can see, using a Non-Participating Pharmacy or not using your ID card at a Participating Pharmacy results in substantially more cost to you than using your ID card at a Participating Pharmacy. Under certain circumstances your copayment amount may be higher than the cost of the medication and no reimbursement would be allowed.

*Dollar amounts listed are for illustration only and will vary depending on your particular prescription.

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

Direct Reimbursement Claim Forms

To obtain a CVS Caremark Prescription Reimbursement Claim Form and information on Participating Pharmacies, visit the CVS Caremark Web site at www.caremark.com/calpers, or contact CVS Caremark Customer Care at 1-877-542-0284. You must sign any Prescription Reimbursement Claim Forms prior to submitting the form (and Prescription Reimbursement Claim Forms for Plan Members under age 18 must be signed by the Plan Member's parent or guardian).

Compound Medications

Compound medications, in which two or more ingredients are combined by the pharmacist, are covered by the Plan's Prescription Drug Program if at least one of the active ingredients requires: (a) a prescription; (b) is FDA-approved; and (c) is covered by CalPERS. Only products that are FDA-approved and commercially available will be considered Preferred for purposes of determining copay. The copay for a compounded medication is determined by the most expensive ingredient used for your compounded medication. There are three ways to obtain compounded medications through the Plan's Prescription Drug Program: (1) through CVS Caremark Mail Service; (2) through a Participating Retail Pharmacy; or (3) from a non-participating compounding pharmacy. The CVS Caremark Mail Service provides compounding services for many medications; however, CVS Caremark does not compound some medications. These compounds must be obtained through a Participating Retail Pharmacy or another compounding pharmacy. At a Non-Participating Pharmacy, you will be required to pay the full cost of the medications at the time of purchase, then submit a direct claim for reimbursement. To receive reimbursement, complete a CVS Caremark Prescription Reimbursement Claim Form and mail it to the address indicated on the form. An example showing how reimbursement will be determined can be found on page 25.

Mail Service Program

Maintenance medications for long-term or chronic conditions may be obtained by mail, for up to a ninety (90) day supply, through CVS Caremark's Mail Service Program. Mail Service offers additional savings, specialized clinical care and convenience if you need prescription medication on an ongoing basis. For example:

- **Additional Savings**: You can receive up to a **ninety (90) day supply** of medication for only ten dollars ($10.00) for each generic medication, forty dollars ($40.00) for each Preferred brand-name medication, one hundred dollars ($100.00) for each Non-Preferred brand-name medication, or seventy dollars ($70.00) for each Partial Waiver of Non-Preferred Brand Copayment. In addition to out-of-pocket cost savings, you save additional trips to the pharmacy.
- **Convenience:** Your medication is delivered to your home by mail.
- **Security:** You can receive up to a 90-day supply of medication at one time.
- **A toll-free customer service number:** Your questions can be answered by contacting a CVS Caremark Customer Care Representative at 1-877-542-0284.
- **Out-of-pocket maximum:** Your maximum calendar year copayment (per person) through the Mail Service Program is one thousand dollars ($1,000). Copayments for Non-Preferred Brand-Name Medications, Discretionary Drugs, and Member Pays the Difference Drugs do not apply to your out-of-pocket maximum.

How To Use CVS Caremark Mail Service

If you must take medication on an ongoing basis, CVS Caremark Mail Service is ideal for you. To use this program, just follow these steps:

1. Ask your physician to prescribe maintenance medications for up to a ninety (90) day supply (i.e., if once daily, quantity of 90; if twice daily, quantity of 180; if three times daily, quantity of 270, etc.), plus refills if appropriate.
2. Send the following to CVS Caremark in the pre-addressed Mail Service envelope:
    a. The original prescription order(s) – **Photocopies are not accepted**.
    b. A completed CVS Caremark Mail Service Order Form. The CVS Caremark Mail Service Order Form can be obtained by visiting the CVS Caremark Web site at www.caremark.com/calpers, or by contacting CVS Caremark Customer Care at 1-877-542-0284 and using the automated phone system or requesting to speak with a customer service representative.

c. A check or money order for an amount that covers your copayment for each prescription: $10 generic, $40 Preferred brand-name, $100 Non-Preferred brand-name or $70 Partial Waiver of Non-Preferred brand-name. Checks or money orders should be made payable to CVS Caremark. CVS Caremark also has a safe, convenient way for you to pay for your orders called Electronic Check Processing. Electronic Check Processing is an electronic funds transfer system that automatically deducts your copayment from your checking account. For more information or to enroll on-line, visit www.caremark.com/calpers or call Customer Care at 1-877-542-0284. If you prefer to pay for all of your orders by credit card, you may want to join CVS Caremark's automatic payment program. You can enroll by visiting the CVS Caremark Web site at www.caremark.com/calpers or by calling toll-free 1-877-542-0284.

