CalPERS PERS Select Basic Plan

Coverage Period: 01/01/2014 – 12/31/2014

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Individual + Spouse, Family|**Plan Type**: PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.anthem.com/ca/calpers or by calling 1-877-737-7776.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$500 person/ $1,000 family** Doesn't apply to preventive care, office visits	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered service you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible.**
Are there other deductibles for specific services?	**Yes, $50** for each emergency room visit.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. For participating providers **$3,000 person / $6,000 family.** No out-of-pocket limit with non participating providers.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services with participating providers. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for specific coverage limits, such as limits on the number of office visits.
Does this plan use a network of providers?	Yes. See www.anthem.com/ca/calpers for a list of participating providers.	If you use an in-network doctor of other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, our in-network doctor of hospital may use an out-of-network **provider** for some services. Plan use the term in-network, **preferred**, or participating for **providers** in their **network.** See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 8. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-877-737-7776 or visit us at www.anthem.com/ca/calpers

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.anthem.com/ca/calpers or call 1-877-737-7776 to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use PPO **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit	40% coinsurance of allowed amount	----------none----------
	Specialist visit	$20 copay/visit	40% coinsurance of allowed amount	----------none----------
	Other practitioner office visit	20% coinsurance for chiropractor, acupuncture, behavioral health and physical therapy.	40% coinsurance of allowed amount	Acupuncture and Chiropractic services limited to 15 combined visits per calendar year
	Preventive care/screening/immunization	No charge	40% coinsurance of allowed amount	----------none----------
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance of allowed amount	----------none----------
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance of allowed amount	Pre-authorization required

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com/calpers	Generic drugs	**$5** 30 day supply **$10** 90 day supply	100% Out of Pocket	After second fill you will pay the appropriate mail service copay for maintenance medications. 90 days supplies allowed at CVS Stores and CVS Caremark Mail Order
	Preferred brand drugs	**$20** 30 day supply **$40** 90 day supply	100% Out of Pocket	After second fill you will pay the appropriate mail service copay for maintenance medications. 90 days supplies allowed at CVS Stores and CVS Caremark Mail Order
	Non-preferred brand drugs	**$50** 30 day supply **$100** 90 day supply	100% Out of Pocket	After second fill you will pay the appropriate mail service copay for maintenance medications. 90 days supplies allowed at CVS Stores and CVS Caremark Mail Order
	Specialty drugs	Specialty follows the tier structure above	100% Out of Pocket	Specialty medication must be dispensed through CVS Caremark Specialty Pharmacy. All orders are dispensed 30 day supplies except RA/MS medication.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
			**Submit a paper claim for reimbursement of the contracted amount minus your copay. You could have out of pocket costs with this option due to the difference between the billed amount and the contract rate.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center ASC)	20% coinsurance	40% coinsurance of allowed amount	Services and supplies for the following outpatient surgeries are limited: colonoscopy limited to $1,500 per procedure; cataract surgery limited to $2,000 per procedure; arthroscopy limited to $6,000 per procedure. Benefits limited to $350 for ASC per day for Non-PPO providers.
	Physician/surgeon fees	20% coinsurance	40% coinsurance of allowed amount	----------none----------

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	20% coinsurance	20% coinsurance of allowed amount	----------none----------
	Emergency medical transportation	20% coinsurance	20% coinsurance of allowed amount	----------none----------
	Urgent care	$20 copayment	40% coinsurance of allowed amount	----------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance/ tier 1 hospital 30% coinsurance/tier 2 hospital	40% coinsurance of allowed amount	Hip and Knee joint replacement surgery will be limited to $30,000 per procedure. A subset of participating hospitals meets this maximum benefit coverage. Pre-authorization required
	Physician/surgeon fee	20% coinsurance	40% coinsurance of allowed amount	----------none----------

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% coinsurance	40% coinsurance of allowed amount	----------none----------
	Mental/Behavioral health inpatient services	20% coinsurance	40% coinsurance of allowed amount	Pre-authorization required
	Substance use disorder outpatient services	20% coinsurance	40% coinsurance of allowed amount	----------none----------
	Substance use disorder inpatient services	20% coinsurance	40% coinsurance of allowed amount	Pre-authorization required
If you are pregnant	Prenatal and postnatal care	20% coinsurance	40% coinsurance of allowed amount	----------none----------
	Delivery and all inpatient services	20% coinsurance	40% coinsurance of allowed amount	----------none----------

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance of allowed amount	Up to 45 visits per calendar year Pre-authorization required
	Rehabilitation services	20% coinsurance	40% coinsurance of allowed amount	Limit of combined 24 visits per calendar year for physical and occupational therapy. Up to $1,500. per calendar year coverage for outpatient pulmonary rehabilitation. Up to 40 visits per calendar year coverage for outpatient cardiac rehabilitation.
	Habilitation services	20% coinsurance	40% coinsurance of allowed amount	All rehabilitation and habilitation visits count toward your rehabilitation visit limit.
	Skilled nursing care	20% coinsurance for the first 10 days/30% coinsurance for the next 90 days	40% coinsurance of allowed amount	Maximum 100 days per calendar year Pre-authorization required
	Durable medical equipment	20% coinsurance	40% coinsurance of allowed amount	----------none----------
	Hospice service	20% coinsurance	40% coinsurance of allowed amount	----------none----------
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	----------none----------
	Glasses	Not Covered	Not Covered	----------none----------
	Dental check-up	Not Covered	Not Covered	----------none----------

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery
- Dental care (adult)
- Infertility treatment
- Long-term care
- Personal development programs
- Private-duty nursing
- Routine eye care (adult)
- Routine foot care

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids
- Most coverage provided outside the United States.

Your Rights to Continue Coverage:

"If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan,. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-877-737-7776. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov."

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, considered an Adverse Benefit Determination (ABD) you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

Anthem Blue Cross

Attention: Grievances and Appeals

P.O. Box 60007

Los Angeles, CA 90060-0007

Telephone: 1-877-737-7776

If Anthem Blue Cross upholds the ABD, that decision becomes a Final Adverse Benefit Determination (FABD) and you may request an independent External Review.

If you are not satisfied with Anthem Blue Cross' FABD, the independent External Review decision or you do not want to pursue the independent External Review Process, you may request an Administrative Review from CalPERS. The request must be mailed to:

CalPERS Health Plan Administration Division

Appeals Coordinator

P.O. Box 1953

Sacramento, CA 95812-1953

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-877-737-7776

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-737-7776

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码**1-877-737-7776

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $4,370
- **Patient pays** $3,170

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$500
Copays	$0
Coinsurance	$2,500
Limits or exclusions	$170
Total	**$3,170**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $430
- **Patient pays** $4,970

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$500
Copays	0
Coinsurance	$540
Limits or exclusions	$2,930
Total	**$4,970**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.