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

   a. To fax prescriptions, your physician may call 1-800-378-5697 for faxing instructions. (CVS Caremark can only accept faxes from your physician.)

   b. To send prescriptions electronically, your physician may enter the prescription on an electronic handheld device or computer.

4. To order your Mail Service refill:

   a. Use CVS Caremark's Web site
   Visit **www.caremark.com/calpers**, your on-line prescription service, to order prescription refills or inquire about the status of your order. You will need to register on the site and log in. When you register you will need the cardholder's ID number which is located on the combined medical and prescription drug ID card.

   b. Call CVS Caremark's Automated Refill Phone System
   CVS Caremark's automated telephone service gives you a convenient way to refill your prescriptions at any time of the day or night. Call 1-877-542-0284 for CVS Caremark's fully automated refill phone service. When you call, be ready to provide the cardholder's ID number, Member's year of birth, and your credit card number along with the expiration date.

   c. Refill by Mail
   Order your refill three weeks in advance of your current prescription running out. Refill dates will be included on the prescription label you receive from CVS Caremark and the refill order forms that will be included with all prescriptions for which refills remain. Mark the appropriate box on the CVS Caremark Mail Service Order Form and mail it, along with your payment to CVS Caremark in the pre-addressed envelope included with your previous shipment.

How to submit a payment to CVS Caremark

You should always submit a payment to CVS Caremark when you order prescriptions through CVS Caremark Mail Service, just as if you were ordering a prescription from a retail pharmacy. CVS Caremark accepts the following as types of payment methods:

- Electronic Check
- Check/Money Order
- Credit Card/Debit Card - Visa®, MasterCard®, Discover®/NOVUS, American Express®
- BillMeLater® - (Visit www.caremark.com/calpers or call CVS Caremark Customer Care to find out if this option is available to you.) BillMeLater® is an easy way to pay in full or over time without using your credit card. BillMeLater® is subject to credit approval as determined by the lender, CIT Bank, Salt Lake City, Utah and is available to U.S. customers who are of legal age in their state of residence.

OUTPATIENT PRESCRIPTION DRUG PROGRAM

CVS Caremark recommends placing a credit card on file if you will be ordering ongoing prescriptions through CVS Caremark Mail Service. A credit card can be placed on your account by logging in to your account at www.caremark.com/calpers, calling Customer Care or filling out the credit card information on CVS Caremark Mail Service Order Form when you mail in your prescription order. If "Default Payment Method" is selected during order, your chosen payment method will automatically be charged every time that a new prescription or refill is ordered.

If you have questions regarding CVS Caremark Mail Service or to find out if your medication is on CVS Caremark's Preferred Drug List, visit the CVS Caremark Web site at www.caremark.com/calpers, or contact CVS Caremark Customer Care at 1-877-542-0284. All prescriptions received through Mail Service will be filled with an FDA-approved bioequivalent generic substitute if one exists.

Getting Your Prescriptions Covered By Medicare Part B

Certain medications and supplies (such as diabetes supplies – test strips, meters, syringes) are covered by Medicare Part B. These prescriptions can be filled through a Medicare Part B mail-order pharmacy or at a participating Medicare Part B retail pharmacy. The pharmacy will verify coverage, file your prescription claims with Medicare, and submit your claims to your secondary insurer for coverage by PERS Select, PERS Choice or PERSCare.

Mail-order pharmacy: Send your prescriptions to CVS Caremark Mail Service. Depending on the prescription submitted, your prescription will be billed to Medicare Part B for primary payment if appropriate. Your medications and supplies will be sent directly to you.

The Medicare Part B participating mail-order pharmacies may require you or your physician to provide additional information on your first fill prior to being able to file your claims through Medicare. If this information is not provided within a timely manner, your prescription may be transferred back to CVS Caremark Mail Service and you may be charged the applicable co-payment for your prescription.

Retail pharmacy: Present your Medicare ID card with your prescriptions. Most independent pharmacies and national chains participate in Medicare Part B. Call Medicare Customer Service at **1-800-633-4227** or visit the Medicare website a **www.medicare.gov/supplier/home.asp** to locate a retail pharmacy near that is a Medicare Part B participating provider.

PRESCRIPTION DRUG COVERAGE MANAGEMENT PROGRAMS

Coverage Management Programs

The Plan's Prescription Drug Coverage Management Programs include a Prior Authorization/Point of Sale Utilization Review Program. Additional programs may be added at the discretion of the Plan.

The Plan may implement additional new programs designed to ensure that medications dispensed to its Members are covered under this Plan. **As new drugs are developed, including generic versions of brand-name drugs, or when drugs receive FDA approval for new or alternative uses, the Plan reserves the right to review the coverage of those drugs or class of drugs under the Plan. The Plan reserves the right to exclude, discontinue or limit coverage of those drugs or class of drugs following such review. Any benefit payments made for a prescription medication shall not invalidate the Plan's right to make a determination to exclude, discontinue or limit coverage of that medication at a later date. The Plan reserves the right to implement programs that allow for Medicare-eligible prescription claims to be filed with Medicare for payment. The Plan may be the secondary payor of these claims.**

The purpose of the Prescription Drug Coverage Management Programs, which are administered by CVS Caremark in accordance with the Plan, is to ensure that certain medications are covered in accordance with specific Plan coverage rules.

Prior Authorization/Point of Sale Utilization Review Program

If your prescription requires a Prior Authorization, the dispensing pharmacist is notified by an automated message before the drug is dispensed. **The dispensing pharmacist may receive a message such as "Plan Limits Exceeded" or "Prior Authorization Required" depending on the drug category.** Your physician should contact CVS Caremark to initiate a coverage review and determine if the prescribed medication meets the Plan's approved coverage rules. Approvals for prior authorizations are typically granted for one year; however, the time frame may be greater or less than one year depending on the drug. This process is usually completed within forty-eight (48) hours. You and your prescriber will receive notification from CVS Caremark of the Prior Authorization outcome. Some drugs that require prior authorization may be subject to a quantity limitation that may differ from the 30-day supply. For example, coverage for erectile dysfunction therapy is allowed for up to eight (8) treatments, doses or units per 30 days.

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

CVS Caremark's Specialty Pharmacy Services

CVS Caremark's Specialty Pharmacy offers convenient access and delivery of specialty medications (as defined in this EOC), many of which are injectable, as well as personalized service and educational support. A CVS Caremark patient care representative will be your primary contact for ongoing delivery needs, questions, and support.

To obtain specialty medications, you or your physician should call 1-800-237-2767. CVS Caremark's Specialty Pharmacy hours of operation are 4:30 AM to 6 PM PST, Monday through Friday; however, pharmacists are available for clinical consultation 24 hours a day, 7 days a week.

Please contact CVS Caremark's Specialty Pharmacy at 1-800-237-2767 for specific coverage information.

Specialty medications will be limited to a maximum thirty (30) day supply.

OUTPATIENT PRESCRIPTION DRUG EXCLUSIONS

The following are excluded under the Outpatient Prescription Drug Program:

1. Drugs not approved by the U.S. Food and Drug Administration (FDA).*
2. Drugs or medicines obtainable without a licensed prescriber's prescription, often called over-the-counter (OTC) drugs or behind-the counter (BTC) drugs, except insulin, diabetic test strips and lancets, and Plan B.
3. Contraceptives, such as, diaphragms, injectable drugs, Intrauterine devices, time-released subdermal implants (e.g., Implanon), are not covered under the Prescription Drug Program, however, they may be considered for coverage through the medical benefit.
4. Dietary and herbal supplements, minerals, health aids, homeopathics, any product containing a medical food, and any vitamins whether available over the counter or by prescription (e.g., prenatal vitamins, multi-vitamins, and pediatric vitamins), except prescriptions for single agent vitamin D, vitamin K and folic acid.
5. A prescription drug that has an over-the-counter alternative.
6. Anorexiants and appetite suppressants or any other anti-obesity drugs.
7. Supplemental fluorides (e.g., infant drops, chewable tablets, gels and rinses).
8. Charges for the purchase of blood or blood plasma.
9. Hypodermic needles and syringes, except as required for the administration of a covered drug.
10. Non-medical therapeutic devices, durable medical equipment, appliances and supplies, including support garments, even if prescribed by a physician, regardless of their intended use. *
11. Drugs which are primarily used for cosmetic purposes rather than for physical function or control of organic disease.
12. Drugs labeled "Caution – Limited By Federal Law to Investigational Use" or non-FDA approved Investigational Drugs. Any drug or medication prescribed for experimental indications.
13. Any drugs prescribed solely for the treatment of an illness, injury or condition that is excluded under the Plan.
14. Any drugs or medications which are not legally available for sale within the United States.
15. Any charges for injectable immunization agents, desensitization products or allergy serum, or biological sera, including the administration thereof. *
16. Professional charges for the administration of prescription drugs or injectable insulin. *
17. Drugs or medicines, in whole or in part, to be taken by, or administered to, a Plan Member while confined in a hospital or skilled nursing facility, rest home, sanatorium, convalescent hospital or similar facility. *
18. Drugs and medications dispensed or administered in an outpatient setting (e.g., injectable medications), including, but not limited to, outpatient hospital facilities, and services in the Member's home provided by Home Health Agencies and Home Infusion Therapy Providers. *
19. Medication for which the cost is recoverable under any workers' compensation or occupational disease law, or any state or governmental agency, or any other third-party payer; or medication furnished by any other drug or medical services for which no charge is made to the Plan Member.
20. Any quantity of dispensed drugs or medicines which exceeds a thirty-four (34) day supply at any one time, unless obtained through CVS Caremark Mail Service or the Maintenance Choice® program. Prescriptions filled using CVS Caremark Mail Service or the Maintenance Choice® program are limited to a maximum ninety (90) day supply of covered drugs or medicines as prescribed by a licensed prescriber.

OUTPATIENT PRESCRIPTION DRUG EXCLUSIONS

21. Refills of any prescription in excess of the number of refills specified by a licensed prescriber.

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

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

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

25. Compounded medications if: (1) there is a medically appropriate Formulary alternative, or (2) the compounded medication contains any ingredient not approved by the FDA. Compounded medications that do not include at least one Prescription Drug, as defined on page 59, are not covered.

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

*Drugs awarded DESI (Drug Efficacy Study Implementation) Status by the FDA were approved between 1938 and 1962 when drugs were reviewed on the basis of safety alone; efficacy (effectiveness) was not evaluated. The FDA allows theses products to continue to be marketed until evaluations of their effectiveness have been completed. DESI drugs may continue to be covered under the CalPERS outpatient pharmacy benefit until the FDA has ruled on the approval application.

Services Covered By Other Benefits

When the expense incurred for a service or supply is covered under another benefit section of the Plan, it is not a Covered Expense under the Outpatient Prescription Drug Program benefit.

BENEFIT LIMITATIONS, EXCEPTIONS AND EXCLUSIONS

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.

* 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 56, 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 which are not derived from a primary psychiatric or psychological diagnosis or condition.

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. **Psychiatric or Psychological Care.**

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

        1. personality disorders;
        2. sexual deviations and disorders;
        3. abuse of drugs;
        4. conduct disorders;
        5. mental retardation and developmental delays;
        6. conditions of abnormal behavior which are not directly attributable to a mental disorder which is the focus of attention or treatment;
        7. attention deficit disorders.

    b. Telephone consultations.

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

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

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

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

18. **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.

19. **Self-injectable drugs.** Injectable drugs which are self-administered by the subcutaneous route (under the skin) by the patient or family member. Drugs with Food and Drug Administration (FDA) labeling for self-administration. Hypodermic syringes and/or needles when dispensed for use with self-injectable drugs or medications. Self-injectable drugs are covered under your Outpatient Prescription Drug Program.

20. **Substance Abuse.** Charges incurred for treatment relating to substance abuse, including addiction to or dependency on tobacco or nicotine.

21. **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.

22. **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.

23. **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.

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

25. **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.

BENEFIT LIMITATIONS, EXCEPTIONS AND EXCLUSIONS

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 dependant upon your employer's participation in the CalPERS Health Benefits Program. If an employer terminates participation in the CalPERS Health Benefits Program, an active or retired employee currently enrolled in COBRA or CalCOBRA will have the option to convert to an individual plan (see Individual Conversion Plan on pages 38-39) or may choose to continue coverage under COBRA or CalCOBRA with the group health plan providing health care coverage to the employer. A participant in COBRA or CalCOBRA may not continue coverage under 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. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage entirely.

Consolidated Omnibus Budget Reconciliation Act (COBRA)

The Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation of group coverage is provided through federal legislation and allows an enrolled active or retired employee or his or her enrolled family members who lose their regular group coverage because of certain qualifying events to elect continuation of coverage for eighteen (18), twenty-nine (29), or thirty-six (36) months.

An eligible active or retired employee or his or her family member(s) is entitled to elect this coverage provided an election is made within sixty (60) days of notification of eligibility and the required premiums are paid. The benefits of the continuation of coverage are identical to the group Plan, and the cost of coverage may not exceed one hundred and two percent (102%) of the applicable group premiums rate, except for the employee or enrolled family member who is eligible to continue group coverage to twenty-nine (29) months because of entitlement to Social Security disability benefits. In this case, the cost of coverage for months nineteen (19) through twenty-nine (29) shall not exceed one hundred and fifty percent (150%) of the applicable group premiums rate. No employer contribution is available to cover the premiums.

Qualifying Events

Two qualifying events allow employees to request the continuation of coverage for eighteen (18) months: (This coverage may be continued for up to twenty-nine (29) months for an employee that is federally recognized disabled.)

1. the covered employee's separation from employment (other than by reason of gross misconduct);

2. reduction in the covered employee's work hours to less than half-time (or a permanent intermittent employee not working the required hours during a control period).

The following five qualifying events allow enrolled family member(s) to elect the continuation of coverage for up to thirty-six (36) months:

1. the active employee's or retired employee's death (and the surviving family member is not eligible for a monthly survivor allowance from CalPERS);

2. the divorce or legal separation of the covered spouse from the active employee or retired employee;

3. the termination of a domestic partnership, defined in Government Code Section 22771;

4. the primary COBRA subscriber becomes entitled to Medicare;

5. a dependent child ceases to be a dependent child.

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

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. A Plan Member whose continuation of group coverage is terminated or expires under the group continuation plan may be eligible to enroll in an individual conversion plan described below.

Individual Conversion Plan

Regardless of age, physical condition or employment status, you and your enrolled dependents may transfer to an individual conversion plan being issued by Anthem Blue Cross at the time enrollment is terminated, other than by voluntary cancellation or failure to continue enrollment or to make contributions while in a non-pay status. The individual conversion plan will also be available to a Plan Member whose continuation of group coverage expires under the group continuation plan. The group continuation plan under COBRA or CalCOBRA must have been elected and exhausted in order for the Plan Member to continue coverage under the Individual Conversion Plan.

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

Applications for the conversion plan must be received by Anthem Blue Cross within sixty-three (63) days from the date coverage under the PERSCare Supplemental Plan is terminated.

To request an application, write to:

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

CONTINUATION OF COVERAGE

Benefits and rates of individual conversion plans will be different from those provided under the PERSCare Supplemental Plan, and the premiums will usually be greater than the PERSCare Supplemental Plan's.

An individual conversion plan is also available to:

- Family members in the event of the employee's death;
- Children upon marrying or attaining age twenty-six (26) while enrolled under the PERSCare Supplemental Plan;
- Family members of a subscriber who enters military service;
- The spouse of a Plan Member whose marriage has terminated
- The domestic partner of a subscriber whose domestic partnership has been terminated.

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

Benefits After Termination

1. In the event the Plan is terminated by the 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.

    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

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 Amount.

This Coordination of Benefits section will apply only to Benefits Beyond Medicare and Vision Care Benefits. This Coordination of Benefits section will NOT apply to the Outpatient Prescription Drug Program. For the Outpatient Prescription Drug Program, refer to the Prescription Drug Coverage Management Programs section on page 29.

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

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

Effect on Benefits

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

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

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

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

1. Assigns to this Plan the right to receive benefits from the other plan to the extent that this Plan would have been obligated to pay as secondary carrier, **and**

2. Agrees to cooperate fully in obtaining payment of benefits from the other plan, **and**

3. Allows Anthem Blue Cross to obtain confirmation from the other plan that the benefits claimed have not previously been paid.

Order of Benefits Determination

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

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

2. When a plan covers a dependent child whose parents are not separated or divorced, and each parent has a group plan which covers the dependent child, the plan of the parent whose birth date (excluding year of birth) occurs earlier in the calendar year shall be primary carrier. If either plan does not have the birthday rule provision of this paragraph regarding dependent children, primary carrier shall be determined by the plan that does not include this provision.

3. When a claim involves expenses for a dependent child whose parents are separated or divorced, plans covering the child as a dependent will determine their respective benefits in the following order:

    a. the plan of the parent with custody of the child;

    b. if the custodial parent has remarried, the plan of the stepparent married to the parent with custody of the child;

    c. the plan of the noncustodial parent 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 APPEAL PROCEDURE

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

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

The following procedures shall be used to resolve any dispute which results from any act, error, or omission with respect to any **medical claim** filed by or on behalf of a Plan Member. (See Utilization Review Appeal Procedure on pages 47-49 for procedures used to resolve any dispute which results from a medical necessity determination by Anthem Blue Cross' Review Center.)

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

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 the Plan Member 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 may 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 Under Your Benefits Beyond Medicare or Vision Care Benefits

1. **Notice of Claim Denial**

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

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

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

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

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

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

MEDICAL CLAIMS APPEAL PROCEDURE

4. Request for Reconsideration

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

5. Request for Administrative Review

If the Plan Member is not satisfied with the response to the Request for Reconsideration, he or she may request a final administrative determination from CalPERS within thirty (30) days using the procedure set forth on pages 52-53.

UTILIZATION REVIEW APPEAL PROCEDURE

This appeal procedure applies only to utilization review conducted for this Plan's Benefits Beyond Medicare (see pages 12-16). You may appeal any Medicare determination with Medicare. Your appeal rights are detailed on the back of the Medicare Summary Notice form that is mailed to you.

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

1. Before services are rendered (prospective utilization review); or
2. During the rendering of services (concurrent utilization review); or
3. After services are rendered (retrospective utilization review).

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

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

Prospective and Concurrent Utilization Review Determinations

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

Step 1: Reconsideration

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

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

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

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

Reconsideration will be handled in the following manner:

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

Step 2: Appeals

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

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

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

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

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

The review will be handled in the following manner:

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

Retrospective Utilization Review Determinations

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

Step 1: Reconsideration

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

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

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

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

The review will be handled in the following manner:

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

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

Step 2: Appeals

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

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

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

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

The review will be handled in the following manner:

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

Request for Administrative Review

Following a prospective, concurrent, or retrospective utilization review determination regarding pre-certification, if the Plan Member contests the Review Center's reconsideration determination after pursuing the matter through the Review Center's Appeal procedure, the Plan Member may request a final administrative determination from CalPERS within thirty (30) days using the procedure found on pages 52-53 of this Evidence of Coverage booklet.

Objection to Denial of Experimental or Investigative Treatment

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

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

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

PRESCRIPTION DRUG APPEAL PROCEDURE

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

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

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

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

If you are dissatisfied with the second level determination made by CVS Caremark, you may request a final administrative review from CalPERS within thirty (30) days of receipt of your appeal denial letter by following the procedure set forth in the CalPERS Final Administrative Determination Procedure section on pages 52-53.

2. Partial Waiver of Non-Preferred Brand Copayment

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

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

Submit your request for a partial waiver to:

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

CVS Caremark's coverage management staff will carefully review your waiver request, and you will be notified in writing of the outcome of your first level appeal. If the partial waiver request is approved, the Non-Preferred brand-name medication copayment will be partially waived, and you will be charged the Partial Waiver of Non-Preferred brand-name medication copayment for that specific Non-Preferred product for one year from the date of approval (see chart on page 23). If you wish to continue to receive the partial waiver at the end of the one year approval period, you will need to make a new request using the process noted above. To avoid paying an increased copayment, it is suggested that you submit your new request 30 days prior to the expiration of the previous approval.

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

If you are dissatisfied with the determination made by CVS Caremark after a second level appeal, you may request a final administrative review from CalPERS within thirty (30) days of receipt of your appeal denial letter using the procedure set forth in the CalPERS Final Administrative Determination Procedure section on pages 52-53.

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

3. Member Pays the Difference

The Member may request an authorization to obtain the brand name product, when medically necessary. See the section Prior Authorization/Point of Sale Utilization Review Program on page 29 on how to get an authorization.

4. All Denials of Direct Reimbursement Claims

Some direct reimbursement claims for prescription drugs are not payable when first submitted to CVS Caremark. If CVS Caremark determines that a claim is not payable in accordance with the terms of the Plan, CVS Caremark will notify the Plan Member in writing explaining the reason(s) for nonpayment.

If the claim has erroneous or missing data that may be needed to properly process the claim, the Member may be asked to resubmit the claim with complete information to CVS Caremark. If after resubmission, the claim is determined to be payable in whole or in part, CVS Caremark will take necessary action to pay the claim according to established procedures. If the claim is still determined to be not payable in whole or in part after resubmission, CVS Caremark will inform the Plan Member in writing of the reason(s) for denial of the claim.

If you are dissatisfied with the second level determination made by CVS Caremark, you may request a final administrative review from CalPERS within thirty (30) days of your receipt of the denial letter using the procedure set forth in the CalPERS Final Administrative Determination Procedure section on pages 52-53.

CalPERS FINAL ADMINISTRATIVE DETERMINATION PROCEDURE

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

The appeal must be mailed to:

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

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

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

-- Failure to properly pay incurred expenses.

-- Denial of approval for covered services.

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

-- Medical malpractice.

-- General exclusions listed on pages 32-35.

If CalPERS accepts the appeal, the following procedures apply.

1. Administrative Review

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

2. Administrative Hearing

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

3. Appeal Beyond Administrative Determination Procedure

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

CalPERS FINAL ADMINISTRATIVE DETERMINATION PROCEDURE

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

Summary of Process and Rights of Plan Members

- **Right to records, generally.** The Plan Member may, at his or her own expense, obtain copies of all non-medical and non-privileged medical records from the administrator and/or CalPERS, as applicable.

- **Records subject to attorney-client privilege.** Communication between an attorney and a client, whether oral or in writing, will not be disclosed under any circumstances.

- **Attorney Representation.** At any stage of the appeal proceedings, the Plan Member may be represented by an attorney. If the Member chooses to be represented by an attorney, the Member must do so at his or her own expense. Neither CalPERS nor the administrator will provide an attorney or reimburse the Member for the cost of an attorney even if the Member prevails on appeal.

- **Right to experts and consultants.** At any stage of the proceedings, the Plan Member may present information through the opinion of an expert, such as a physician. If the Member chooses to retain an expert to assist in presentation of a claim, it must be at the Member's own expense. Neither CalPERS nor the administrator will reimburse the Member for the costs of experts, consultants or evaluations.

Service of Legal Process

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

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

MONTHLY RATES

Type of Enrollment	Enrollment Code	Cost
Insured Only	2791	$432.43
Insured and One Dependent	2792	$864.86
Insured and Two or More Dependents	2793	$1,297.29

State Employees and Annuitants. The rates shown above are effective January 1, 2012, and will be reduced by the amount the State of California contributes toward the cost of your health benefits plan. These contribution amounts are subject to change. Any such change will be accomplished by the State Controller or affected retirement system without action on your part. For current contract information, contact the Health Benefits Officer at your employing agency or retirement system.

Public Agency Employees and Annuitants. The rates shown above are effective January 1, 2012, and will be reduced by the amount your public agency contributes toward the cost of your health benefits plan. This amount varies among public agencies. For assistance in calculating your net cost, contact 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

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

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 the Act and Regulations.

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

Appeal – refers to the Member's right to request review of decisions relating to the Member's rights under the Plan. The term includes all of the following: the internal review by Anthem Blue Cross and the Pharmacy Benefit Administrator, sometimes referred to as a Plan grievance procedure; the Plan's final administrative review by CalPERS; the fair hearing accorded by statute; and any administrative and judicial review thereof.

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

Behind the Counter Drugs (BTC) — a drug product that does not require a prescription under federal or state law and is available to members only through facilitation of the pharmacist or pharmacy staff. The PERSCare Supplemental Plan outpatient prescription drug program does not cover BTC products.

Billed Charges – the amount the provider actually charges for services provided to a Member.

Board – the Board of Administration of the California Public Employees' Retirement System (CalPERS).

Brand–Name Medication (Brand-Name Drug) – a drug which is under patent by its original innovator or marketer. The patent protects the drug from competition from other drug companies.

Calendar Year – a period commencing at 12:01 a.m. on January 1 and terminating at 12 midnight Pacific Standard Time on December 31 of the same year.

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, 2012, through December 31, 2012.

DEFINITIONS

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.

Disability – an injury, an illness (including any mental disorder), or a condition (including pregnancy); however,

1. all injuries sustained in any one accident will be considered one disability;

2. all illnesses existing simultaneously which are due to the same or related causes will be considered one disability;

3. if any illness is due to causes which are the same as or related to the causes of any prior illness, the succeeding illness will be considered a continuation of the previous disability and not a separate disability.

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

Drug – see definition under Prescription Drugs on page 59.

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

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

Experimental or Investigational – any treatment, therapy, procedure, drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supplies which are not recognized in accordance with generally accepted professional medical standards as being safe and effective for use in the treatment of an illness, injury, or condition at issue. Additionally, any services that require approval by the federal government or any agency thereof, or by any state governmental agency, prior to use, and where such approval has not been granted at the time the services were rendered, shall be considered experimental or investigational. Any services that are not approved or recognized 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 – an employee's or annuitant's spouse or domestic partner, and any child including an adopted child, a stepchild, or recognized natural child.

FDA – U.S. Food and Drug Administration.

Generic Medication (Generic Drug) – a Prescription Drug manufactured and distributed after the patent of the original Brand-Name Medication has expired. The generic drug must have the same active ingredient, strength and dosage form as its Brand-Name Medication counterpart. A generic drug costs less than a Brand-Name Medication.

Health Professional – dentist; optometrist; podiatrist or chiropodist; clinical psychologist; chiropractor; acupuncturist; clinical social worker; marriage, family and child counselor; physical therapist; speech pathologist; audiologist; licensed occupational therapist; physician assistant; registered nurse; registered dietitian 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.

Incentive Copayment Structure – Members may receive any covered drug with copayment differentials between a generic medication, Preferred brand-name medication, and Non-Preferred brand-name medication.

DEFINITIONS

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

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

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

Maintenance Medications – Drugs that do not require frequent dosage adjustments, which are usually prescribed for long-term use, such as birth control, or for a chronic condition, such as arthritis, diabetes, or high blood pressure. These drugs are usually taken longer than sixty (60) days.

Medically Necessary – 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.

Medication – see Prescription Drugs

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

Negotiated Network Amount — the rate that the Prescription Drug benefit administrator has negotiated with Participating Pharmacies under a Participating Pharmacy Agreement for Prescription Drug covered expense. Participating Pharmacies have agreed to charge Members presenting their ID card no more than the negotiated network amount. It is also the rate which the Prescription Drug benefit administrator's Mail Service Program has agreed to accept as payment in full for Mail Service Prescription Drugs. In addition, if medications are purchased at a Non-Participating Pharmacy, it is the maximum allowable amount for reimbursement.

Non-Participating Pharmacy — a pharmacy which has not agreed to CVS Caremark's terms and conditions as a Participating Pharmacy. Members may visit the CVS Caremark Web site at www.caremark.com/calpers or contact CVS Caremark's Customer Care at 1-877-542-0284 to locate a Participating Pharmacy.

Non-Preferred Brand-Name Medication — Medications not listed on your printed CVS Caremark Preferred Drug List. If you would like to request a copy of CVS Caremark's Preferred Drug List, please visit the CVS Caremark Web site at www.caremark.com/calpers, or contact CVS Caremark Customer Care at 1-877-542-0284. Medications that are recognized as non-preferred and that are covered under your Plan will require the highest (third tier) copayment.

DEFINITIONS

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 (e.g. an individual physician) who bills Anthem Blue Cross using the code for a Non-Preferred Provider (e.g. medical group) for a service rendered on a specific date shall be considered a Non-Preferred Provider for that service on that date. An individual Preferred Provider may be considered a Non-Preferred Provider if services are rendered outside the geographic area specified in the Prudent Buyer Plan Participating Provider Agreement.

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

Over-the-Counter Drugs (OTC) – a drug product that does not require a prescription under federal or state law. The PERSCare Supplemental Plan's outpatient prescription drug program does not cover OTC products, with the exception of insulin.

Participating Pharmacy — a pharmacy which is under an agreement with CVS Caremark to provide prescription drug services to Plan Members. Members may visit the CVS Caremark Web site at www.caremark.com/calpers or contact CVS Caremark Customer Care at 1-877-542-0284 to locate a Participating Pharmacy.

Pharmacy – a licensed facility for the purpose of dispensing prescription medications.

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). The PERSCare Supplemental Plan is a self-funded health plan established and administered by CalPERS (the plan administrator and insurer) through contracts with third-party administrators: Anthem Blue Cross and CVS Caremark.

Plan Member – any employee, annuitant, or family member enrolled in 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 Brand-Name Medication — A medication found on CVS Caremark's Preferred Drug List and evaluated based on the following criteria: safety, side effects, drug-to-drug interactions, and cost effectiveness. If you would like to request a copy of CVS Caremark's Preferred Drug List, please visit CVS Caremark's Web site at www.caremark.com/calpers or contact CVS Caremark Customer Care at 1-877-542-0284.

Preferred Drug List — A list of medications that are more cost effective and offer equal or greater therapeutic value than the other medications in the same drug category. CVS Caremark and its Therapeutics Committee conducts a rigorous clinical analysis to evaluate and select each Preferred Drug List medication for safety, side effects, drug-to-drug interactions and cost effectiveness. The preferred product must (1) meet participant's treatment needs, (2) be clinically safe relative to other drugs with the same indication(s) and therapeutic action(s), (3) be effective for FDA approved indications, (4) have therapeutic merit compared to other effective drug therapies, and (5) promote appropriate drug use.

DEFINITIONS

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 in the geographic area set forth in the Prudent Buyer Participating Provider Agreement, and bills Anthem Blue Cross 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.

Prescriber (licensed prescriber) — a licensed health care provider with the authority to prescribe medication.

Prescription – a written order issued by a licensed prescriber for the purpose of dispensing a Drug.

Prescription Drugs (Drug) – a medication or drug that is (1) a prescribed drug approved by the U.S. Food and Drug Administration for general use by the public; (2) all drugs which under federal or state law require the written prescription of a licensed prescriber; (3) insulin; (4) hypodermic needles and syringes if prescribed by a licensed prescriber for use with a covered drug; (5) glucose test strips; and (6) such other drugs and items, if any, not set forth as an exclusion.

Prescription Order – the request for each separate drug or medication by a licensed prescriber and each authorized refill of such request.

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.

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.

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

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

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.

Specialty Drugs – drugs that have one or more of the following characteristics: (1) therapy of chronic or complex disease; (2) specialized patient training and coordination of care (services, supplies, or devices) required prior to therapy initiation and/or during therapy; (3) unique patient compliance and safety monitoring requirements; (4) unique requirements for handling, shipping and storage; or (5) potential for significant waste due to the high cost of the drug.

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.

DEFINITIONS

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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Health Plan Administration Division
Self-Funded Health Plans
California Public Employees' Retirement System
PER-0112-SP1